Home and Community Care National Service Standards: Comparison with the Disability Service Standards, Community Health Accreditation and Standards Program, and the Australian Council of Healthcare Standards

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Contents

1. INTRODUCTION

The comparisons contained in this working paper were undertaken in the course of the Home and Community Care (HACC) National Service Standards Project. The Project was undertaken by the Aged Care Unit at the Australian Institute of Health and Welfare, under the auspices of the HACC Officials Standards Working Group. The Working Group, comprising Commonwealth and State representatives, has responsibility for development and implementation of quality assurance initiatives in the HACC Program. The AIHW project team comprised Dr Diane Gibson, Ms Anne Jenkins and Ms Elizabeth Butkus.

The central aim of the HACC National Service Standards Project was to develop a reliable and valid Instrument to measure quality of service against the National Service Standards in Australia's over 3,300[1] HACC funded projects. The project was made complex by the structure of the HACC program, which involves federal, state and local levels of government, the voluntary sector and the private-for-profit sector in a variety of combinations, the large range of agency sizes, and the vast array of service types provided by HACC agencies. Other complications included special issues around rural and remote services and ethno-specific services.

Furthermore, the development of the HACC National Service Standards Instrument could not sensibly proceed without regard to other quality appraisal mechanisms already in use by some agencies within the HACC program. Most notably, some agencies providing services to younger disabled people had been required to undergo Disability Service Standards reviews, and the present expectation is that the Disability Service Standards process of quality appraisal will continue to be applied in the future. Other agencies operating within a more medical or nursing framework had already opted to undertake quality improvement processes involving Community Health Accreditation and Standards Program or Australian Council of Healthcare Standards reviews of service delivery.

While the majority of HACC agencies were not engaged in a standardised quality appraisal and review process (hence the need for the development of the HACC National Service Standards Instrument), for those who had opted or been required to undertake another quality appraisal process, the question of comparability between the various processes is highly germane. If the processes were very similar, a requirement on, for example, agencies funded by both HACC and disability services to undergo both the Disability and HACC Service Standards review processes may well constitute unnecessary duplication and an inefficient use of resources. On the other hand, if the quality appraisal mechanisms differ significantly, for example, if whole areas of relevance to the HACC Service Standards are missing from the Disability Review process, then both processes may well be necessary. Another possibility is, of course, that of some amalgam of the two processes, whereby an agency could be certified against both sets of standards. On the down side, while this solution may maximise efficiencies of resource use, the aim of the process, to appraise quality using a uniform instrument, is undoubtedly compromised where some agencies use one process, and others another.

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[1]   Department of Health and Family Services 1996. Community Care Statistics 1995-96.

In order to inform both the development of the HACC National Service Standards Instrument being undertaken by the AIHW project team, and the more general deliberations of the HACC Officials Standards Working Group, a detailed comparison of common quality appraisal mechanisms with the HACC National Service Standards Instruments was undertaken. The comparisons are presented in this working paper for comment and use by persons involved in the development, review or use of quality appraisal instruments in the community care field.

One final caveat is necessary with regard to the content of this paper. Considerable difficulties arise in attempting to make direct comparisons between different quality appraisal mechanisms based on the content of their standards, when interpretation and the process of their actual implementation in the field is also clearly salient to an overall comparative review. These difficulties are compounded by the differing levels of specificity characteristic of various sets of standards, and by the particular terminology employed by standards which have emerged from quite different sectors of the health and welfare fields. The material presented here compares the content of the standards, and does not attempt to review or compare their processes of implementation. While recognising this as a limitation, it was a constraint which served to make the project a manageable one. In further fieldwork to be undertaken on the HACC National Service Standards Project, we will be comparing the outcomes of the review processes described in this paper. While the numbers of agencies involved in these comparisons will necessarily be quite modest, the information gained should shed further light on this very important issue.

2. COMPARISON OF HACC AND DISABILITY SERVICE STANDARDS[2]

2.1 OVERVIEW

HACC SERVICE STANDARDS

The HACC Service Standards comprise 26 standards grouped according to seven objectives:

1.   Access to Services
2.   Information and Consultation
3.   Efficient and Effective Management
4.   Co-ordinated, Planned and Reliable Service Delivery
5.   Privacy, Confidentiality and Access to Personal Information
6.   Complaints and Disputes
7.   Advocacy

DISABILITY SERVICE STANDARDS

The Disability Service Standards comprise 22 minimum, 65 enhanced, and 14 eligibility supporting standards, grouped into eleven sections:

1.   Service Access
2.   Individual Needs
3.   Decision Making and Choice
4.   Privacy, Dignity and Confidentiality
5.   Participation and Integration
6.   Valued Status
7.   Complaints and Disputes
8.   Service Management
9.   Employment Conditions
10. Employment Support
11. Employment Skills Development

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[2]   Commonwealth of Australia. Disability Services Standards for services funded under   the Commonwealth Disability Services Act 1986. AGPS. 1994.

2.2 COMPARISON

IN THIS COMPARISON OF HACC AND DISABILITY SERVICE STANDARDS, DISABILITY SERVICE STANDARDS ARE GROUPED ACCORDING TO HACC OBJECTIVES

HACC OBJECTIVE 1:   ACCESS TO SERVICES

HACC Service Standards

1.1   Assessment occurs for each consumer.
1.2   Consumers are allocated available resources according to prioritised need.
1.3   Access to services by consumers with special needs is decided on a non-discriminatory basis.
1.4   Consumers in receipt of other services are not discriminated against in receiving additional services.
1.5   Consumers who reapply for services are assessed with needs being prioritised.

Disability Service Standards

1.1   The agency has developed written entry and exit policies and procedures.
1.3   The agency implements its written entry and exit policies and procedures.
1.4   The agency's entry and exit policies and procedures are reviewed regularly with consumers.
1.5   The agency establishes clear entrance criteria for determining the priority for service for each person with a disability.
1.6   The agency's entrance criteria provide for access to be given on the basis of relative need.
1.7   Other than relative need, the access of a person with a disability to a service is decided on a non-discriminatory basis.
2.la   The agency has developed written policies and procedures on planned approaches to meeting individual needs.
2.1b   The agency has developed, in consultation with consumers, written policies and procedures on planned approaches to meeting individual needs.
2.2   The agency's policies and procedures on planned approaches to meeting individual needs are made available to consumers in appropriate formats.
2.6   The agency's policies and procedures on planned approaches to meeting individual needs are reviewed regularly with consumers.

HACC OBJECTIVE 2:   INFORMATION AND CONSULTATION

HACC Service Standards

2.1   Consumers are aware of their rights and responsibilities.
2.2   Consumers are aware of services available.
2.3   Consumers are informed on the basis of service provision, including changes that may occur.

Disability Service Standards

1.2   The agency's entry and exit policies and procedures are accessible by potential and current consumers.
1.9   The agency targets its information activities to be accessible by all identifiable groups within the target population.
3.la   The agency has developed written policies and procedures on mechanisms which maximise consumer participation in decision making at the individual and service level.
3.1b   The agency has developed, in consultation with consumers, written policies and procedures which maximise consumer participation in decision making at the individual and service level.
3.2   The agency's policies and procedures to maximise consumer participation in decision making are made available to consumers in appropriate formats.
3.3   The agency offers each person with a disability support to make informed decisions and choices in relation to the service he or she receives.
3.4   The agency informs each consumer of other services that might meet his or her needs.
3.5   The agency implements its policies and procedures to maximise consumer participation in decision making at the individual and service level.
3.6   The agency's policies and procedures to maximise consumer participation in decision making are reviewed regularly with consumers.

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[3]   This apparent gap in the Disability Service Standards may be simply an issue of terminology. Comprehensive assessment may well be included in the care planning processes referred to in standards 2.1b, 2.2 and 2.6.

standards in the Disability Service Standards in contrast to 3 HACC standards).
Potentially, agencies which meet the Disability Service Standards could demonstrably
meet HACC standards 2.1 and 2.2.

Gaps in Disability Service Standards:
The issue of consumers being informed about the basis of service provision and payment
is not addressed.

Gaps in HACC Service Standards:
The emphasis on written policies and procedures concerning approaches to meeting
need and consumer participation is absent from the HACC Service Standards.
The issues of exit and consumer choice and participation are again not explicitly
included, although rights and responsibilities are mentioned in this HACC objective,
thereby including some element of individual client decision-making.

HACC OBJECTIVE 3:   EFFICIENT AND EFFECTIVE MANAGEMENT

HACC Service Standards

3.1   Consumers receive appropriate services provided through the processes of
        ongoing planning, monitoring and evaluation of services.
3.2   Consumers receive services from agencies that adhere to accountable
        management practices.
3.3   Consumers receive services from appropriately skilled staff.

Disability Service Standards

2.5   The agency implements its policies and procedures on planned approaches to
        meeting individual needs.
3.la   The agency has developed written policies and procedures on mechanisms
        which maximise consumer participation in decision making at the individual and
        service level.
3.8   The right of each person with a disability to exercise control over his or her life
        is not restricted by the policies and procedures of the agency.
3.9   The agency takes reasonable care to avoid forseeable risks without unduly
        limiting the ability of each person with a disability to take responsibility for his
        or her own decisions.
8.1   The agency ensures the legal and human rights of people with a disability are
        upheld within the service.
8.2   The agency provides a safe physical environment for its consumers.
8.3   Consumers have the opportunity and support to take part in the planning,
        management and evaluation of the service.
8.4   The agency monitors its activities and regularly evaluates whether it is meeting
        its objectives and the Disability Services Standards.
8.5   The roles and responsibilities of the board, committee of management, and staff
        of the agency are clearly defined, documented and available.
8.6   People with a disability receive services from appropriately skilled and
        competent staff.
8.7   The agency ensures that its employed and volunteer staff receive appropriate
        support; and that they understand their role, the administration of the agency and
        the service, and their accountability for their work related activities.

8.8   The agency implements a policy on affirmative action with regard to employment of people with a disability.

8.9   The agency develops and implements written policies and procedures relating to complaints and disputes by staff and other persons.

8.10   Resources are managed to maximise the funds available to provide services for consumers.

8.11   The agency has available, upon request, annual reports that demonstrate consumer, service and financial outcomes.

Appraisal
As for objective 2, there are considerably more standards under the Disability Service Standards, and of a more prescriptive nature, than the corresponding HACC standards (15 Disability Service Standards in contrast to 3 HACC Service Standards). The prescriptive and detailed Disability Service Standards cover accountable management practices well, including consumer involvement, and also address the issues of monitoring and evaluating services, and employment of appropriately skilled staff.

Gaps in Disability Service Standards:
Information is not sought under the Disability Service Standards about methods of service planning.

Gaps in HACC Standards:
Differences in the level of detail are particularly significant here. Substantive areas include consumer participation, individual rights, safe environment, written policies and procedures, roles and rights of volunteer staff, and affirmative action with regard to staffing practices.

HACC OBJECTIVE 4:   CO-ORDINATED, PLANNED AND RELIABLE SERVICE DELIVERY

HACC Service Standards

4.1   Each consumer receives ongoing assessment (formal and informal) that takes all support needs into account.

4.2   Each consumer has a service delivery/care plan which is tailored to individual need and outlines the service he or she can expect to receive.

4.3   Consumers cultural needs are addressed.

4.4   Consumers receive services which include appropriate coordination and referral processes.

Disability Service Standards

2.3   The agency, in consultation with each consumer, identifies and documents the individual, ongoing and changing needs of the person with a disability and the approaches for meeting those needs.

2.4   The agreed approach for meeting each consumer's individual ongoing and changing needs is implemented and reviewed with that consumer within an agreed timeframe.

2.7   The agency considers the appropriateness of general community facilities and services in meeting the individual needs of each person with a disability.

2.8   Each person with a disability is provided with support in a manner which maximises his or her potential to reach personal goals.

2.9   Services are provided in a manner sensitive to the age, sex, and the cultural, linguistic and religious background of each person with a disability.

2.10   The agency supports each consumer's efforts to gain access to general community facilities and services and/or to other specialist agencies and/or services.

5.2   Services are provided in a way that facilitates the integration and participation of each person with a disability in the community, at times and in ways similar to other members of the community.

5.3   Each consumer is provided with information about general community facilities and services and how to use them.

8.12   The agency has a process of co-ordination with other agencies, advocacy and consumer organisations in the area.

HACC OBJECTIVE 5:   PRIVACY, CONFIDENTIALITY AND ACCESS TO PERSONAL INFORMATION

HACC Service Standards

5.1   Consumers are informed of the privacy and confidentiality procedures and understand their rights in relation to these procedures.
5.2   Consumers have signed confidentiality release forms
5.3   Consumers are able to gain access to their personal information.

Disability Service Standards

4.1a   The agency has developed written policies and procedures on protecting consumers' privacy, dignity and confidentiality.
4.2   The agency's policies and procedures on protecting consumers' privacy, dignity and confidentiality are made available to consumers in appropriate formats.
4.3   The agency only collects consumer information that is directly relevant to effective service delivery.
4.4   Each consumer is informed of the types of personal information that the agency holds and the reasons for holding this information.
4.5   Each consumer's consent is obtained before any information about him or her is sought or released by the agency.
4.6   Each consumer's right to dignity and privacy is recognised, respected and protected in relation to personal activities.
4.7   The agency implements its policies and procedures on protecting consumers' privacy, dignity and confidentiality.
4.8   The agency's policies and procedures on protecting consumers' privacy, dignity and confidentiality are reviewed regularly with consumers.
4.9   Each consumer has the right to see any information the agency keeps in respect of him or her.

HACC OBJECTIVES 6 & 7:   COMPLAINTS AND DISPUTES / ADVOCACY

HACC Service Standards

6.1   Each consumer's complaint about a service, or access to a service is dealt with fairly, promptly, confidentially and without retribution.

6.2   Consumers are aware of the complaints process.

6.3   Services are modified as a result of "upheld" complaints.

6.4   Each consumer receives assistance, if requested, to help with the resolution of conflict about a service that arises between the frail elderly person or younger person with a disability and his/her carer.

7.1   Each consumer has access to an advocate of his/her choice.

7.2   Consumers know of their rights to use an advocate.

7.3   Consumers know about advocacy services - where they are and how to use them.

7.4   The agency involves advocates in respect to representing the interests of the consumer.

Disability Service Standards

3.7   Each person with a disability can involve an advocate in making decisions about the service he or she receives.

7.1a   The agency has developed written policies and procedures on the resolution of consumers' complaints and disputes.

7.1b   The agency has developed, in consultation with consumers, written policies and procedures on the resolution of consumers' complaints and disputes.

7.2   The agency's policies and procedures on consumers' complaints and disputes resolution are made available to consumers in appropriate formats.

7.3   Each consumer is able to have resolved issues regarding aspects of the agency or service with which he or she is dissatisfied.

7.4   Complaints or disputes are handled in a manner consistent with the agency's policies on privacy.

7.5   The agency implements its policies and procedures on consumers' complaints and disputes resolution.

7.6   The agency's policies and procedures on consumers' complaints and disputes resolution are reviewed regularly with consumers.

7.7   Each consumer is encouraged and assisted to raise any concerns he or she has about the agency or service, without fear of retribution.

7.8   The complaints and disputes procedure allows for the participation of the consumer's advocate, where requested.

7.9   Each consumer is provided with information on relevant complaints and disputes processes available in the community.

7.10   The agency ensures that progress towards resolution of each complaint or dispute is reviewed within an agreed timeframe.

DISABILITY SERVICE STANDARDS: EMPLOYMENT

HACC Service Standards

Nil

Disability Service Standards

9.1   The agency ensures that each employee with a disability has the same rights, protections and responsibilities as other people in the workforce.

9.2   The agency ensures that each employee with a disability receives an agreed minimum wage or salary which reflects progress toward an award-related wage.

9.3   Where the agency is also the employer, the budgeted costs of the agency, reflect progress towards an award-related wage.

9.4   The agency recognises that labour costs of employees with a disability are an integral cost of running a business and accordingly are a part of the budget costs.

9.5   The agency's budget reflects that Government contributions do not subsidise the wages and salaries of employees with a disability.

9.6   The agency provides opportunities for career advancement, including access to training and skills development consistent with the opportunities provided in the general workforce.

9.7   The agency ensures that each employee with a disability works in a job and in a work environment in which he or she receives the same employment conditions, rights, protections and responsibilities as those expected and enjoyed by other people in the general workforce.

9.8   The agency ensures that employees with a disability are supported on the basis of their needs and interests and are not grouped solely on the basis of their disability.

9.9   The agency ensures that each employee with a disability receives award wage rates or pro-rata award wage rates determined through an independent industrial relations process.

9.10 The agency ensures that each employee is employed under an award or industrial agreement.

10.1 The agency has a commitment to successful long-term employment for each person with a disability.

10.2 The support activities of the agency are directed towards assisting people with a disability to achieve and/or maintain employment in jobs which satisfy the employment conditions standard.

10.3 Each person's support program is based on an individual assessment.

10.4 The level of support to be provided is agreed between the agency and each person with a disability.

10.5 The agency develops a range of supports to meet the employment related goals of each person with a disability.

10.6 The agency provides work support and work-related support to assist with skills development, job-seeking, job participation and job retention of each person with a disability.

10.7 The provision of support allows the maximum participation and integration of each employee with a disability into the work and social activities of the workplace.

10.8 The agency regularly reviews the level and type of support provided to meet the agreed ongoing and changing needs of each person with a disability.

10.9 The agency provides or facilitates training to each person with a disability covering his or her industrial rights and the industrial relations environment.

10.10 The agency ensures that each person with a disability is supported on the basis of his or her need and interests and is not grouped solely on the basis of his or her disability.

11.1 The agency has a commitment to successful long-term employment for each person with a disability.

11.2 The agency ensures that people assisted in Commonwealth funded employment services before 1 March 1993, continue to receive a "wage", allowance or other payment not less, in real terms, than they received at that date.

11.3 The agency provides a range of training and work experience that is employment focused and directed towards developing and maintaining skills which are relevant to current and future labour market needs.

11.4 Each person with a disability is assessed within a maximum of three years by a Disability Support Pension panel or an equivalent mechanism to determine the nature and scope of appropriate post-skills development support and eligibility for continuing employment skills development.

11.5 The agency ensures that people in receipt of support in funded employment services on 1 March 1993 will have the opportunity for continued support.

11.6 The agency, in consultation with each person with a disability, identifies and documents his or her training and skills development needs and the approaches to meeting those needs.

11.7 The agency ensures that the agreed approach to meeting the training and skills development needs of each person with a disability is implemented and reviewed with that person in terms of progress towards securing open employment within a defined and agreed time limit.

11.8 The agency provides access to work experience and on-the-job training in areas of employment that focus on marketable skills and/or realistic opportunities for employment.

11.9 The agency provides assistance and support in job seeking and job participation through developing formal links with employment placement agencies.

11.10   The agency is taking steps to accredit courses, recognise trainers and register training providers in accordance with the objectives of the National Framework for the Recognition of Training (NFROT).

11.11   Any training, including on-the-job training is in accord with the objectives of the National Framework for the Registration of Training (NFROT).

Appraisal
This area is not relevant to HACC Service Standards as currently conceived.

2.3   SUMMARY

COMPARISON OF HACC AND DISABILITY SERVICE STANDARDS

Agencies which conform to the Disability Service Standards would be required to provide additional evidence to satisfy HACC requirements in the following key areas:

.   assessment and review assessment of consumers, although it should be noted that this apparent 'gap' may be a result of terminology rather than practice,
.   provision of information to consumers in regard to the basis of service provision,
.   information gathered to enable effective and appropriate service planning and development,
.   responsiveness to 'upheld' complaints, and
.   assistance provided to consumers should there be a conflict between a consumer and his or her primary carer.

It should be noted that:

.   Differences between the two systems would essentially preclude the existence of a meaningful comparative score;
.   Potentially, an add-on system could be developed, which would allow an appraisal of the "missing" elements of the HACC standards;
.   If this approach were adopted and developed, the duplication of quality appraisal processes would be reduced, with the trade-off being loss of comparability between these "combined" appraisals and the straight HACC appraisals.

3. COMPARISON OF HACC AND COMMUNITY HEALTH ACCREDITATION AND STANDARDS PROGRAM (CHASP) STANDARDS[4]

3.1 OVERVIEW

HACC SERVICE STANDARDS

The HACC Service Standards comprise 26 standards, grouped according to seven objectives:

1. Access to Services
2. Information and Consultation
3. Efficient and Effective Management
4. Co-ordinated, Planned and Reliable Service Delivery
5. Privacy, Confidentiality and Access to Personal Information
6. Complaints and Disputes
7. Advocacy

CHASP STANDARDS

The CHASP standards comprise 414 standards or indicators grouped according to 58 objectives, which in turn are organised into ten sections:

1. Assessment and Care
2. Early Identification and Intervention
3. Health Promotion
4. Community Liaison and Participation
5. Rights of Consumers
6. Client Health and Program Records
7. Education, Training and Development
8. Planning, Quality Improvement and Evaluation
9. Management
10. Work and its Environment

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[4]   Australian Community Health Association. Manual of Standards for Community and   Other Primary Health Care Services. 3rd edition. 1993.

3.2   COMPARISON

IN THIS COMPARISON OF HACC AND CHASP SERVICE STANDARDS, THE CHASP STANDARDS ARE GROUPED ACCORDING TO HACC OBJECTIVES

HACC OBJECTIVE 1:   ACCESS TO SERVICES

HACC Service Standards

1.1	Assessment occurs for each consumer.
1.2	Consumers are allocated available resources according to prioritised need.
1.3	Access to services by consumers with special needs is decided on a non-discriminatory basis.
1.4	Consumers in receipt of other services are not discriminated against in receiving additional services.
1.5	Consumers who reapply for services are assessed with needs being prioritised.

CHASP Service Standards

1.1.1	Does the service have written policies on assessment and care which include: (a) a multidisciplinary approach (b) addressing physical, emotional, social, cultural and environmental factors in relation to health (c) encouraging clients' independence, informed choice and rights (d) opportunities for the early identification of health problems (e) an emphasis on prevention (f) the provision of out of hours services? Are the policies dated within the last three years?
1.1.2	Are all staff aware of the policies on assessment and care of individuals' health? How do they find out about it?
1.1.5	Are there any waiting lists for services? What has been done to shorten the length of the waiting list/s?
1.2.1	Do all staff registering clients use a written procedure for registration, allocation and referral?
1.2.2	Do facilities and equipment ensure that: (a) there is privacy to take phone calls and to talk in person (b) up to date information is available on services offered and community resources?
1.2.3	Is there a uniform registration system which includes name, address/phone number, service requested by the person, whether an interpreter is needed, source of referral?
1.2.4	Have staff who register and provide intake to clients had initial and ongoing training in communication skills, confidentiality, dealing with aggressive clients, use of interpreter services (face-to-face and telephone), consumer rights?
1.4.1	Does the service ensure that clients are assessed by the most appropriate team members? How does this happen?
1.4.2	Does the service ensure that clients are assessed promptly? How does this happen?
4.4.1	Can the service be easily reached by public or community transport from all parts of its area?
4.4.2	Is there inexpensive public car parking near the service?
4.4.3	Is there parking for people with disabilities at the service?

4.4.4   Is the service reception area adequately staffed? Are reception services available through lunchtime?

4.4.5   Does the service employ bilingual professional and reception staff who cover languages spoken in the area?

4.4.6   Does the telephone system operate efficiently, and does it provide information 24 hours a day

4.4.7   Has the service made arrangements to deal with after-hours crisis calls (eg, roster system, telephone diversion to local casualty unit)? How does this happen?

4.4.8   Do the facilities of the service include: (a) ramps or lifts to any upper floors (b) automatic doors (c) private space for breastfeeding (d) nappy change facilities and secure space for prams (e) wheelchair access to toilet (f) physical layout that facilitates wheelchair access (g) a hearing wand for use with consumers who are hearing impaired (h) provision for guide dogs?

4.4.9   Does the service make sure that any fees charged do not prevent people from using the service?

4.4.10   Are the service's hours of operation flexible and responsive to community needs? Do opening hours meet the needs of people who are in the workforce?

4.4.11   Does the service provide staff with a pool of cars or a private mileage allowance to make sure they are mobile in the community?

4.4.12   Does the service encourage community groups to use its buildings and equipment? Is out-of-hours use also encouraged?

4.4.13   Does the service provide child care? If not, has it liaised with local child care agencies to provide child care for consumers where appropriate? Is it at low cost to consumers?

Appraisal
Both sets of standards in relation to this objective include the need for a comprehensive and individual assessment of each consumer. Both sets of standards also address the issue of access to services by consumers with special needs, although the HACC Service Standards frame this issue in terms of discrimination while the CHASP standards refer to 'overcoming barriers' to service use by special needs groups.[5] It is likely, however, that the information provided in relation to the CHASP Standards would be sufficient to demonstrate fulfilment of the HACC Service Standards. In general, the CHASP Standards are much more detailed with regard to the process necessary, eg child care, parking availability.

Gaps in CHASP standards:
The issues of resource allocation according to prioritised need, and discrimination against consumers in receipt of other services, are not addressed.

Gaps in HACC Service Standards:
A requirement to have written procedures in regard to intake of clients is not included. Physical access to the service by consumers, and ease of access in terms of opening hours and language skills of staff, are also not addressed.

HACC OBJECTIVE 2:   INFORMATION AND CONSULTATION

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[5]   CHASP Standards 5.1.1, 5.1.2, 5.1.3, 5.1.4, 5.1.5 and 5.1.6 in regard to agency policy on the rights of consumers are also relevant to ensuring non-discriminatory treatment of consumers.

HACC Service Standards

2.1 Consumers are aware of their rights and responsibilities.
2.2 Consumers are aware of services available.
2.3 Consumers are informed on the basis of service provision, including changes that may occur.

CHASP Service Standards

1.2.5 Are clients informed at registration of (a) the range of services provided (b) availability of interpreter where needed (c) appointment times (d) possible waiting times (e) staff member they will be seeing (d) any costs attached to service? How does this happen?

1.3.6 Does the service lend relevant books and audiovisual materials on health issues to clients?

1.3.7 Does the service offer clients regular education sessions on health care (eg, asthma talks, First Aid for children, carer discussion sessions, diabetes seminars)?

1.3.8 Does the service encourage clients to participate in self help/support groups? Has the service assisted the development of any such groups? What are some examples?

1.3.12 Does the service inform clients of the availability and suitability of other services and agencies? How does this happen?

4.3.1 Is there at least one signpost near the service directing people to it? Is it easy to read?

4.3.2 Does the service have a sign prominently displayed outside the building, with the service's name, telephone number and hours of operation in appropriate community languages? Is it easy to read?

4.3.3 Does the service have one or more pamphlets which include: (a) what services are available (b) how to use them (c) philosophy of the service/mission statement (d) address, telephone number and hours of operation (e) how clients can participate in the service (f) rights of consumers (g) any fees and what they are for?

4.3.4 Is the service pamphlet easy to read and available in appropriate community languages? Was it developed in consultation with consumers?

4.3.5 Does the service distribute information about the service's activities through a wide range of places in the area (eg, schools, shopping centres, libraries, workplaces, chemists, community information boards, etc)?

4.3.6 Is the local media (eg, newspapers, am/fm radio, television) used to publicise the service and its activities? What are some examples? Is a record kept (eg, press clippings file)?

4.3.7 Do staff tell consumers their name and position when they meet?

4.3.8 Does the service have an information board that displays information: (a) about the service and its activities (including current and forthcoming programs) (b) the photographs and names of staff and Committee of Management (where appropriate) (c) other agencies, community groups or members' activities?

5.1.1 Does the service have a written policy on the rights of consumers? Does it include the right to: (a) quality and respectful health care (b) non-discriminatory health care (c) confidentiality and privacy (d) be informed and make decisions about their health care (e) consent to or refuse any assessment or treatment procedures (except where legislation prevents this) (f) choose who will be

present at a consultation (g) request transfer to another staff member (h) have an advocate (i) remain anonymous (j) fair investigation of complaint (k) continued access to services after making a complaint (l) refuse to take part in research and experiments (m) refuse services from students (n) read their own health records (o) receive written information about their rights at the time of first contact with staff?

5.1.2   How do staff implement the consumer rights policy in their practice?

5.1.3   Is there a leaflet on consumer rights written in language that is easy to understand?

5.1.4   Is appropriate information on rights of consumers available for consumers who don't speak or read English? How does this happen?

5.1.5   Does the service make sure that consumers receive verbal explanation as well as the consumer rights leaflet at initial assessment? How does this happen? Is this recorded in client files?

5.1.6   Does the service have a sign clearly displayed in the reception area that tells consumers about their rights? Is it in appropriate community languages?

Appraisal
Both sets of standards require agencies to inform consumers of their rights and responsibilities, and the full range of services offered by the agency. It is likely that an agency's fulfilment of the CHASP Standards in relation to these issues would be sufficient to demonstrate fulfilment of the corresponding HACC Service Standards. Again, a myriad of detail is included in the CHASP Standards.

HACC OBJECTIVE 3:   EFFICIENT AND EFFECTIVE MANAGEMENT

HACC Service Standards

3.1   Consumers receive appropriate services provided through the processes of ongoing planning, monitoring and evaluation of services.

3.2   Consumers receive services from agencies that adhere to accountable management practices.

3.3   Consumers receive services from appropriately skilled staff.

CHASP Service Standards

1.4.5   Do staff use specific protocols to help with the assessment of particular health problems (eg, in mental health, primary medical care, child and/or family counselling, rehabilitation)? Are these up-to-date and consistent with current professional practice?

1.4.6   Do all staff providing services to individuals comply with codes of ethics and standards of professional practice where these exist? What are some examples?

4.1.7   Are local newspapers and other media used as a source of information on general community affairs and local health issues? How does this happen?

4.6.1   Does the service's statement of philosophy and/or goals include the importance of community participation in the service's planning and operations?

4.6.2   Have any services been developed at the request of community groups? What are some examples?

4.6.3   Does the service conduct any activities using appropriate community members as group leaders on a sessional paid basis? What are some examples?

4.6.4   Does the service provide opportunities for community members and groups to be involved in planning service activities (eg, suggestion box, vision/planning day, focus group on health issues)? What are some examples?

4.6.5   Does the service provide opportunities for community members and groups to be involved in implementing service activities (eg, getting consumers to assist in drafting Consumer Rights pamphlet, co-facilitating a support group with community members, community newsletter run by consumers, volunteer programs for library services and transport, young people doing peer education)? What are some examples?

4.6.6   Does the service provide opportunities for community members and groups to be involved in evaluating service activities (eg, consumer survey, asking someone from paraplegic organisations to evaluate wheelchair accessibility at the service)?

4.6.7   Has the service a Committee of Management/Advisory Committee? How is appropriate composition ensured?

4.6.8   Does the health authority/Area Health Service encourage community input and participation in health services? How does this happen?

6.4.1   Does the service have a uniform or compatible system of registration that identifies the location of records on early identification and intervention, health promotion and community development work?

6.4.2   Is there a person responsible for maintaining the system for program records?

6.4.3   Does the service's policy on program records include (a) the need for them to have records (b) procedures for registration of records (c) procedures for retrieval, refiling and the storage of records (d) guidelines for staff on completing records?

6.4.4   Does the service make sure staff understand and use the system for activity records?

6.5.1   Are all client health records filed and stored so that authorised staff can find them easily? How does this happen?

6.5.2   Is there a procedure to make sure that client health records which have been in use are refiled promptly? How does this happen?

6.5.3   Is there a tracer system for client health records?

6.5.4   Is sufficient space available for current client health record storage?

6.5.5   Is there a system for non-current storage, that identify client health records in storage?

6.5.6   Are all program records filed so that staff can locate and retrieve them? Is a tracer system used?

7.1.1   Does the service have a policy on staff development that includes: (a) methods of identifying education needs, which are derived from service goals and staff appraisal systems (b) criteria for allocating resources to staff education activities (c) staff education entitlements including provision for all staff to attend staff development activities for at least five days per year pro rata (d) methods to share knowledge and skills gained in staff development?

7.1.2   Does the service have an identifiable budget for staff development? Is it adequate?

7.1.3   Is there a designated person or group that is responsible for initiating, planning and providing staff development?

7.1.4   Have most staff attended staff development activities for at least five days (pro rata) in the past year? Have particular categories of staff missed out (eg, administrative staff)?

7.1.5   Is there study leave provision that enables staff to do approved postgraduate and post registration studies?

7.1.6   Are funds available to staff to pay registration costs of approved external education activities?

7.1.7   Does the health service have funds available for the purchase of books and journals to support staff in their work?

7.1.8   Do staff have convenient access to external library services that contain adequate material on professional and community/primary health matters (eg, contents pages of journals circulated)?

7.1.9   Does the service encourage staff to develop networks with other health services and agencies in order to exchange knowledge and experience? How does this happen?

7.1.10   Does the health authority/Area Health Service encourage the provision of appropriate continuing education for staff? What are some examples?

7.2.1   Does the service's annual planning process include identifying staff development needs of administrative and professional staff? Are staff involved in this process?

7.2.2 Do these identified staff development needs relate to the community's main health issues? What are some examples?

7.2.3 Does the service keep a central record of staff development activities staff have attended in paid time? Is this reviewed annually to ensure equitable distribution of staff development opportunities?

7.2.4 Are all staff routinely informed about forthcoming staff development activities (internal and external)? How does this happen?

7.2.5 Is there a procedure for staff attending courses to report back to the team about the content of the course and its applications? How does this happen?

7.2.6 What are some recent examples of how knowledge and skills gained in staff development have been applied? Are there any major obstacles to applying newly gained knowledge and skills?

7.2.7 Has the service initiated or collaborated in continuing education programs with the assistance of universities, other training bodies or other agencies? What are some examples?

7.3.1 Is responsibility for orientation clearly delegated? Does this include role definition and responsibilities?

7.3.2 Does the service have a written orientation manual or kit for new staff, relief and locum staff, and students which includes: (a) service goals, activities and policies (b) management structures, team processes and staff list (c) descriptive profile of the community and its main health issues (d) staff entitlements, position descriptions and working conditions (e) service's last Annual Report (f) Committee of Management's role and responsibilities (g) occupational health and safety issues (h) location of first aid and fire equipment (i) EEO policies and issues (j) Relevant Health Authority/Area Health policies? Is this dated within the last three years?

7.3.3 Does the service have an orientation program for new staff which includes information on: (a) role, function and responsibilities (b) supervision and accountability (c) communication channels within the service (d) visits to appropriate agencies (e) meetings with key staff in other services (f) familiarisation with the local area (g) meeting the local hospital staff and Committee of Management where appropriate (h) attendance at a workshop on general community/primary health principles and practices (where appropriate) (i) a checklist to record whether staff have completed the program (j) an evaluation feedback form for staff comment on the program?

7.3.4 Did staff receive appropriate orientation soon after joining the service?

8.1.1 Do the service's policies cover planning, quality improvement and evaluation? Do they include: (a) explicit time allocation for all staff to undertake these activities (b) the need for planning to be based on identified health needs of the community (c) criteria for priority setting (d) the need for members of the community to be involved in developing service plan/s (e) processes for planning, quality improvement and evaluation to take place (eg, timeframes, methods, who will be involved, who is responsible)?

8.1.2 Does the service have at least one staff member with designated responsibility for ensuring that planning, evaluation and quality improvement take place regularly? How does this happen?

8.1.3 How does the service ensure staff have sufficient time to plan and evaluate their activities (eg, monitoring and reviewing time spent on planning and evaluation)?

8.1.4 Are there opportunities for staff to increase their knowledge and skills in planning, quality improvement and evaluation (eg, staff development courses, project work)?

8.1.5   Does the service have access to resources and equipment needed for planning, quality improvement and evaluation (eg, computing, printing, data processing, State/National Health Goals and Targets)?

8.1.6   Is practical support (eg, information, skill development and networking) available from the health authority/Area Health Service to help with planning, evaluation and quality improvement at the local level?

8.2.1   Has the service provided a range of opportunities for community members to involved in identifying health issues (eg, specific issue forums, community newsletters)? What are some examples?

8.2.2   Has the service participated in a survey or consultation process of community members' needs and opinions about health issues within the past three years?

8.2.3   Does the service have up-to-date demographic information about the area that it serves that describes: (a) population size (b) age and gender structure (c) family/household structure (d) rate of population change (e) ethnic composition and languages spoken (f) Aboriginal population?

8.2.4   Does the service have up-to-date epidemiological information about the area that it serves that describes: (a) main causes of death (b) main illnesses and health problems (c) major contributing factors to these health problems (d) health problems presenting at the service, hospitals and other agencies (e) number of people with disabilities?

8.2.5   Does the service's collection of social, economic and environmental indicators on the area it serves include information on: (a) types of housing (b) income levels (c) types of employment (d) numbers of people receiving pensions and benefits (e) cultural and religious communities (f) main economic activities (g) environmental health issues (h) other social indicators (eg, crime statistics, domestic violence) (i) range and number of health and social services in the area (eg, child care, youth refuges)?

8.2.6   Does the service analyse data collected from its own activities (eg, consumer satisfaction survey, number of clients and services used, program evaluations)? How does this happen?

8.2.7   Does the health authority/Area Health Service provide the health service with regular information on the demography and epidemiology of the area it serves?

8.4.1   Does the service monitor its one-to-one activities by recording and compiling information on (a) individual attendances (b) individual characteristics (eg, gender, age) (c) presenting problems (d) type of service delivered (e) any outcomes of services delivered? Is this information regularly summarised in accessible form?

8.4.2   Does the service monitor its other activities by recording and compiling information on (a) number of groups, activities and projects conducted by staff (b) number of attendances and participant type at groups and programs (c) number and type of community groups assisted by the service (d) number and type of consultations/assistance provided to other agencies? Is this information regularly summarised in accessible form?

8.4.3   Does the service record numbers and length of any staff vacancies including sick leave and turnover rates during the year?

8.4.4   Has the service conducted any surveys of how staff time is allocated? For example: (a) type of service (eg, treatment, early identification, health promotion) (b) methods used (eg, casework, groupwork, community development) (c) staff education, travel, etc (d) time spent on administration (e) time spent on planning and evaluation.

8.4.5   Does the service contribute to the data collection system of the health authority/Area Health Service? Does this data include: (a) number and

characteristics of consumers using services (b) type of service (eg, assessment and care, prevention, health promotion) (c) methods used (eg, casework, groupwork, community development) (d) time spent on administration, staff education, travel, etc?

8.4.6 Does the health authority/Area Health Service regularly inform the service of data that could be useful to their activity (eg, child health screening, hospital readmissions at an area level)?

8.5.1 Does the service annually review its range of services and programs and evaluate the achievement of its overall goals (in planning days, workshops, subcommittees, etc)?

8.5.2 Does the service use criteria to evaluate its specific services and programs? Do the criteria include: (a) level of participation (b) achievement of outcome objectives (c) adequacy of resources (d) appropriateness of goals and target group (e) capacity of methods to achieve desired outcomes (f) any unintended effects? What are some examples?

8.5.3 Does the service document evaluations of its specific services and activities? What are some examples?

8.5.4 Does the service provide a range of opportunities for community members to be involved in evaluating the service's activities (eg, designing evaluation criteria, suggestion boxes, surveys, focus groups, consumer advisory group)? What are some examples?

8.5.5 Have evaluation findings been used to modify and improve services and programs? What are some examples?

8.5.6 Does the service regularly compare the characteristics of its clients and program participants with the community as a whole (eg, age, gender, ethnicity, disability, postcode etc)? What are some examples?

8.5.7 Have any surveys that assess consumers' satisfaction with the service and its activities been conducted in the last year? Were findings acted upon?

8.5.8 When the service evaluates its activities, does it routinely report findings to consumers and others involved in the activity? What are some examples?

8.6.6 Does the service ensure that all professional staff are meeting standards or requirements set by professional associations or registration authorities for ongoing skill development? How does this happen?

8.6.7 Do all staff have access to appropriate professional supervision and/or consultation regarding their work? How does this happen?

8.6.8 Are the roles of any professional supervisors clearly specified?

8.6.9 Does the service conduct staff performance reviews as part of its quality improvement activities? How does this happen? Does this process include: (a) staff's achievements in relation to goals set (b) self-assessment of performance (c) further education needs (d) obstacles to achieving goals (e) plan of action (f) review of statement of duties? Do these occur at least annually?

9.1.1 Is the geographic area or community group for which the health service is responsible clearly defined?

9.1.2 Has the service established written goals and philosophy in consultation with its defined community? How does this happen?

9.1.3 Has the service been involved in negotiation with its funding body regarding these goals? How does this happen?

9.1.4 Are the members of the service's management at all levels familiar with the health centre's written statement of goals?

9.1.5 Does the service have an identifiable budget for each financial year?

9.1.6 Does the service's management receive and discuss regular financial statements? How does this happen? Do these reports include details on: (a) income (b)

salaries (c) categorised operating costs in a format that indicates budgeted and actual accounts ?

9.1.7 Does the service publish an annual report that includes: (a) an audited financial report (b) description of the service's goals and progress reports on their achievement (c) main health issues in its defined community (d) services provided, including health promotion programs and participation rates (e) particular achievements and problems (f) community participation in the services? Is it widely circulated to the community, other organisations and agencies?

9.1.8 Are there opportunities in addition to the annual report for the community to receive information about the activities of the service?

9.1.9 Does the management of the service make regular reports on finance, staffing and activities to the health authority/Area Health Service?

9.1.10 Has the service participated in a formal agreement with its relevant funding body on its goals and services (eg, Victorian Health Service Agreement)?

9.2.1 Is there an organisational chart that clearly describes the service components and the management structures of the service? Are there clear lines of responsibility and accountability? Is the chart reviewed regularly and dated?

9.2.2 Does the organisational chart identify a position of appropriate level with responsibility for managing and co-ordinating the service? Is the time allocated to this position appropriate considering the role, size and staffing of the service?

9.2.3 Does the statement of duties of the Manager/Co-ordinator include the following: (a) responsibility for management of staff (b) service planning, coordination and evaluation (c) multidisciplinary team development (d) financial planning (e) qualifications required (eg, education, training, experience)?

9.2.4 Does the Manager/Co-ordinator participate in the development and negotiation of budgets?

9.2.5 Do staff have access to reports on finance, staffing, activities and management decisions? Do they have opportunities to comment to management about these matters?

9.2.6 Are there opportunities that encourage staff participation in decision-making? What are some examples?

9.2.7 Are all health staff working from the service responsible to management? If not, what arrangements for management of staff are in place?

9.2.8 Where the service location is used by other agencies to deliver services, is there a contract specifying rights and responsibilities, including adherence to the service's broad goals and philosophy?

9.2.9 Does the service ensure that policies are regularly reviewed (at least every three years) and that staff are involved in policy development and review? How does this happen?

9.3.1 Does the service provide an appropriate mix of treatment, early identification and intervention, and health promotion activities? What are some examples?

9.3.2 Does the service ensure that its resources (funds, space and planning) are equitably shared between its different services and activities? What are some examples?

9.3.3 Are the responsibilities of and links between service components or subteams clearly defined? Is there effective coordination between service components at all levels?

9.3.4 Do senior staff or representatives of any subteams meet regularly with management to discuss common issues and co-ordinate services?

9.4.1 Does the service have regular multidisciplinary staff meetings in order to share information, discuss policy and participate in decision-making?

9.4.2   Do all staff attend staff meetings?

9.4.3   Do the subteams of the service have a multidisciplinary structure, or easy access to multidisciplinary networks?

9.4.4   Are there opportunities for staff to work in a multidisciplinary way to deliver services and run programs? What are some examples?

9.4.5   Where clinical staff have specific case loads to fulfil, does the service ensure that their broader involvement in community health services is possible? What are some examples?

9.5.1   Do all staff have a written statement of duties that contains: (a) description of duties (b) line of accountability (c) necessary qualifications and certification (where appropriate) (d) responsibility to work within a multidisciplinary team or network (e) responsibility to liaise with community agencies and groups (f) frequency and type of performance appraisal (g) date of last revision?

9.5.2   Do all staff have clear and appropriate lines of accountability?

9.5.3   Does the service have written procedures for the recruitment of personnel (advertising, shortlisting, composition of selection panel, interviewing and appointment)?

9.5.4   Are the personnel recruitment procedures consistent with Equal Employment Opportunity principles and relevant legislation?

9.5.5   Do staff selection criteria for professional staff and management include an understanding of and/or experience in the following: (a) multidisciplinary approaches (b) primary health care principles and practices (c) community participation (d) client rights (e) EEO principles and practices?

9.5.6   Are staff and/or management involved in the selection of new staff? How does this happen?

9.5.7   Does the service have confidential personnel records for each member of staff ?

9.5.8   Does the service have a time-in-lieu system or overtime payments when staff are required to work additional hours? Are these procedures satisfactory?

9.5.9   Do staff have access to information on their entitlements (including industrial awards, leave and salary matters and right to check personal file), and are they satisfied with personnel procedures?

9.5.10   Does the service ensure that its health professionals are covered by professional indemnity insurance? How does this happen?

9.5.11   Does the service have appropriate insurance coverage for volunteers and consumers involved in the service's activities?

9.5.12   Are there clear and appropriate procedures for the use of motor vehicles (including car allocation and bookings, repairs, petrol, monitoring of mileage, parking and security, car replacement)?

9.5.13   Is there an up-to-date inventory of service equipment?

9.5.14   Does the service have clear and appropriate delegations and efficient procedures to order goods and services (eg, building and equipment repairs, stationery, furniture, clinical supplies, etc)?

9.5.15   Are there clear procedures to ensure the security of the building?

9.5.16   Are there sufficient clerical, word processing and administrative resources to support the activities of the service?

9.6.1   Is there a written document (eg, organisation chart) that defines and describes the role of the next level of decision-making in relation to the service (eg, District or Regional Office, Area Health Service, hospital)?

9.6.2   Do staff with responsibility for community/primary health care matters within the next level of decision-making have regular access to the executive level of their organisation?

9.6.3   Does the next level of decision-making have an overall or strategic plan which includes community/primary health care services? Was this developed in consultation with these services? Has it been distributed to relevant services?

9.6.4   Does the strategic plan for community/primary health care services include a specific allocation of resources based on the health needs of the community?

9.6.5   Does the next level of decision-making have policies that support and promote community/primary health care services?

9.6.6   Has the service contributed to the next level of decision-making's development of priorities and resource allocation for community/primary health? How does this happen?

9.67   Does the next level of decision-making encourage the co-ordination of community-based health services that are provided to a common geographic area by different agencies? What are some examples?

9.6.8   Are there regular forums where the service manager/co-ordinator meets with appropriate representatives of the next level of decision-making to discuss issues, implement policy and make decisions?

9.7.1   Does the service systematically inform local community members of how they can participate in the committee of management? How does this happen?

9.7.2   Does the service encourage wide participation (including people of different ages, genders and cultural backgrounds who are appropriately skilled and informed) in the management of the service? How does this happen?

9.7.3   Does the service encourage wide community participation in the selection of the committee of management? How does this occur?

9.7.4   Does the service ensure that people seeking election or appointment to the committee of management are informed of their responsibilities and the likely time commitment involved? How does this happen?

9.7.5   Does the board or committee that manages the service include representatives from the range of localities within the service's geographic area?

9.7.6   What is the role of the committee of management in: (a) developing policy (b) employment of staff (c) planning (d) decision-making (e) evaluation (f) financial management?

9.7.7   Does the committee of management meet regularly?

9.7.8   Does the committee of management have regular forums to discuss the service with staff, managers and the community? What are some examples?

9.7.9   Are members of the committee of management aware of their responsibilities under relevant statutory requirements (eg, meeting attendance, liability, confidentiality, pecuniary interest)?

HACC OBJECTIVE 4:   CO-ORDINATED, PLANNED AND RELIABLE SERVICE DELIVERY

HACC Service Standards

4.1   Each consumer receives ongoing assessment (formal and informal) that takes all support needs into account.

4.2   Each consumer has a service delivery/care plan which is tailored to individual need and outlines the service he or she can expect to receive.

4.3   Consumers cultural needs are addressed.

4.4   Consumers receive services which include appropriate coordination and referral processes.

CHASP Service Standards

1.1.3   Does the service provide the range of services needed to assess and care for physical, emotional, cultural, social and environmental factors in relation to health? Are there any gaps? What are some examples?

1.1.4   Where there are identified gaps in services, what has been done to assist clients to get the care they need? What are some examples?

1.3.1   Do staff discuss with clients the broader influences on their health (eg, the environmental or social influence on health)? How does this occur?

1.3.2   Do staff provide clients with information and assist in skill development so they can actively manage their health? What are some examples?

1.3.3   Are clients supported in making informed decisions about their health care options? What are some examples?

1.3.4   Do staff explain to clients the purpose, value and possible problems of diagnostic and/or treatment methods that are available? What are some examples?

1.3.5   Are language-appropriate pamphlets and booklets on various health issues available in the service's reception area? Are these given to clients as part of care? What are some examples?

1.3.9   Do staff involved in the prescription, dispensing and/or supervision of medication give clients easy to understand verbal and/or written information on

its use? Does this include (a) drug name and dosage (b) possible side effect (c) when to take (d) drug interactions? What are some examples?

1.3.10   Does the service ensure that clients who do not speak or read English have access to information, education and skills in the care of their health? What are some examples?

1.3.11   Does the service ensure that clients who have low literacy have access to information, education and skills in the care of their health? What are some examples?

1.4.3   Where clients consent, do staff have opportunities to consult with multidisciplinary team members to help with comprehensive assessment? How does this happen?

1.4.4   Do staff make use of health assessments for the early identification of health problems? What ares some examples?

4.1.1   Do staff have access to an up-to-date and comprehensive resource file or directory that lists: (a) health, legal and welfare services (b) Commonwealth and State Government services and entitlements (c) local government services and activities (d) community organisations and groups (e) other sections/branches of the health authority/Area Health Service? Do staff use the community resources file? What are some examples?

4.1.2   Has responsibility been delegated for keeping the community resources file up-to-date? How does this happen?

4.1.3   Does the service find out about and make contact with local organisations, community groups and networks? How does this happen?

4.1.4   Do staff meet regularly with members of ethnic groups in the area, in order to learn about their health issues and needs? How does this happen?

4.1.5   Do staff meet regularly with members of other disadvantaged groups in order to learn about their health issues and needs (eg, gay and lesbian groups, single parents, unemployed)? How does this happen?

4.1.6   Do staff meet regularly with members of the Aboriginal/Torres Strait Islander communities in the area, in order to learn about their health issues and needs? How does this happen?

4.1.8   Does the service make sure that new information about community resources and issues is available to staff? How does this happen?

4.2.1   Do the statements of duties of staff cover liaison with community agencies and groups?

4.2.2   Does the health service hold regular discussions with other health service agencies (eg, hospitals, Divisions of General Practice, Family Planning Associations, Aboriginal health services) on issues of common interest? What are some examples?

4.2.3   Does the health service send a representative to interagency meetings (eg, involving local council, voluntary agencies, self help groups)?

4.2.4   Have links been established with State and Federal Government departments (eg, education, housing, community/welfare services) in the local area? What are some examples?

4.2.5   Does the service have a formal role in the local implementation of procedures drawn up by the appropriate state emergency services agency?

4.2.6   Do staff know their responsibilities in dealing with any possible emergency or disaster in their area? Have they received appropriate training for this? Have links been established between the community disaster plan and the hospital emergency plan?

4.2.7   Have links been established with any local community advocacy bodies (eg, Health and Social Welfare Councils, District Health Forums, Primary Health

Care Councils, Aboriginal Land Councils, consumer organisations, other advocacy groups)??

4.2.8   Does the health service provide advice and consultation to other agencies in the community, to help them address health issues in the area? What are some examples?

4.5.1   Does the service have easy access to accredited interpreters that cover the languages spoken in the area served?

4.5.2   Does the service have easy access to a signing interpreter for consumers who are deaf?

4.5.3   Are the available interpreters trained in health issues (eg, mental health, domestic violence)?

4.5.4   Does the service have written guidelines for deciding when an interpreter is needed? Do these include: (a) when to use face-to-face or telephone interpreters (b) to use independent, accredited interpreters rather than family members?

4.5.5   Does the service make provision in its budget for interpreter services? Does this include allowances for staff using their bilingual skills when needed?

4.5.6   Are training sessions on the use of sign and other language interpreters available for staff? Have most staff received this training?

4.5.7   Does the service tell consumers that interpreters are available when using the service? How does this happen?

6.1.1   Does the service have a uniform or compatible system of client registration?

6.1.2   Is there a person who is responsible for maintaining the client health record system?

6.1.3   Does the service have written policies and procedures for its client health record system that include: (a) criteria for registration of a client (b) the creation of a record for each registered client (c) retrieval, refiling and storage of records (d) guidelines for staff in completing records (e) security arrangements for transport of records?

6.1.4   Does the service have the appropriate State legal guidelines for client health records? Do these include: (a) how to process a subpoena for records (b) processing FOI requests (c) procedure for destroying and storing records (d) confidentiality? Are appropriate staff aware of these guidelines?

6.1.5   Does the service make sure all staff understand and follow the service's system and policy for client health records? How does this happen?

6.1.6   Does the format for client health records follow the four components of a problem or issues oriented system: (a) data base (b) problem/issue list (c) management/care plans (d) progress and review notes?

6.1.17   Does the service have access to advice and consultation about its client health record system from an appropriate Medical Record Administrator?

6.3.1   In a sample of randomly selected client health records, is the following information included: (a) registration number (b) client's name (c) date of birth (d) address (e) occupation (f) language used at home (g) source of referral (h) whether an interpreter is needed?

6.3.2   In the sampled client health records, is there information on (a) a general health history (b) a list of presenting and identified problems and issues (c) a plan of management/care (d) progress in addressing identified problems/issues (e) if further services are expected/required (f) case reviews (g) referrals as appropriate?

6.3.3   Have presenting and identified problems or issues been recorded objectively in the client health records?

6.3.4   Do the sampled client health records show the date, signature, name and profession off each health worker providing services to the client?

6.3.5   Are all entries in the sampled client health records legible?

6.3.6   Is there a procedure for placing appropriate incoming correspondence in client health records? How does this happen?

6.3.7   Does the service ensure that notes are completed in client health records promptly after service provision? How does this happen?

8.2.8   Are there services in the community that address the health needs of Aboriginal/Torres Strait Islander people? How has the service considered Aboriginal/Torres Strait Islander health needs?

8.29   Has the service identified groups within the community who have least access to health services and/or poor health (eg, youth, people of non-English speaking background, women, unemployed)?

8.2.10   Does the service liaise with other agencies to identify needs and to prevent unnecessary duplication of services? How does this happen?

8.2.11   Where gaps or unnecessary duplication of service have been identified, what steps have been taken to address these?

8.2.12   Does the service collate its information on health needs in order to assess regularly the main health issues to be addressed? How does this happen?

8.3.1   Does the service have a current overall plan for its activities (eg, strategic or annual plan) which includes: (a) analysis of data collected to identify needs (b) rationale for priorities identified (c) goals (d) specific objectives (e) target groups (f) selected methods or strategies (g) indicators of effectiveness (h) assessment of resources needed (eg, time, staffing, budget, facilities, equipment)?

8.3.2   Does the service have mechanisms for linking the planning of specific activities or services to the overall plan? Do specific plans include: (a) assessment and care services (b) health promotion (c) early identification and intervention (d) continuing education (e) quality improvement?

8.3.3   Does the service's planning process involve staff in setting priorities and developing the overall plan? How does this happen?

8.3.4   Does the service provide community members with opportunities to contribute to planning for the service as a whole? How does this happen?

8.3.5   Have members of the service's management structures participated in the development of the current overall plan of programs and services? How does this happen?

8.3.6   What are some examples of how the services' current goals and activities correspond to the identified main health issues of the community? Are there any gaps?

8.3.7   Where health issues have been identified but are not being responded to within the service's current plan, what steps are being taken to address these issues in the long term?

8.3.8   Does the service use explicit criteria for considering program proposals and allocating resources for new and ongoing activities? Do the criteria include: (a) consistency with the service's overall goals (b) effectiveness of methods (c) skills of staff (d) availability of resources (staff, money, equipment, etc)?

Appraisal
Both sets of standards address issues of re-assessment of consumers and a requirement for agencies to coordinate/refer to other services as appropriate, and are comparable in this regard. As noted in relation to other objectives, the relevant CHASP Standards are again much more detailed and specific than the corresponding HACC Service Standards.

> **Gaps in CHASP Standards:**
> *The issue of providing consumers with written care plans is not specifically addressed. Additionally, while CHASP Standard 4.5.1 refers to providing consumers with access to interpreter services, this is not sufficient to meet the much broader HACC Service Standard 4.3 relating to addressing consumers cultural needs.*
>
> **Gaps in HACC Service Standards:**
> *No obvious gaps, although the CHASP standards place greater emphasis on an agency liaising with other agencies and promoting a teamwork approach to service delivery.*

HACC OBJECTIVE 5:   PRIVACY, CONFIDENTIALITY AND ACCESS TO PERSONAL INFORMATION

HACC Service Standards

5.1   Consumers are informed of the privacy and confidentiality procedures and understand their rights in relation to these procedures.
5.2   Consumers have signed confidentiality release forms
5.3   Consumers are able to gain access to their personal information.

CHASP Service Standards

5.1.1   Does the service have a written policy on the rights of consumers? Does it include the right to: (a) quality and respectful health care (b) non-discriminatory health care (c) confidentiality and privacy (d) be informed and make decisions about their health care (e) consent to or refuse any assessment or treatment procedures (f) choose who will be present at consultation (g) request transfer to another staff member (h) have an advocate (i) remain anonymous (j) fair investigation of complaint (k) continued access to services after making a complaint (l) refuse to take part in research and experiments (m) refuse services from students (n) read their own health records (o) receive written information about their rights at the time of first contact with staff?

5.1.2   How do staff implement the consumer rights policy in their practice?

5.1.3   Is there a leaflet on consumer rights written in language that is easy to understand?

5.1.4   Is appropriate information on rights of consumers available for consumers who don't speak or read English? How does this happen?

5.1.5   Does the service make sure that consumers receive verbal explanation as well as the consumer rights leaflet at initial assessment? How does this happen? Is this recorded in client files?

5.1.6   Does the service have a sign clearly displayed in the reception area that tells consumers about their rights? Is it in appropriate community languages?[6]

5.1.7   Does the service allow access to and photocopies of their health records on request (except where laws explicitly prohibit this)? Are all references to third parties/other individuals removed when this is done?

5.2.1   When consumers provide personal information at reception, how is confidentiality maintained?

5.2.2   Do interview and treatment spaces in the centre have sight and sound privacy?

5.2.3   Are staff on reception easily able to make and receive telephone calls in privacy? Does this require them to leave reception unattended?

5.2.4   Does the service ask for consumers' consent before discussing confidential information with other health professionals within or outside the service? Is consent recorded? How does this happen for non-English speaking clients?

5.2.5   Does the service explain to consumers that their records may be audited or used for data collection? How does this occur?

5.2.6   Do staff know their professional and legal responsibilities to protect confidentiality? How do they carry these out?

5.2.7   Does the service make sure that names and appointment times of consumers are not publicly observable? How does this happen?

5.2.8   Within group work, do group facilitators discuss with participants what information is to be kept confidential within the group? What are some examples?

6.2.1   Is there a separate lockable space (room or cabinet) where all records containing information about clients are stored?

6.2.2   Are there adequate security arrangements to prevent loss, defacement and unauthorised use of records? How does this happen?

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[6]   Note, CHASP Standards 5.1.1, 5.1.2, 5.1.3, 5.1.4, 5.1.5 and 5.1.6 have also been included under HACC Objective 2, Information and Consultation, Objective 6, Complaints, and Objective 7, Disputes/Advocacy.

6.2.3   Are there procedures to make sure that the confidentiality of records is maintained, if their removal from the service by staff is necessary (eg, locked briefcase, registered mail)?

6.2.4   Where aspects of the record system are computerised, how is confidentiality ensured (eg, nor linkage of client names with information when computers are networked, password)?

6.2.5   Does the agency make sure records are not left unsupervised (eg, on desks, not having names on front covers, filing cabinets) and cannot be read by unauthorised people? How does this happen?

Appraisal
The two sets of standards vary somewhat in focus - the CHASP Standards being largely concerned with agency work practices in contrast to the HACC Services which are more concerned with consumer's 'ownership' of personal information.

Gaps in CHASP Standards:
No evident gaps

Gaps in HACC Standards:
Demonstration of appropriate processes to ensure consumer's rights to privacy and confidentiality are respected.

HACC OBJECTIVES 6 & 7:   COMPLAINTS AND DISPUTES/ ADVOCACY:

HACC Service Standards

6.1   Each consumer's complaint about a service, or access to a service is dealt with fairly, promptly, confidentially and without retribution.

6.2   Consumers are aware of the complaints process.

6.3   Services are modified as a result of "upheld" complaints.

6.4   Each consumer receives assistance, if requested, to help with the resolution of conflict about a service that arises between the frail elderly person or younger person with a disability and his/her carer.

7.1   Each consumer has access to an advocate of his/her choice.

7.2   Consumers know of their rights to use an advocate.

7.3   Consumers know about advocacy services - where they are and how to use them.

7.4   The agency involves advocates in respect to representing the interests of the consumer.

CHASP Service Standards

5.1.1 Does the service have a written policy on the rights of consumers? Does it include the right to: (a) quality and respectful health care (b) non-discriminatory health care (c) confidentiality and privacy (d) be informed and make decisions about their health care (e) consent to or refuse any assessment or treatment procedures (f) choose who will be present at consultation (g) request transfer to another staff member (h) have an advocate (i) remain anonymous (j) fair investigation of complaint (k) continued access to services after making a complaint (l) refuse to take part in research and experiments (m) refuse services from students (n) read their own health records (o) receive written information about their rights at the time of first contact with staff?

5.1.2 How do staff implement the consumer rights policy in their practice?

5.1.3 Is there a leaflet on consumer rights written in language that is easy to understand?

5.1.4 Is appropriate information on rights of consumers available for consumers who don't speak or read English? How does this happen?

5.1.5 Does the service make sure that consumers receive verbal explanation as well as the consumer rights leaflet at initial assessment? How does this happen? Is this recorded in client files?

5.1.6 Does the service have a sign clearly displayed in the reception area that tells consumers about their rights? Is it in appropriate community languages?[7]

5.3.1 Does the health service have a written policy and procedures describing how it receives, investigates and addresses verbal and written complaints from consumers and other agencies? Do these include: (a) process to be followed in investigating minor and more serious complaints (b) mediation steps (c) access to an independent mediator (d) the need for prompt action (e) provision for the person/s being complained about to be informed of the complaint and to make their case (f) ways of making sure that people who complain have continued access to the service (g) provision for the complainant to be informed of the outcome (where appropriate)?

5.3.2 Are staff aware of the procedures for receiving and investigating complaints?

5.3.3 Does the service tell consumers how to make a complaint and what will be done? How does this happen?

5.3.4 After a consumer or other agency makes a complaint does the service tell the person or agency what has been done? How does this happen?

5.3.5 Has the service changed any aspect of its activities as a result of complaints? What are some examples?

5.3.6 Does the service keep a record of complaints and their outcomes?

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[7] Note, CHASP Standards 5.1.1, 5.1.2, 5.1.3, 5.1.4 and 5.1.6 have also been included under HACC Objective 2, Information and Consultation and Objective 5, Privacy, Confidentiality and Access to Personal Information.

Appraisal
The CHASP Standards adequately cover most of the issues addressed by the HACC Standards in relation to complaints.

Gaps in CHASP Standards:
The issue of assisting consumers to resolve conflicts they may have with their primary carer is not addressed. The CHASP Standards also do not comprehensively address the issue of providing information to consumers about advocates, and encouraging the involvement of advocates, however, information provided under CHASP Standard 5.1.2 in regard to implementation of consumer rights policy may well provide information of relevance to the HACC advocacy standards. HACC Standard 7.2 is explicitly covered.

Gaps in HACC Standards:
None.

CHASP STANDARDS: EARLY IDENTIFICATION AND INTERVENTION

HACC Service Standards

nil

CHASP Service Standards

2.1.1 Do the service's policy documents on early identification and intervention include: (a) the need for early identification of environmental, social, emotional, cultural and physical factors in relation to health problems in individuals and the community (b) the efficacy of undertaking different activities (c) the need to link appropriate intervention to any problems identified (d) planning and evaluation methods that guide approaches to early identification and intervention (e) the idea that individual participation in early identification is voluntary (f) the linking of early identification and intervention approaches to current standards of practice and research? Is the policy dated within the last three years?

2.1.2 Does the service's annual plan for early identification and intervention include: (a) need to identify and prioritise health issues in the community that are appropriate for early identification and intervention (b) rationale and goals for the service's early identification and intervention activities (c) goals, methods and indicators of effectiveness (d) assessment of resources needed (time, staff, equipment, funds)? What are some examples?

2.1.3 Have all professional staff identified possibilities for early identification within their area of work? What are some examples?

2.1.4 Has the service used client and health status data to identify common problems in the community? Has this data been used to plan appropriate early identification and intervention programs and activities? What are some examples?

2.1.5 Are there opportunities for community participation in planning early identification and intervention programs and activities? How does this happen?

2.1.6 Has the health service sought funds (where appropriate) to support its work in early identification and intervention (eg, National Mental Health Program, National Women's Health Program)?

2.1.7   Does the service receive assistance from the health authority in its early identification and intervention programs and activities? Does this include assistance in training, materials, planning, data analysis and coordination of activities? What are some examples?

2.1.8   Do staff have access to training to develop their knowledge and skills in early identification and intervention? What are some examples?

2.19   Does the service use current research information on appropriate identification and intervention approaches? What are some examples?

2.2.1   Does the service use a range of methods for the early identification of health problems (eg, monitoring of individuals, screening, community surveys or assessments, client record audits)? What are some examples?

2.2.2   Does the service conduct early identification activities for groups in the community at risk of specific health problems (eg, homeless youth, women over fifty, computer data entry workers)? What are some examples?

2.2.3   Does the service identify environmental hazards which could affect the health of the community (eg, traffic danger spots in the area, farm chemical storage, amount of unshaded areas in children's playgrounds/schools)? What are some examples?

2.2.4   Does the service have early identification approaches that address social causes of ill health (eg, debt levels of individuals or groups in the community which could lead to stress, survey of young women's eating patterns and self image to identify eating disorders)? What are some examples?

2.2.5   Does the service have early identification approaches for emotional health problems (eg, depression, dealing with anger)? What are some examples?

2.2.6   Does the service have early identification approaches for physical health problems (eg, mobility in older women, cervical cancer smears)? What are some examples?

2.2.7   Has the service established links with other agencies who could assist in the identification of environmental health hazards (eg, Environmental Protection Authority, local council, advocacy groups)? What are some examples??

2.3.1   Does the service inform the community of its early identification and intervention programs and activities and encourage their participation? What are some examples?

2.3.2   Do staff explain to people and communities participating in early identification and intervention programs and activities: (a) the health problem being identified (eg, domestic violence, water quality) (b) benefits and associated risks (eg, HIV testing has both benefits for early intervention and possible adverse social effects; environmental testing could improve air quality but may adversely affect employment) (c) the identification procedure (eg, surveys, Pap smears, baby weighing scales, air quality) (d) intervention activities (eg, referral to other professionals, support groups, education, health promotion, advocacy) (e) that participation in the activity is voluntary (f) the efficacy of undertaking the activity? How does this happen?

2.3.3   Does early identification and intervention take place in locations that are accessible to and appropriate to the community? What are some examples?

2.3.4   Does the service promptly inform individuals and communities participating in early identification activities of their results? What are some examples?

2.3.5   Does the service offer pre and post counselling for consumers where this may be appropriate (eg, detection of HIV or Hepatitis B)?

2.3.6   Does the service involve the community in developing appropriate intervention strategies following identification? What are some examples?

2.3.7　　Are people encouraged, where appropriate, to continue their involvement in early identification programs and activities (eg, lead monitoring of children, Pap smears, monitoring high cholesterol level)? What are some examples?

2.4.1　　Does the service use written procedures and validated benchmarks to guide its early identification activities (eg, measurement of blood pressure, alcohol intake assessment, nutrition assessments)?

2.4.2　　Do the written identification procedures used conform to current professional knowledge and practice (eg, consistent with NH&MRC Screening Guidelines, nursing standards, RACGP Guidelines for Prevention)? How is this ensured?

2.4.3　　Do the staff have access to appropriate equipment/written materials for early identification (eg, baby scales, psychology scales, computer programs, spirometers, risk indicators for child abuse, balance and gait lists)?

2.4.4.　　Do the service's early identification activities take place in environments that enable accurate measurement?

2.4.5　　Where another agency conducts part of the early identification testing, does the service use only agencies that meet appropriate standards to maintain accuracy (eg, cytology standards for Pap tests, lead testing, audiometry)? How does this happen?

2.4.6　　Do staff attend training and/or refresher courses to gain and maintain the skills required for accurate early identification?

2.5.1　　Does the service provide early intervention activities (including referral) for individuals or communities? What are some examples?

2.5.2　　Do the early intervention activities include a range of approaches (eg, individual care, self help groups, health promotion programs, advocacy)? What are some examples?

2.5.3　　Do staff work in a multidisciplinary way to provide early intervention activities to individuals or the community where there are multiple causes of the health issue (eg, environmental health officer, chemist, GP, school teachers, physiotherapist, social worker, youth worker, Chamber of commerce)? What are some examples?

2.5.4　　Does the service promptly refer people with identified problems or contributing factors to the appropriate intervention services? What are some examples?

2.5.5　　Where a community-wide problem is identified does the service attempt to ensure that appropriate intervention activities occur? What are some examples?

2.6.1　　Does the service use systematic methods to monitor, assess and record its early intervention programs and activities? Does this information include: (a) number and range of early identification programs and activities (b) number of participants (c) number and nature of problems identified (d) reduction of the risk factors identified (e) the type/s of early intervention strategies used (eg, individual care plans, self help groups) (f) numbers of people attending education or self help groups (g) numbers of people referred to other appropriate services (h) the effectiveness of intervention strategies used on identified health problems? Is this information summarised in a readily accessible form?

2.6.2　　Look at two documented early identification/intervention programs. Do they include rationale, identification methods, participating groups or individuals, intervention strategies, effectiveness methods, participant feedback?

Appraisal
This area is not included in the HACC National Service Standards as currently conceived.

CHASP STANDARDS: HEALTH PROMOTION

HACC Service Standards

nil

CHASP Service Standards

3.1.1   Does the service have a written policy on health promotion for its defined community? Does it include the need to: (a) commit resources (staff, time, funding) to promoting the health of the community (b) have a comprehensive approach based on the Ottawa Charter on Health Promotion (c) relate health promotion activities to the main health issues in the community (d) ensure community participation in planning and implementing health promotion activities (e) make links where appropriate with other sectors which may have an impact on health (eg, transport, food distributors, hotel industry) (f) relate health promotion activities to early identification and intervention in health problems? Is the policy dated within the last three years?

3.1.2   Are all staff aware of the service's policy on health promotion?

3.1.3   Do all staff have the opportunity to participate in health promotion? How does this occur?

3.1.4   Does the service have an identifiable health promotion budget or ready access to funds to support health promotion?

3.1.5   Does the service have a committee, working group or individual responsible for coordinating health promotion programs? Does the role of this group/individual include (a) planning (b) assessment of proposed programs (c) ensuring that programs are documented (d) assessment of evaluations of programs?

3.1.6   Does the service regularly seek external funds for health promotion (eg, Health Promotion Foundations, Office of Status of Women Grant Program, NCADA, etc)? What proportion of the funding applications has been successful?

3.1.7   Do the staff have access to appropriate audiovisual and printed resource materials to support health promotion? Are there materials available in appropriate community languages? Do they include: (a) consumer information leaflets/videos on various health issues (b) teaching materials for use in group work (eg, Healthwise, Photo language, videos) (c) planning, evaluation and support materials (eg, Cases for Change, Planning Healthy Communities, Health Education and Promotion System (HEAPS), Evaluating Health Promotion)?

3.1.8   Do staff have access to training to develop their knowledge and skills in health promotion? What are some examples?

3.1.9   Does the service have access to a Health Authority/Area Health Service health promotion unit which provides advice, training and materials to support its work? How has the service used this support?

3.2.1   Have National/State/Area health promotion priorities (eg, relevant goals and targets) been addressed in planning and adapted where appropriate?

3.2.2   Do the service's current health promotion activities and programs correspond to the identified main health issues in its community? Do these activities and programs reflect the health promotion policy? What are some examples?

3.2.3   Is health promotion an integral component of all activities of the service (eg, developing personal knowledge and skills in individuals with a chronic condition such as diabetes; strengthening community action by encouraging new parents to set up a playgroup; creating supportive environments by working with

local government to improve the boarding houses used by people who are chronically mentally ill, etc)? What are some examples?

3.2.4 Do the staff seek input from the proposed participants when planning new health promotion programs (eg, consultations with community members before program is run, asking about participants' expectations at the start of the program)? What are some examples?

3.2.5 Does the service have a uniform format to assist staff to plan, implement, evaluate and document health promotion programs? Does this format encourage: (a) input from relevant members of the community to be recorded in each stage of program design and implementation (b) staff to consult the national data base on health promotion programs and resources (HEAPS) when developing a new program (c) comprehensive needs assessment to identify the causes and contexts of health problems/issues (d) the program goals, objectives and multiple strategies to be logically derived from this analysis (e) the outcomes that the program is intended to achieve to be clearly identifiable (f) the resources required to implement the program to be fully specified?

3.2.6 Is there a formal process of review of health promotion plans before programs are implemented?

3.2.7 Look at a sample of health promotion program records? Do the records reflect the requirements of the uniform format?

3.3.1 Does the service use a systematic process to inform all staff of current and forthcoming health promotion programs within the health service and the local area? How does this happen?

3.3.2 Are there opportunities for staff to consult with team members, other agencies and community organisations about the health promotion they conduct? What are some examples?

3.3.3 Have the service's health promotion programs been placed on the national health promotion data base? How does this happen?

3.4.1 Does the service conduct a range of health promotion programs and activities that address social, emotional, cultural, environmental and physical factors in relation to health? What are some examples?

3.4.2 Does the service work with local agencies and community groups to strengthen community action in identifying health issues and in promoting health (eg, working with older people to improve local transport, working with young people to increase the availability of condom vending machines in discos)? What are some examples?

3.4.3 Does the service run programs that assist people to develop personal skills for health (eg, nutrition education, exercise classes, parenting skills, carers' support groups, injury prevention for older people)? What are some examples?

3.4.4 Are interactive learning strategies used that acknowledge and value participants' experience when conducting health promotion activities? What are some examples of such strategies?

3.4.5. Is the service involved in activities and/or programs that seek to create environments supportive to health (eg, availability of affordable, nutritious food, parent co-operative child care, safe footpaths)? What are some examples?

3.4.6 Is the service involved in activities and/or programs that seek to develop public policies that are conducive to health at the local level (eg, school canteen healthy food policies, building standards to lower hot water system thermostats, skin cancer prevention)? What are some examples?

3.4.7 How is the service working towards the reorienting of its health services towards health promotion? What are some examples (eg, encouraging Pap smears,

increasing all staff's involvement in health promotion, participating in CHASP, establishing a Healthy Cities Committee)?

3.4.8 Does the service regularly conduct health promotion programs/activities in coordination with other agencies in the local area (eg, conducting Drink Safe campaigns in pubs with local police)? What are some examples?

3.5.1 Does the service inform community members and organisations about current health issues and their potential impact on the community? What are some examples?

3.5.2 Does the service work with community organisations and groups to investigate the impact that physical, social and environmental issues could have on the health of the community and to take action? What are some examples?

3.5.3 Does the service participate in public forums and other activity in order to protect the health of the community? What are some examples?

3.6.1 Does the service have written guidelines to assist staff in evaluating health promotion programs and activities?

3.6.2 Does the service evaluate all its health promotion programs and activities in terms of process: (a) were they implemented as planned (b) did they reach their intended target group (c) were participants satisfied (d) were resources and strategies appropriate (e) any unintended outcomes? Are there examples in the sampled health promotion records?

3.6.3 Does the service evaluate the impact and outcomes of any of its programs and activities by assessing the level of attainment of goals, objectives and indicators of effectiveness? Are there examples within the sampled health promotion records?

3.6.4 Does evaluation and discussion of the appropriateness of goals, objectives, target groups, program costs and strategies happen in order to improve future programs? What are some examples?

Appraisal
This area is not included in the HACC Service Standards as currently conceived.

CHASP STANDARDS: STUDENT EDUCATION

HACC Service Standards

nil

CHASP Service Standards

7.4.1 Is there a written policy that guides the service's student education activities? Does it include: (a) criteria for accepting student placements based on resources of service (b) supervisory arrangements (c) education institution's responsibility for resourcing the placement and providing feedback on the student program (d) role of staff and students in the service?

7.4.2 Is a contract developed with the student specifying what their work will involve? Does it include: (a) confidentiality requirements (b) treating consumers with respect (c) supervisory arrangements and lines of responsibility (d) starting and finishing times (e) role of student while on placement?

7.4.3 Does the service ensure that students know that consumers can refuse services or observations from them?

7.4.4   Does the service work with tertiary education institutions so that a community/primary health perspective is included in health and related teaching programs? What are some examples?

7.4.5   Does the service encourage undergraduate and postgraduate students to plan and conduct projects which can contribute to community/primary health goals and activities? What are some examples?

Appraisal
This area is not included in the HACC Service Standards as currently conceived.

CHASP STANDARDS: INTEGRATED QUALITY IMPROVEMENT ACTIVITIES

HACC Service Standards

nil

CHASP Service Standards

8.6.1   Do the service's written policies cover quality improvement? Do these include: (a) a commitment to continuous quality improvement (b) the need for all staff to be involved in quality improvement activities (c) that activities to improve quality include consumer input (where appropriate)?

8.6.2   Does the service have a quality improvement plan? Does the plan identify: (a) a range of activities (b) who will be involved (c) the process to be used (d) information to be collected (e) the standards/best practice to be used (f) how findings will be linked to planning and evaluation work?

8.6.3   Has the service conducted a range of quality improvement activities in the last year? What are some examples?

8.6.4   Does the health authority/Area Health Service provide support to the quality improvement activities in the service? How does this happen?

8.6.5   Does the service conduct regular audits of client health records? Is a recent report available?

Appraisal
This area is not explicitly included at this level of detail in the HACC National Service Standards as currently conceived, although the CHASP Standards are relevant to HACC Standard 3.1 in relation to modifying service design or delivery as a result of evaluation activity.

CHASP STANDARDS: RESEARCH

HACC Service Standards

nil

CHASP Service Standards

8.7.1   Has the service developed guidelines for research? Do these include: (a) the need for informed consent of research participants (b) the right to confidentiality of research participants (c) the need for research to be useful in improving the health of the community (d) an assessment of the time and resources involved (e) that the methodology is appropriate to the research task (f) the need for information gained to be disseminated to those involved in the research in an accessible way (g) when it is appropriate to submit the research to an ethics committee?

8.7.2   Has the service sought funding from schemes which support research and evaluation in community/primary health (eg, Commonwealth Research and Development grants, Public Health Research and Development Committee, Rural Health Support, Education and Training Program)? What are some examples?

8.7.3   Has liaison been established with academic institutions and other non government agencies to facilitate joint research in community/primary health care? What are some examples?

8.7.4   Has the service undertaken any recent research projects? Are these consistent with its research guidelines? What are some examples?

> *Appraisal*
> *This area is not included in the HACC National Service Standards as currently conceived.*

CHASP STANDARDS: WORK AND ITS ENVIRONMENT

HACC Service Standards

nil

CHASP Service Standards

10.1.1   Do staff and management think that the skills for which they have been employed are appropriately used in their work?

10.1.2   Do staff think that their employment provides them with opportunities for career development?

10.1.3   Can staff, management and Management/Advisory Committee members cite examples where their contribution to the service has been acknowledged?

10.1.4   Do staff, management and Management/Advisory Committee members feel that the service team or teams work well together?

10.1.5   Do the current communication channels in the service operate effectively? What are some examples?

10.1.6   Does the service have procedures to resolve staff grievance and conflict? Do these include: (a) the process for resolution of conflict (b) appointment of an

appropriate mediator (c) access to union/professional association representation (d) confidentiality and fairness (e) prompt attention to disputes?

10.1.7 Are the Management/Advisory Committee members satisfied with their role and responsibilities?

10.2.1 Does the service have written policy on occupational health and safety that includes: (a) designation of person/committee responsible for identifying occupational health and safety issues and relevant training (b) methods for identification of issues (c) informing and educating staff on their rights and responsibilities and any relevant legislation (d) methods for addressing issues raised?

10.2.2 What actions have been taken to implement the service's policy on occupational health and safety?

10.2.3 Are there written procedures that address the following (where appropriate): (a) reporting of accidents (b) safe use of equipment (eg, VDUs, photocopiers) (c) security of staff involved in work activities outside of the service's premises or outside routine working hours (d) debriefing after critical/stressful incidents?

10.2.4 Does the service have a policy and procedures to prevent the transmission of any communicable diseases (eg, HIV, Hepatitis B)? Does it include: (a) training for staff (b) use of universal infection control guidelines (c) system for sharps/other waste disposal (d) procedures for needlestick injuries (e) access to vaccination?

10.2.5 Has the service dealt with any health or safety hazards that have been identified? What are some examples?

10.2.6 Does the service prohibit smoking in its premises? Are there designated external areas for smoking?

10.2.7 Does the service have appropriate insurance coverage for volunteers?

10.2.8 Does the service have procedures, security equipment and training programs to address the management of situations involving aggressive people?

10.2.9 Does the service have practices that support the health of staff (eg, ensuring regular breaks are taken, fitness programs, good nutrition, QUIT smoking, car maintenance, driving skills)? What are some examples?

10.3.1 Do the service's facilities have: (a) rooms for consultations, treatment, counselling and interviews (b) rooms to run groups and programs (c) adequate and ergonomically designed office equipment for staff (d) adequate storage areas (e) secure parking for cars (f) meeting rooms available for use by community groups (g) wheelchair accessibility in all parts of the building/s (h) toilet and shower facilities (i) suitable entry/loading dock for moving equipment (j) sick bay (k) non-slip floors?

10.3.2 Are the reception and waiting areas welcoming, and do they have adequate space and facilities (eg, chairs, refreshments, reading materials, toys)?

10.3.3 Is there a staff room that has kitchen facilities?

10.3.4 Are adequate lighting, ventilation and heating provided in all areas?

10.3.5 Is the service adequately cleaned?

10.3.6 Is there an identifiable item in the budget for repairs and maintenance of facilities?

10.3.7 Are any outdoor areas adjoining the service well maintained?

10.3.8 Are all drugs kept in a locked, secure cupboard? How is its security ensured?

10.3.9 Is there a separate fridge available for the storage of appropriate drugs and pathology specimens? How is security ensured?

10.4.1 Do all staff have access to the equipment that is necessary for their clinical/professional practice?

10.4.2 Does the service have adequate procedures to ensure the hygiene and maintenance of appropriate clinical equipment?

10.4.3 Does the service have adequate office equipment (eg, fax, photocopier, computer/s)? Is equipment regularly maintained?

10.4.4 Do staff have access to appropriate communication systems when providing mobile services (eg, mobile phones, two-way radios, beepers)?

10.4.5 Are staff trained and regularly updated in the use of equipment?

10.4.6 Are staff familiar with the location of the first aid equipment? Is it comprehensive and accessible? Is it regularly checked?

10.4.7 Are all cars fitted with a first aid kit and a fire extinguisher? Are they regularly checked?

10.5.1 Has there been a recent inspection of the fire safety of the building/s and equipment by the appropriate fire agency? Have any shortcomings been rectified?

10.5.2 Are there illuminated fire exits and a written procedure/floor plan for the evacuation of the premises? Are they prominently displayed?

10.5.3 Are there appropriate fire fighting equipment and/or systems (eg, detectors, blankets, hoses, extinguishers)? Are they regularly maintained?

10.5.4 Have staff been instructed in the proper use of fire fighting equipment and what to do in the case of fire?

10.5.5 Does the service have regular fire drills?

10.6.1 Are environmental issues considered when designing/ redesigning facilities (eg, heating, use of natural light, ventilation)? What are some examples?

10.6.2 Does the service have a recycling system in place? Does it include paper, glass and cans?

10.6.3 Has the service conducted an environmental review of its activities (eg, use of disposable clinical equipment, use of disposable cups, transport, chemical usage, waste disposal, heating, cooling and lighting)? Have any changes been made as a result?

10.6.4 Are environmental issues considered when purchasing equipment (eg, fuel efficient cars, cleaning agents, photocopiers able to print double-sided)? What are some examples?

10.6.5 Does the service promote the importance of consideration of environmental issues to staff and consumers? How does this happen?

Appraisal
This area is not included in the HACC National Service Standards as currently conceived.

3.3   SUMMARY

COMPARISON OF HACC AND CHASP SERVICE STANDARDS

A significant difference between the two sets of standards is the level of specificity. The CHASP Service Standards are considerably more numerous, detailed and prescriptive than the HACC Service Standards.

Agencies which conform to the CHASP Service Standards would be required to provide additional evidence to satisfy HACC requirements in the following key areas:

.   resource allocation according to prioritised need,
.   approach to providing services to consumers in receipt of other services,
.   informing consumers of the basis of service provision, including changes which may occur,
.   comprehensively addressing consumer's cultural needs,
.   assisting consumers in resolving conflicts they might have with their carers, and
.   all the HACC Standards relating to advocacy, with the exception of Standard 7.2.

It should be noted that:

.   Differences between the two systems would essentially preclude the existence of a meaningful comparative score;
.   Potentially, an add-on system could be developed, which would allow an appraisal of the "missing" elements of the HACC standards;
.   If this approach were adopted and developed, the duplication of quality appraisal processes would be reduced, with the trade-off being loss ofcomparability between these "combined" appraisals and the straight HACC appraisals.

4. COMPARISON OF HACC AND COMMUNITY HEALTH ACCREDITATION AND STANDARDS PROGRAM (HOME BASED CARE) STANDARDS[8]

4.1 OVERVIEW

CHASP (HOME BASED CARE) STANDARDS

The CHASP (Home Based Care) Service Standards comprise 61 standards, organised into ten sections.

1.   Assessment and Care
2.   Early Identification and Intervention
3.   Health Promotion
4.   Community Liaison and Participation
5.   Rights of Consumers
6.   Client and Program Records
7.   Education, Training and Development
8.   Planning, Quality Improvement and Development
9.   Management
10.   Work and its Environment

4.2 SUMMARY - JUNE 1995 DRAFT VERSION

The standards contained in the June 1995 draft version of the CHASP (Home Based Care) Standards do not differ substantially from the generic CHASP Standards discussed in the previous section. Generally, the standards are in fact the same, but refer to the 'home based care service' rather than the 'community/primary health care service'. For this reason, a comprehensive comparison of the HACC Standards against the June 1995 draft of the CHASP (Home Based Care) Standards has not been carried out.

Three additional standards are included in the CHASP (Home Based Care) Standards. These are listed below, with comments in regard to their relevance to the HACC Service Standards.

1.8   The home based care service will consider the option of brokering services to other agencies when this is in the best interests of both the client's needs and the suitability of the agency to provide the required services.

Information provided in relation to this standard would be relevant to the performance information required to demonstrate consumer outcome 4.4 of the HACC Service

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[8]   Australian Community Health Association. <u>Manual of Standards for Home Based   Care Services</u>. Draft, June 1995

        Australian Community Health Association. <u>Manual of Standards for Home Based   Care Services</u>. Draft, October 1996.

Standards - consumers receive services which include appropriate coordination and referral processes. The issue of brokering services to other agencies is not specifically addressed in the HACC Service Standards.

5.2   The home based care service will ensure that each client and carer has access to an advocate of his or her choice.

This standard reflects consumer outcome 7.1 of the HACC Service Standards - each consumer has access to an advocate of his/her choice.

5.3   The home based care service will ensure that reduction or termination of services will be conducted fairly and in consultation with clients and carers.

Information provided in relation to this standard could be relevant to information required under HACC consumer outcomes 1.2 - consumers are allocated available resources according to prioritised need, and 2.3 - consumers are informed of the basis of service provision, including changes that may occur.

These additional standards partially address the gaps between the HACC Service Standards and the generic CHASP Standards noted in the previous section, but the comments made in that section generally still apply.

4.3   SUMMARY - OCTOBER 1996 DRAFT VERSION

The Institute has received a partially completed revised draft of the CHASP (Home Based Care) Standards dated October 1996. This document contains a revised section 1 (Assessment and Care). The standards outlined in this section address the same issues as those in the earlier draft version, but some have been reworded to emphasise the importance of consumer needs, rather than the processes in place in the agency. The remaining 9 sections are yet to be revised.

5. COMPARISON OF HACC AND AUSTRALIAN COUNCIL OF HEALTHCARE STANDARDS[9] (ACHS)

5.1 OVERVIEW

HACC SERVICE STANDARDS

The HACC Service Standards comprise 26 standards grouped according to seven objectives:

1. Access to Services
2. Information and Consultation
3. Efficient and Effective Management
4. Co-ordinated, Planned and Reliable Service Delivery
5. Privacy, Confidentiality and Access to Personal Information
6. Complaints and Disputes
7. Advocacy

ACHS STANDARDS

The ACHS Standards comprise 160 standards or indicators grouped according to 22 objectives, which are in turn organised into six sections:

1. Continuum of Care
2. Leadership and Management
3. Human Resources Management
4. Information Management
5. Safe Practice and Environment
6. Improving Performance

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[9] Australian Council on Healthcare Standards. The EQuIP Guide: Standards and Guidelines for the ACHS Evaluation and Quality Improvement Program. 1996.

5.2 COMPARISON

IN THIS COMPARISON OF HACC AND ACHS STANDARDS, ACHS STANDARDS ARE GROUPED ACCORDING TO HACC OBJECTIVES

HACC OBJECTIVE 1:   ACCESS TO SERVICES

HACC Service Standards

1.1   Assessment occurs for each consumer
1.2   Consumers are allocated available resources according to prioritised need.
1.3   Access to services by consumers with special needs is decided on a non-discriminatory basis.
1.4   Consumers in receipt of other services are not discriminated against in receiving additional services.
1.5   Consumers who reapply for services are assessed with needs being prioritised.

ACHS Standards

1.1.3   The organisation and services within it can be easily located.
1.1.4   Physical access to the organisation is appropriate to the needs of the community.
1.2.1   An arrival process for patients/clients and carers addresses their needs and enables efficient and timely entry to the organisation.
1.2.2   Information necessary for efficient patient/client care is obtained and communicated prior to arrival, when appropriate.
1.2.3   Assessment needed before admission is completed, documented and communicated to relevant persons.
1.3.1   A comprehensive assessment of the patient/client is performed by professionals with appropriate skills.

Appraisal
Both sets of standards address the issue of consumers being comprehensively assessed prior to entry to the service.

Gaps in ACHS Standards:
The focus on assessment as a means of determining resource allocation on the basis of prioritised consumer need is not evident. In particular, the issue of ensuring consumers' non-discriminatory access to services is not addressed

Gaps in HACC Service Standards:
The issue of the service being physically accessible to consumers and having processes in place to ensure convenience for consumers is not addressed.

HACC OBJECTIVE 2:   INFORMATION AND CONSULTATION

HACC Service Standards

2.1   Consumers are aware of their rights and responsibilities.
2.2   Consumers are aware of services available.
2.3   Consumers are informed on the basis of service provision, including changes that may occur.

ACHS Service Standards

1.1.2   The community is made aware of services that the organisation provides.
1.2.5   All patients/clients are informed of their rights and responsibilities including providing relevant information for the delivery of care.
1.5.5   Patients/clients acknowledge their rights and responsibilities in the implementation of care.
1.5.6   Rights and needs of patients/clients are considered and respected by all staff.
2.1.29   Rights and responsibilities of patients/clients are respected and addressed through policies and procedures which are in accordance with the values of the organisation, professional codes of ethics and relevant standards and statutory requirements.

Appraisal
Both sets of standards emphasise the importance of consumers being made aware of their rights and responsibilities, as well as being provided with information about their care plan.

Gaps in ACHS Standards:
In relation to the provision of information about services, the ACHS Standards focus largely on providing information to the general community about the services offered by the agency, rather than informing consumers of services offered which are relevant to the consumer's assessed need. These Standards do not specifically address advising consumers of the basis of service provision, including services to be offered, for how long, and fees payable.

Gaps in HACC Service Standards:
No obvious gaps.

HACC OBJECTIVE 3:   EFFICIENT AND EFFECTIVE MANAGEMENT

HACC Service Standards

3.1   Consumers receive appropriate services provided through the processes of ongoing planning, monitoring and evaluation of services.
3.2   Consumers receive services from agencies that adhere to accountable management practices.
3.3   Consumers receive services from appropriately skilled staff.

ACHS Service Standards

1.1.1   The community that the organisation serves is defined and information gathered on its requirements is used for the planning and provision of services.

1.1.5   Hours of operation of various services of the organisation are appropriate for the community served and for the role of the organisation. The community is made aware of the hours of operation of the organisation.

1.5.10   Medico-legal issues in relation to care are recognised, addressed, monitored and statutory requirements are met.

2.1.1   The governing body, its officers and members of its committees are appointed according to specific requirements and terms of office.

2.1.2   The governing body specifies why the organisation exists (mission) and what it wants to achieve (goals).

2.1.3   The governing body provides leadership and has overall responsibility for the organisation's achievements, the quality of care and the organisation's resources.

2.1.4   The governing body ensures there are effective working relationships within the organisation and with the community, and with other relevant organisations and individuals.

2.1.5   The governing body ensures community and staff participation in organisational planning and policy issues.

2.1.6   The governing body meets regularly and provides for continuity of governance between meetings so that corporate business is conducted efficiently.

2.1.7   Suitable mechanisms assist the governing body in fulfilling its responsibilities and assessing the organisation's performance.

2.1.8   Terms of reference, membership and procedures are defined for the meetings of the governing body and all committees within the organisation.

2.1.9   Activities of the governing body and all committees are recorded and confirmed.

2.1.10   Newly appointed members of the governing body are oriented to ensure they understand their responsibilities and duties.

2.1.11   Members of the governing body participate in ongoing education to assist them in fulfilling their role.

2.1.12   The governing body regularly reviews its own performance to ensure improvement in the quality of care and effective and efficient management of the organisation.

2.1.13   The governing body delegates the necessary authority to the chief executive and managers and ensures their responsibilities are defined to enable the organisation to operate effectively.

2.1.14   The governing body authorises an individual to act for the chief executive when required.

2.1.15   The chief executive and managers provide leadership and act in accordance with corporate policies, delegated authority and instructions of the governing body and are responsible for the management of the organisation and its specific services.

2.1.16   The performance of the chief executive and each manager is reviewed regularly.

2.1.17   The organisation's values and goals direct the organisation's actions and behaviour, and are reflected in its culture.

2.1.18   The organisation's role is responsive to the needs and expectations of its customers and the community it serves.

2.1.19   The organisation's strategic and operational plans are developed in consultation with, and made known to, management, staff, the community and other relevant health service providers and authorities.

2.1.20   Operational plans of individual services are consistent with the organisation's strategic plan and other services' operational plans.

2.1.21   The organisation's strategic and operational plans are implemented and revised as necessary. The achievement of the plans is monitored and action taken to address any improvements required.

2.1.24   Service delivery is facilitated by the structure of the organisation.

2.1.25   Established lines of responsibility, authority and communication support leadership, teamwork and the integration of services both within the organisation and with other service providers.

2.1.26   The organisational structure is reviewed annually or whenever there is a significant change, such as alteration of the role of the organisation or its services.

2.1.27   The organisation's by-laws, Articles of Association, and each service's policies and procedures support the delivery of care and are consistent with the organisation's goals, accepted standards, statutory requirements and the organisation's community and regional responsibilities.

2.1.28   Compliance with the organisation's policies and procedures occurs throughout the organisation. The policies and procedures are reviewed and revised as necessary.

2.1.30   Ethical issues are formally considered and resulting policies are implemented and evaluated.

2.1.31   All activities are consistent with recognised ethical requirements of the professions and the organisation.

2.1.32   Research projects are reviewed and approved by an ethics committee constituted under the National Health and Medical Research Council's guidelines.

2.1.33   Human resources policies and practices assist with achieving the organisation's goals and are consistent with its values.

2.1.34   The organisation's human resources policies and practices comply with statutory requirements, including industrial relations, equal employment opportunities, occupational health and safety and contractual arrangements.

2.1.35   Financial management is used in the achievement of the organisation's goals and strategic plans.

2.1.36   The governing body oversees the finances of the organisation. Management processes are established to ensure the financial resources of the organisation are appropriately managed, reported and consistent with accepted standards and statutory requirements.

2.1.37   Relevant information management systems meet the organisation's needs.

2.1.38   The physical environment, including buildings, grounds, plant and equipment is managed and maintained in order to: (a) ensure patient/client, staff and visitor safety, privacy and comfort, (b) support efficient organisational performance and (c) meet statutory requirements.

2.1.39   Documented agreements/contracts cover the appointment of contractors and provision of external services.

2.1.40   Relevant agreements/contracts specify that the quality of services provided is consistent with the appropriate standards of the Australian Council on Healthcare Standards, the organisation's policies and procedures, and other standards, codes of practice and statutory requirements.

2.1.41   Agreements/contracts specify that the external service providers will be willing to participate in the accreditation survey by the Australian Council on Healthcare Standards.

2.1.42   External services are evaluated by the organisation and action taken to address any improvements required.

2.1.43 The governing body, chief executive and managers create a culture and provide leadership, direction and adequate resources for an integrated approach to improving performance throughout the organisation.

3.1.1 Human resources planning is undertaken to support and meet the organisation's strategic plans. Staff are involved in this process.

3.1.2 Planning ensures that appropriately trained and/or qualified personnel are available to undertake the type and level of activity performed by the organisation.

3.1.3 Workload monitoring is used to ensure appropriate numbers and skill mix of staff are available to achieve desired patient/client and organisational outcomes.

3.1.4 Planning ensures that appropriately trained, qualified and, where relevant, credentialed personnel are available, and sought for consultation and advice when expertise is not available within the organisation.

3.2.1 The recruitment, selection, appointment and reappointment procedure ensures appropriate competence, training, experience and registration of all appointees.

3.2.2 On appointment, staff receive a written statement of their accountabilities and responsibilities that specifies how their role contributes to achieving the organisational goals. The statements are reviewed and revised as necessary.

3.2.3 Accurate and complete personnel records are created and maintained, and are confidential. They are accessible to authorised personnel including the relevant employee.

3.2.4 All services and programs are managed by a person with appropriate qualifications, experience or training.

3.2.5 All health professionals are licensed, registered and/or credentialed, as appropriate.

3.3.1 Staff understand and act in accordance with their responsibilities to ensure organisational values and goals are achieved and quality care is maintained.

3.3.2 Staff are accountable for the care and/or services they give and for their delineated responsibilities.

3.4.1 An induction program ensures staff understand their roles, responsibilities and the organisation' values and goals and how these contribute to providing quality care and services.

3.4.2 Staff, including trainees, new graduates and external contractors are adequately supervised by qualified staff.

3.4.3 Staff achievements and improvement opportunities are assessed through a structured performance evaluation system that also involves the staff member.

3.4.4 Educational needs of the organisation and all staff are met through a relevant training and development program.

3.4.5 Staff training and development programs are evaluated and improved ensuring they meet organisational and individual needs.

3.5.1 Industrial relations policies and practices comply with statutory requirements and action is taken to address any improvements required.

3.5.2 Management, employees and where applicable, their representative associations, are actively involved in human resource issues.

3.6.1 Staff are aware of, and have access to, employee assistance for a range of suitable services.

3.6.2 Managers understand their role in recognising employee needs for assistance and facilitate access to appropriate services.

4.1.1 Information is managed to support the organisation's strategic plan.

4.1.2 Strategic planning of the management of information enables a coordinated approach and efficient use of information resources for effective delivery of patient/client care and management.

4.1.3 The information management systems are routinely evaluated and improved to ensure internal and external needs are met.

4.2.1 Relevant, accurate, quantitative and qualitative data are collected in a timely and efficient manner for delivery of patient/client care and management of services.

4.2.7 Indexing of data facilitates information retrieval.

4.2.8 Useful, timely and accurate information is made available to staff in an understandable format for use in delivery of patient/client care and management of services.

4.2.9 Clinical, managerial, reference and research information is collected and managed for use by staff in achieving the organisation's goals.

4.5.1 There is an integrated approach for the planning and use of information technology within the organisation.

4.5.2 Systems for information technology provision meet appropriate standards and encompass (a) licensing (b) security of systems and information (c) disaster recovery for system failure of any nature (d) standard operating environment enforcement (e) management of ongoing costs (f) a mechanism for necessary updates.

4.5.3 Information technology systems are used effectively and efficiently.

4.5.4 Technology and system serviceability is ensured through ongoing maintenance.

Appraisal
The ACHS Standards in relation to this objective are considerably more numerous and prescriptive than the corresponding HACC Service Standards. The ACHS Standards appear to comprehensively cover the issues addressed in the HACC National Service Standards, with the exception of consumer involvement in service management. Therefore, agencies which meet the ACHS Standards listed above could demonstrably meet HACC Standards 3.1 and 3.3 and could also demonstrate compliance with Standard 3.2 with minimal additional information.

Gaps in ACHS Standards:
The issue of consumer involvement in service management is not specifically addressed.

Gaps in HACC Service Standards:
Differences in the level of detail are particularly significant here. Substantive areas include clear specification of management responsibilities, the role of the physical environment in supporting organisational performance, contract arrangements with external service providers, and management of information technology.

HACC OBJECTIVE 4:   CO-ORDINATED, PLANNED AND RELIABLE SERVICE DELIVERY

HACC Service Standards

4.1 Each consumer receives ongoing assessment (formal and informal) that takes all support needs into account.

4.2 Each consumer has a service delivery/care plan which is tailored to individual need and outlines the service he or she can expect to receive.

4.3 Consumers cultural needs are addressed.

4.4 Consumers receive services which include appropriate coordination and referral processes.

ACHS Service Standards

1.1.6   If emergency services are not available, or are restricted, instructions guide access to available services.

1.2.4   Informed consent is obtained by the health professional responsible for the care of the patient/client.

1.2.6   Ongoing communication occurs and information relevant to their care is conveyed in a manner that is understandable by, and readily accessible to, patients/clients, carers and all relevant providers.

1.2.7   Throughout the care process care providers document all aspects of care necessary to assist communication.

1.2.8   Planning for separation begins at first contact with the organisation and is ongoing throughout the continuum of care.

1.2.9   Separation planning is interdisciplinary, coordinated and involves patients/clients, carers and all relevant external providers necessary for a coordinated approach to continuing care and separation.

1.3.2   Assessment is coordinated to reduce unnecessary repetition.

1.4.1   The plan is developed in consultation with patients/clients and carers and provides for the relevant clinical, social and emotional needs of the patient/client and carers.

1.5.1   Care is timely and appropriate.

1.5.2   Care is delivered according to professional standards and statutory requirements.

1.5.3   Care is delivered in a safe and comfortable environment.

1.5.4   Care is delivered in partnership with the patient/client and their carers.

1.5.7   Care is coordinated in order to ensure continuity of care and follow-up to avoid duplication of the provision of service.

1.5.8   The plan of care and goals are revised in response to patient/client progress.

1.5.9   Education helps the patient/client and carers to understand the patient's diagnosis, prognosis, treatment, and health promotion and illness prevention strategies. The education is given by appropriate professionals.

1.6.1   Patient/client progress, in relation to achievement of planned goals, is monitored by the health care team.

1.6.2   Patient/client data are analysed to provide information for care improvement.

1.6.3   Indicator data are collected and used for the evaluation of patient/client care and management of services.

1.6.4   Comparative analysis is undertaken and reasons for individual variance are ascertained by the health care team.

1.7.1   Patients/clients and carers understand instructions for continuing management.

1.7.2   Information, relevant to care and continuing management, is given to the patient/client and carers, and relevant health providers, and is included in the medical record of the patient/clients.

1.8.1   Priority of the patient's/client's needs for community management is indicated to relevant community services.

1.8.2   Communication between the organisation and community services is timely.

1.8.3   The organisation arranges access, and ensures the patient/client is aware of appropriate community services prior to separation.

2.1.22 Where the organisation is part of an area health service or multi-hospital system, the organisation participates in discussions and decisions on its current and future operations.

2.1.23 The organisation's services are integrated with others providing health services.

4.2.3   Every patient/client has a unit record which is sufficiently detailed to enable continuity of care, evaluation, education, research and medico-legal integrity.

4.2.4   All patients/clients, including newborn infants, are uniquely identified within the organisation.

4.2.5   Persons who provide care, document details in the medical record. All entries are legible, dated and signed with designation.

4.2.6   All documents associated with care given are filed in the medical records. These should be originals whenever possible.

4.3.1   Medical records are managed to ensure they are readily accessible for the continuity of patient/client care, that confidentiality is maintained, they are safe, and all statutory requirements and Australian Standards are met.

4.3.2   Medical record data are coded to ensure the timely production of quality patient/client care information.

4.3.3   All other records are managed to enable rapid retrieval for continuity of care, management of services, education and research.

4.4.3   Statutory notifications are reported to appropriate authorities.

Appraisal
As noted in relation to other HACC objectives, the relevant ACHS Standards are more numerous and prescriptive. The HACC Service Standards in relation to ongoing assessment, regular review of care plans, and coordination of service delivery are well met by the ACHS Standards.

Gaps in ACHS Standards:
The issue of ensuring that consumers cultural needs are addressed is not included in the ACHS Standards.

Gaps in HACC Service Standards:
Issues of emergency access to services, separation planning and education of consumers to enable them to participate in their own care, are not specifically stated, but may well be covered by compliance with professional and statutory requirements.

HACC OBJECTIVE 5:   PRIVACY, CONFIDENTIALITY AND ACCESS TO PERSONAL INFORMATION

HACC Service Standards

5.1   Consumers are informed of the privacy and confidentiality procedures and understand there rights in relation to these procedures.

5.2   Consumers have signed confidentiality release forms.

5.3   Consumers are able to gain access to their personal information.

ACHS Service Standards

4.2.2   The collection of data complies with professional and statutory requirements.

4.4.1   Confidentiality of patient/client and staff information is preserved.

4.4.2   Access to patient/client information adheres to relevant professional and statutory requirements.

HACC OBJECTIVES 6 & 7: COMPLAINTS AND DISPUTES/ ADVOCACY

HACC Service Standards

6.1 Each consumer's complaint about a service, or access to a service is dealt with fairly, promptly, confidentially and without retribution.
6.2 Consumers are aware of the complaints process.
63. Services are modified as a result of "upheld" complaints.
6.4 Each consumer receives assistance, if requested, to help with the resolution of conflict about a service that arises between the frail elderly person or younger person with a disability and his/her carer.
7.1 Each consumer has access to an advocate of his/her choice.
7.2 Consumers know of their rights to use an advocate.
7.3 Consumers know about advocacy services - where they are and how to use them.
7.4 The agency involves advocates in respect to representing the interests of the consumer.

ACHS Service Standards

ACHS STANDARDS: SAFE PRACTICE AND ENVIRONMENT

HACC Service Standards

nil

ACHS Service Standards

5.1.1 Safe practices and facilities are in accordance with relevant statutory requirements, codes of practice and Australian Standards.

5.1.2   Risks are identified, assessed and appropriately controlled. Where substitution is not able to used or the risks are unable to be eliminated, adequate warning and protection devices are used.

5.1.3   Management is responsible for safe practices and facilities throughout the organisation and day-to-day management is delegated to an appropriate person(s).

5.1.4   All staff within the organisation understand and fulfil their role in safe practice.

5.1.5   Policies, facilities, resources and staff responsibilities are incorporated into a program for the effective safe management of all work practices and all aspects of the environment.

5.1.6   Responsibility for coordinating, monitoring, evaluating and reporting on all aspects of safety is delegated by management to a group of relevant staff.

5.1.7   An incident reporting system demonstrates causal and contributing factors enabling corrective and preventative action to be taken.

5.1.8   The prevention and control of infection is achieved with inter-disciplinary involvement.

5.1.9   All service operations minimise infection risk in accordance with the infection control program.

5.1.10   To reduce the risk of infection to both patients/clients and staff, cleaning, disinfecting, drying, packaging and sterilising of equipment and maintenance of associated environments, conforms to a system that is in accordance with relevant statutory requirements, codes of practice and Australian Standards.

5.1.11   Staff have access to first aid, medical attention and rehabilitation for work related incidents.

5.1.12   Protection of patients/clients, staff, visitors and the resources of the organisation is achieved by a coordinated approach to security measures.

5.1.13   Patients/clients who are unable to maintain their own safety are monitored but not restricted except where their own safety, or the safety of others, is at risk.

5.1.14   Fire risk is minimised by: (a) complying with relevant statutory requirements, codes of practice and Australian Standards (b) ensuring activities that are a fire risk, are eliminated, minimised or performed in a safe manner (c) inspection from an appropriate fire authority in the past three years or in the event of any major building reconstruction (d) taking action in response to recommendations made following an inspection by the appropriate fire authority

5.1.15   The organisation plans and practices it response to ensure an effective coordinated approach to internal emergencies and, where applicable, external disasters.

5.1.16   Emergency plans comply with relevant statutory requirements, codes of practice, Australian Standards and are coordinated with statutory and civil authorities as appropriate.

5.1.17   Management is responsible for ensuring that radiation safety measures comply with relevant statutory requirements, codes of practice and Australian Standards.

5.1.18   Planning of facilities and selection of equipment and supplies involves relevant staff and is in consultation with appropriately qualified personnel.

5.1.19   When planning and purchasing equipment and supplies, consideration is given to, at least: (a) infection control (b) occupational health and safety (c) waste creation and disposal (d) cost benefits.

5.1.20   Safe and efficient practice is ensured through the provision of appropriate equipment and supplies that support the organisation's role and level of service.

5.1.21   Specialised equipment is operated only by appropriately trained staff.

5.1.22 Items designated by the manufacturer for single use are not re-used unless the organisation has specific policies and guidelines for safe re-use in accordance with relevant statutory requirements, codes of practice and Australian Standards.

5.1.23 A program for the maintenance, refurbishment and upgrading of buildings and plant ensures a functional, safe and comfortable environment.

5.1.24 To facilitate safe and efficient practices, consideration is given to the functional and geographic layout of the organisation that conforms with relevant statutory requirements, codes of practice and Australian Standards.

5.1.25 Whatever the design or purpose of the unit, sufficient space is provided for routine and emergency care of the patient/client.

5.1.26 Appropriate storage of equipment and supplies enables safe and efficient work practices.

5.1.27 When water is obtained from a source other than a public water supply it is periodically microbiologically tested by a National Association of Testing Authorities (NATA) approved laboratory, and treated as necessary.

5.1.28 Water towers, and evaporative condensers associated with air-conditioning systems, are inspected regularly in accordance with relevant statutory requirements, codes of practice and Australian Standards.

5.1.29 Water stored at less than 55 degrees C is checked regularly and treated as necessary to ensure it is clean and maintained at a microbiologically accepted standard.

5.1.30 Energy management systems do not compromise the safety and welfare of patients/clients and staff.

5.1.31 Emergency light and/or power supply is provided in accordance with relevant statutory requirements, codes of practice and Australian Standards.

5.1.32 The environment within the organisation is clean and safe for patients/clients, visitors and staff.

5.1.33 Registers of clinical and non-clinical equipment are maintained.

5.1.34 A clean, safe environment is ensured through regular maintenance of grounds and equipment in accordance with relevant statutory requirements, codes of practice, Australian Standards or manufacturers' specifications.

5.1.35 Equipment is serviced only by people trained in the maintenance of that equipment.

5.1.36 Current information and scientific data from manufacturers concerning their products are available for reference and guidance for the operation and maintenance of plant and equipment.

5.1.37 Equipment is replaced according to a program for upgrading and replacement.

5.1.38 The use of appropriate procedures and equipment that conform to relevant statutory requirements, codes of practice and Australian Standards, ensure the safe and efficient handling, collection and disposal of waste.

5.1.39 Waste disposal is managed through a program of re-use, reduction and recycling.

Appraisal
With the exception of safe work practices, this area is not included in the HACC Service Standards as currently conceived.

ACHS STANDARDS: IMPROVING PERFORMANCE

HACC Service Standards

nil

ACHS Service Standards

6.1.1   The governing body is responsible for ensuring there is a system of performance improvement that is consistent with the values and goals of the organisation.

6.1.2   The chief executive is responsible for coordinating and evaluating the performance improvement system and its day-to-day management is delegated to an appropriate person (s).

6.1.3   The performance improvement system supports a culture of continuous improvement, sets priorities for quality activities and ensures a planned and coordinated organisational approach.

6.1.4   All services and staff have responsibility for, are committed to, and demonstrate active involvement in, quality activities to improve performance.

6.1.5   Managers and staff evaluate the effectiveness of the performance improvement system and take action to address any improvements required.

6.1.6   Quality activities are documented and enable continuous performance improvement and must incorporate the following elements: (a) monitoring, assessing, analysing and evaluating activities (b) taking appropriate and timely action (c) evaluating the effectiveness of any action taken (d) feeding back results.

6.1.7   The organisation demonstrates improvement resulting from quality activities.

6.1.8   Confidentiality of patients/clients, staff and other care providers is protected within quality activities.

Appraisal
This area is not explicitly included at this level of detail in the HACC National Service Standards as currently conceived, although the ACHS Standards are relevant to HACC Standard 3.1 in relation to modifying service design or delivery as a result of evaluation activity.

5.3 SUMMARY

COMPARISON OF HACC AND ACHS SERVICE STANDARDS

The key areas which would require additional evidence by agencies which fulfilled the ACHS Standards are:

.   resource allocation on the basis of prioritised consumer need,
.   informing consumers of services offered by the agency which are relevant to the consumers assessed need,
.   advising consumers of the basis of service provision, including services to be offered, for how long, and fees payable,
.   consumer involvement in service management,
.   ensuring that consumers cultural needs are addressed,
.   informing consumers of privacy and confidentiality procedures
.   granting consumers access to their personal information, and
.   all the HACC Service Standards relating to complaints and disputes, and advocacy.

None of the seven objectives contained in the HACC National Service Standards are completely covered by the ACHS Standards. It is therefore likely that agencies that have completed an ACHS review will never-the-less be required to undergo a HACC National Service Standards review.

6. BIBILIOGRAPHY

The following documents were used for the comparisons undertaken in this document.

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The following documents/working materials provided by Steering Group Members were useful in completing the working paper.

Analysis of international quality standards in the social welfare area provided by Ronda Schultz.

Towards a Quality Assurance Framework for Home and Community Care funded services in South Australia provided by Ronda Schultz.

HACC National Service Standards - consistency between HACC and CHASP standards provided by Megan Gardiner.

HACC National Service Standards - consistency between HACC and ACHS standards provided by Megan Gardiner.