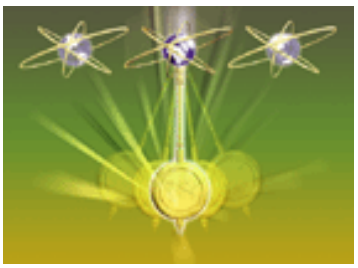
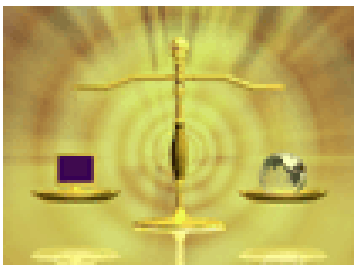
PASCAS HEALTH SANCTUARY

BEST PRACTICE & BENCHMARKING in HEALTHCARE





"Peace And Spirit Creating Alternative Solutions"

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SCHEDULE **Page**

ACHS - Australian Council on Healthcare Standards

Major reference: "**Health Management Bulletin**" published by CCH Australia Limited
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The QUEST for ORGANISATIONAL EXCELLENCE:

Management research tends to validate program effectiveness in two ways: there are those studies that attribute the entire success of a particular organisation or industry to a particular strategy and there are studies that compare high-performance sectors with low-performing ones in the hope that a basic ingredient can be identified that might explain the difference in performance. Along these lines, we now have an Australian study.

Conducted over a period of ten years by the Centre for Manufacturing Management at the University of Melbourne, Professor Danny Samson distilled accumulated experience into 10 key points:

- Improvement initiatives are integrated into the overall business system in a longer-term plan and driven by more fundamental issues affecting the organisations;
- Performance measurement and high standards of project management were observed in excellent companies;
- Operation performance measures critical to the outcome of a unit are meticulously measured and fed back to the people responsible for carrying out the operation;
- External benchmarking helps to define the performance objectives of excellent companies;
- Rewards are consistently aligned with operation performance;
- Workers are asked to take on a distributed form of leadership and ownership over the tasks that have been assigned to them;
- A strong sense of accountability, both for when things go right as well as when they go wrong, exists;
- Leading organisations are open to their stakeholders in terms of feedback, input and participation;
- Leading organisations know hot to strike a balance between short term and long term goals; and
- Perhaps most importantly, leading companies have an alignment across their workforce from the shopfloor to the topfloor, and a realisation that they need to embrace change.

With some similarity to these principles, Dr Denis King reviewed a decade of experience in implementing Clinical Management at St George Hospital by means of Clinical Divisions. At a conference organised under the banner of the National Demonstration Hospitals Program, Dr King reviewed his hospital's experience of restructuring into Divisions, managed by a Divisional Director, a Divisional Nurse Manager and a Divisional Business Manager. He spoke of the difficulties in reconciling the many competing interests, including the Hospital Executive, and provided some valuable lessons for managers in any industry.

- Clinicians should be allowed to manage;
- When responsibility is devolved, so must authority;
- Specific organisational structures don't matter so long as the party that has the greatest interest in making it work be given responsibility to manage and that the difference between administration and clinical viewpoints are clearly highlighted;
- Appointments should be made on administrative merit rather than technical proficiency; and
- Adequate information must be provided to managers who are not trained in finance and administration.

CLINICAL PATHWAYS: A SERIOUS BUSINESS?

A clinical pathway can be developed for any patient care activity. However, the majority in use concern elective admissions to hospital for which there are relatively well established methods of care. The hospital focus reflects a view that there is a greater need for synchronisation of inputs from a variety of professions as a consequence of urgency and the greater risks of harm to patient well0being. The emphasis on elective admissions reflects the greater degree of predictability of the patient's condition (and consequent care needs) at admission, and the greater ease of ensuring agreement where all clinicians share the same work location.

However, there is no intrinsic reason why clinical pathways should be restricted in this way. Indeed, since 1990 there have been many more reports of their use in outpatient services, rehabilitation and psychiatry, nursing home care, and home care.

Finally, there is growing interest in the construction of clinical pathways which facilitate coordination across care settings. There are additional logistical problems, but greater expected benefits (if only because many of the most obvious weaknesses in patient care coordination are at the interfaces between settings for patients with chronic conditions, or with conditions best managed in more than one setting for other reasons). The national coordinated care trials will need to develop care pathways of this type, and similar ideas are contained in the national mental health costing and classification system project.

EVALUATION the BENEFITS

Clinical pathways help reduce errors of synchronisation and risks of omission or duplication of care, discourage idiosyncrasies of practice (where they carry significant penalties to the care team as a whole), encourage collaboration and communication between clinical professions, facilitate a change of emphasis from measurement of previous costs to the management of future costs, and help ensure that the process of formal trade-off between cost and outcomes involves the clinically knowledgeable. Other significant benefits include those to patients and their relatives of knowing what is likely to happen.

There are three main types of constraints to the use of clinical pathways. First, there are technical difficulties such as those relating to the analysis of variances and estimation of standard costs. Second, there are resourcing problems including the apparent lack of funds to pay clinicians to develop and refine the pathways. Third, and perhaps most important, there are cultural constraints: that is, established patterns of thought and action which are not easily questioned. These constraints are best illustrated by their practical manifestations in criticisms of pathways, of which the following are most common.

INNOVATION

It is suggested that clinical pathways limit innovation. There is no requirement to adhere to a pathway, but only to make a record of any deviation. Clinicians whose practice is most at odds with pathway specifications tend to be those who are most fixed in their ways. The testing of new methods should not be discouraged, but there is surely good reason to ensure that protocols for tests are developed and subjected to appraisal by the care team as a whole.

LEGAL RISK

Clinical pathways tend to favour the view that risk of litigation is reduced, especially where the pathways have been well designed. All good systems are associated with precise statements about the need to accept the precedence of individual clinical judgements over the contents of the pathway itself. The process of pooling of knowledge which is inherent in pathway development is likely to reduce rather than increase the risk of error.

"COOKBOOK" MEDICINE

Frequent reference is made to "cookbook" medicine: pathways that encourage or require the treatment of patients as types rather than as individuals. Adherence is not mandatory. Good systems positively encourage customisation to individuals' needs.

DEALING with HETEROGENEITY

It is often argued that there is no basis for definition of common processes because all patients are different. This would be devastating if true: no clinical practice could be judged to be good or bad in the absence of any patterns. The concept of the pathway is that there are common features, and they should be recognised to the extent that there is benefit in so doing. It is widely agreed that pathways for some episodes of care are suitable without variance sufficient to merit annotation in at least 75% of cases. However, pathways would still be useful if the frequency of variance were much higher. Moreover, one can reduce the level of variance reporting by simply inserting more flexibility in the definitions of "standard" practice. There is good reason to suppose that pathways are of most use where clinical management is the most complicated.

LACK of TIME

It is claimed that clinicians are too busy to be involved in pathway development and use. There is some degree of justification here. However, the argument is weakened if one accepts that some of the "busyness" is a direct consequence of problems resulting from the absence of pathways.

KEEPING UP-TO-DATE

There is the concern that, by the time pathways have been established, they are out of date. Indeed, there is no doubt that practices are continually changing. However, it is probably easier to note and take account of new ideas where pathways are well-established.

GETTING ON WITH the JOB

There is also a strong case for proaction. For example, pathway developments should be adequately funded. One approach might involve offering budget increases for those departments which make the most progress.

It is surely feasible to ensure that all the major case types (accounting for perhaps 60% of the cost and volume) be covered by pathways within a year, even when starting from scratch. There are now several excellent sources of information about methods of development and use. The key is commitment, and clinician ownership is critical in this regard. If this does not yet exist, no effort should be spared. If this means many face-to-face meetings, cautious and sympathetic listening, or any other investment you can think of, it will be worthwhile.

Report by Professor Don Hindle, UNSW – published in Issue 1 of the Health Management Bulletin – September 97

MANAGED CARE: an AUSTRALIAN PERSPECTIVE:

The concept of managed care is not new, having started in the American west in the 1930s when employers and employee groups established prepaid service contracts with group practices. Essentially, managed care is an arrangement whereby an organisation assumes responsibility for all necessary health care for an individual in exchange for a fixed payment. Modern managed care encompasses a variety of health care delivery systems including health maintenance organisations (HMOs), preferred-provider organisations (PPOs), and point-of-service financing and delivery systems. Basically, all forms of managed care represent attempts to control costs by modifying the behaviour of doctors (or other professionals who initiate treatment).

Control over doctors is exerted by selecting doctors on the basis of their history of resource use, by the use of primary care doctors to act as gatekeepers to specialised services, by the rigid adherence to clinical guidelines, and by the use of utilisation managers to ensure that a doctor's clinical management decisions accord with prescribed guidelines. The utilisation managers are usually nurses or managers who must approve such activities as inpatient admission, specialist consultations, or the use of expensive technologies, and who will review inpatient stay to ensure the earliest possible discharge.

A study in California revealed that HMOs have reduced the rates of hospitalisation by 40% and are shifting the acute hospital from the centre toward the periphery of the care system. The fundamental structure of American academic medicine has been threatened by managed care organisations which decline to fund teaching and research and prefer to refer their patients elsewhere to avoid the greater costs of specialised academic centres. The most far reaching impact of managed care has been on doctors, many of whom have been traumatised and disillusioned by these sudden changes to their career paths, relationships, and incomes. HMOs depend heavily on primary care practitioners (GPs in Australian practice) supported by nurse practitioners and physician assistants so that they require fewer doctors overall and far fewer specialists. Forecasts of the effects of managed care on US medical workforce requirements have indicated that by the 2005, there will be an overall surplus of 165,000 doctors, and the supply of specialists will outstrip the requirement by more than 60%. The opposite is occurring within Australia.

For the patient, managed care has meant a restriction in choice of doctor. The doctor may now find himself or herself responsible to the manage care company rather than to the patient.

We are at a crossroad in Australian health care policy with plummeting enrolments in private health insurance having been reversed by government incentives, administrators concerned with cost control and greater accountability by providers, doctors concerned at the imposition of rigid treatment protocols and third party intrusion into the doctor-patient relationship. Is managed care the answer? Opinion is NO. It arose in the US in response to spiralling health care costs and dysfunctional, fragmented services. It represents the invasion of commerce into medical care. It is still evolving and has not yet been fully evaluated. But there are some aspects of managed care which are useful and we should seriously consider adapting for ourselves, such as the concept of disease management which uses evidence based medicine and outcome; clinical pathways; and a commitment to the integration of care across the primary, secondary, and community care sectors to provide a co-ordinated approach to the delivery of health care.

Report by Professor Leslie Lazarus, UNSW – Health Management Bulletin – September 97

MAKING the TRANSITION to CRITICAL PATHWAYS:

A critical path defines an optimal sequencing and timing of intervention by physicians, nurses, and other medical providers and staff for a particular diagnosis or procedure designed for better use of resources, to maximise quality of care, and to minimise delays. Critical paths provide a means to visualise the course of treatment and the potential for recovery or stabilisation within a given time frame for a specific illness or diagnosis.

Several different terms are applied to this method to better coordinate care including critical pathways, critical paths of care and care maps. This is helpful to the care provider(s), as well as to the consumer and his/her family or support system.

Critical pathways are most typically used for high risk, high costs, and high volume diagnoses and procedures, however, they may be designed and used to illustrate the typical course of treatment for any diagnosis. Pathways may be designed to cover varying periods of times. A critical pathway will address the complete episode of care beginning at the time the patient or consumer presents at the service delivery site and continues through the termination of care and any follow-up indicated. Activities are projected and tracked through the pathway and generally involve such things as consultations and assessments, treatments, medications, safety precautions, teaching events, and discharge planning.

Although the use of critical pathways has a significant number of critics in the medical field and resistance is present many hospitals have started to apply CPM to the delivery of patient care. Commonly cited benefits include a reduction in costs, more consistently positive patient outcomes, and improved communications between provides. A decrease in the length of stay, the enhancement of staff training and patient education efforts, more effective and more easily managed case coordination, and improvements in continuity of care are also noted. Thus critical paths have been shown to assist in identifying expectations of patient care, providing a framework for specifying the events that are critical to the appropriate length of stay, and outlining methods of improving the quality and cost-effectiveness of service of care provided.

Publications continually caution against developing or adopting critical pathways for service delivery in isolation from the care providers and other persons essential to determining the success of the treatment endeavour. Lack of pertinent staff involvement in the development process can lead to increased resistance and the ultimate failure in compliance to standards of care proposed.

When leadership makes the decision to reorganise the service delivery around critical pathways, it needs to be understood that this will not be an easy task. A major shift in paradigms for both staff and consumers will be required if the effort is to be successful. Significant staff time and energies is required from persons already working extended hours and making outstanding contributions to the organisation beyond that which is considered strictly a “normal part of the job”.

A three-phase approach may well be adopted. Although each phase is dependent on the completion of the previous phase with some overlap occurring, each phase has a distinct mission and tasks. The phases being:

1. Research and initial planning.
2. Product development, continued planning, and transmission, and
3. Full implementation.

It is anticipated that the first phase will take about 10 to 12 weeks. A longer time period is required if the final pathways are to be developed in full. This phase is primarily geared toward information gathering, assimilation, and initial drafting.

The second phase is project to involve more intense work and the implementation of select pathways and other related efforts. It is anticipated to take 10 to 12 months. The actual date to move into phase III, full implementation, is dependent on the adoption of a considered system for identified funded services.

Best practice and Benchmarking in Healthcare – May/June 1996 – article by John Barnette and Frances Clendenen – A Community Behavioural Health Centre's Approach.

INJURY PREVENTION:

The best practice approach to injury prevention put forward by the Head of Workers Compensation Authorities (HWCA) relies on managerial commitment, consultative arrangements, risk management, training for all workers, supervisor accountability of safety, and the use of workers compensation data for local risk control.

Free copies of the report, "Promoting Excellence – National Consistency in Australian Workers' Compensation", are available from the HWCA – phone 03 9641 1555.

Shiftwork and Safety.

The body clock, which keeps a person more active during the day and less active at night, cannot easily be altered. It also controls digestion and slows it down at night, regardless of whether the person is active then or not. Well timed meals of quality foods can prevent common digestive problems in shiftworkers, such as indigestion, heartburn and constipation. Light meals, high in carbohydrates, are recommended.

The Queensland Government has produced two brochures to help both workers and managers prepare for safe shiftwork. "Hints for Shiftwork" is designed to help the workers, their families and friends to adjust to a new routine. "Managing Shiftwork" helps managers design work rosters and programs to protect the well-being of shiftworkers. For more information, phone the Queensland Division of Workplace Health and Safety on 07 3225 2210.

In a related development, the Australian Medical Association announced that a consultant has been appointed to co-ordinate its safe hours project. The stated aims of this project is to review rostering and work practices for hospital medical staff, develop agreed standards and codes and to promote examples of best practice.

GREAT or SMALL: QUALITY is for ALL:

Total Quality Management (TQM) is concerned with organisational-wide activity which attempts to involve everyone in defining and creating quality and to harness their ideas, commitment and energy. Serving the customer / patient is central to the quality improvement philosophy and leadership for the cause, emanating from the most senior managers and opinion leaders, is said to be essential. Various tools are used including re-examining processes, analysing data, constructing flow charts or fishbone diagrams and integrating quality improvement methods into routine practice.

Cultural and sustainable improvement in most TQM strategies will take five years or longer to achieve.

Wilmont J. Quality improvement in general practice. British Journal of General Practice 1997

MEASURING PATIENT SATISFACTION:

There are only a limited number of ways to measure patient satisfaction in health care organisations:

Qualitative methods include:

- Managerial observation;
- Worker feedback programs;
- Work teams (sometimes called quality circles);
- Focus groups.

Quantitative methods include:

- Customer comment cards;
- Mail surveys;
- Personal patient feedback;
- Telephone interviews;
- "Mystery shoppers", i.e. trained observers posing as patients.

Ford RC, Bach SA, Fottler MD. Methods of measuring patient satisfaction in health care organisation. Health Care Management Review 1997.

RISK MANAGEMENT:

Those doctors with the highest incidence of claims also had the highest incidence of complaints against them. Patients are more likely to sue if they feel that their doctors do not show concern or do not inform them adequately. The implications of this for risk reduction is obvious. Can this message, however, be translated to the hospital setting? The answer is almost certainly be "yes".

It would seem that institution could do much to ameliorate the risk of litigation by ensuring that an on-site risk manager is able to deal with an incident, to the patient's satisfaction, as soon as it occurs and prior to the patient's discharge from the hospital. To do this the risk manager must be informed of the incident and must have the ability and authority to take steps to rectify the situation without delay. Ideally, the risk manager should have direct access to a senior administrator who can authorise the immediate payment of compensation for, say, the lost dentures or clothing, and to waive fees or out of pocket expenses for additional treatment which may be necessary because of something the hospital staff did, or did not do, and for which the hospital is likely to be found liable.

Systemic problems might arise from inadequate funding, poor resources, overwork or inadequate funding, poor resources, overwork or inadequate staffing.

Risk management saves money.

Health Management Bulletin November 1997. Dr Craig M Lilienthal

TRENDS of the INTERNATIONAL QUALITY MOVEMENT:

In a recent review paper of quality of care within hospitals, Pickering identified nine global trends.

- Trend 1: The growth and spread of hospital accreditation. Many countries now have a hospital accreditation system, with Japan recently establishing such a program. The international trend is to move from structure and process in accreditation programs to an emphasis on outcomes.
- Trend 2: The involvement of government in quality. Governments in many countries have sought to be involved in establishing quality programs usually through policy measures or by encouraging quality of care by releasing comparative data.
- Trend 3: Utilisation review. Waste of resources through inappropriate procedures, unnecessary stays in hospital or unnecessary medications are endemic features of health system. Utilisation review seeks to assess the extent of waste and reduce or eliminate it.
- Trend 4: Standardisation of treatment patterns. The use of DRGs and clinical pathways to standardise care is becoming ubiquitous. Organised medicine in many countries is still dismissive but there seems to be little doubt that most countries are embracing treatment standardisation.
- Trend 5: Involvement and education of patients. For many reasons the idea of patients having to leave their brains at the door with their role being limited to doing what they're told is coming to an end. There is a trend toward involving patients in clinical decision making and in educating patients such that they can be active participants in decisions about care and procedures.
- Trend 6: Assessment of technologies and procedures. Another aspect of quality is for there to be rigorous evaluation of new technologies and procedures. The trend here is that there is growing awareness that evaluation of new technologies and procedures needs to be conducted prior to their introduction, not afterwards.
- Trend 7: Financial disincentives. Many countries are experimenting with payment methods to act as disincentives for poor quality care. Although there are many examples of this, the introduction of co-payment systems and the shift from fee-for-service payments to capitated systems are two cases in the point.
- Trend 8: Risk management. Health systems pose many risks to patients and to workers. For example, in Britain, one million people per year are injured in accidents in hospitals. The ideas of managing risk and trying to reduce the incidence of, for example, accidents and post-operative infection rates are increasingly receiving attention.
- Trend 9: Toward evidence-based medicine. Depending on the specialty, it is estimated that somewhere between 15% - 80% of medicine is demonstrably worthwhile. For the remainder, there is either no proven benefit or possibly harm being inflicted. Evidence-based medicine requires making available good quality data to clinicians.

Pickering concludes his overview by suggesting that the key to embracing these trends is to improve our understanding of how to change behaviour. Health workers and managers are being confronted by these trends and will need to change in response to them.

Pickering E. Quality hospital care – global trends and future challenges. World Hospitals and Health Services 1997.

MORE ABOUT QUALITY of CARE:

On the subject of quality of care, a recent paper by Hofer and colleagues at the University of Michigan argued that developing quality indicators for hospital care was not easy but was nevertheless an extremely important and worthwhile pursuit. They suggested a four step framework to develop valid quality indicators. These are as follows:

- Step 1: Develop a list of candidate indicators. A review of published data, clinical practice and information from the literature will suggest candidate quality indicators.
- Step 2: Establish an expert panel. An external panel should be established to examine the candidate indicators and identify explicit review instruments. Clinical indicators can then be ranked by the expert panel as to their appropriateness.
- Step 3: Conduct a chart review of cases and controls. This stage involves conducting an evaluation of the sensitivity and specificity of the explicit review instruments.
- Step 4: Simulate the use of the indicators. In this step, the goal is to evaluate the measure selected to confirm its usefulness and accuracy.

Hofer TP, Bernstein SJ, Hayward RA. Validating quality indicators for hospital care. Journal on Quality Improvement 1997.

MANAGEMENT of PEOPLE:

The message is simple: if you want to improve your strategic management and decision making processes it is much better to be inclusive and incorporate middle level managers in discussions, strategic formulation and strategic thinking.

Floyd SW, Wooldridge B. Middle management's strategic influence and organisation performance. Journal of Management Studies 1997.

Organisation life is a constant process of working with others with some level of trust and interdependence, and being held to account and giving an account to others for what we are doing. Public sector managers need to be accountable to many people and groups – politicians; colleagues at work including peers and subordinates; to their patients, clients or customers; to the wider public including those in the local community in which their organisation is located; and to taxpayers generally and even more broadly to citizens at large.

Quirk B. Accountable to everyone: Public Administration 1997.

It is better to have many organisations thinkers looking at a complex strategic problem than few.

Sharfman MP, Dean JW. Flexibility in strategic decision making: informational and ideological perspectives. Journal of Management Studies 1997.

BEST PRACTICE: SUMMARY:

Pascas Health Sanctuary's testimonial to our pursuit of Best Practice is already evident in our corporate foundation documents, particularly in:

- Our commitment to building a centre of health care excellence using the world's best technology, systems, and practices;
- Our commitment to recruit clinical experts (both medical and nursing) in all specialties and modalities; and
- Our commitment to recruit managers with world leading expertise in health care management.

At the outset, Pascas Health Sanctuary will use the management tool of benchmarking to identify Best Practice in clinical, managerial and strategic issues that are critical to the success of private hospitals and associated clinics, providing health care in advanced markets. Our benchmarking partners will be other leading health care institutions around the world. We will tap into the benchmarking studies already undertaken by third parties such as those coordinated by consultancies (specifically Best Practice Australia Pty Ltd) and those offered by associations – the Private Hospitals' Association of Queensland (PHAQ) and the Australian Private Hospitals' Association (APHA).

This positions us with a unique opportunity – to identify who is setting the benchmark in business critical areas, and to adapt these practices to a Greenfield site. To ensure we are providing excellence in clinical care, our Best Practice Plan includes benchmarking such things as:

- **Clinical Indicators** – using the Australian Council on Healthcare Standards Care Evaluation Program – we will use the clinical indicator data set as the foundation for collecting information on clinical outcomes. Along our quality journey, in addition to the ACHS clinical indicators we will establish our own clinical outcome indicators that are of specific relevance to our hospital as well as associated clinics. This is part and parcel of our commitment to a quality philosophy for Pascas Health Sanctuary where ever it functions throughout the world.
- **Variance Analysis** – using one Managed Care concept – the Critical Path Method – we will design multidisciplinary Critical Paths and track clinical outcomes by analysing patient variance from their path.
- **Casemix Indicators** e.g., length of stay for [initially] the Diagnostic Related Groups (DRGs) that exhibity:
    - high volume
    - high cost
    - high interest (in terms of clinical and action research)
    - high risk (in terms of the risk of complications)

Operation issues – We are aware of the operational benchmarking activities co-ordinated by APHA. We do not seek to re-invent the wheel, but to learn from this association's findings and participate in their benchmarking studies. Operational issues are critical to the day-to-day functioning of a large private hospital and measure the economic viability of specific functions within the health facilities. Some of the operational indicators to be benchmark include:

- Financial indicators e.g., expense ratios, profit per bed, workers compensation, overhead costs.
- Utilisation (occupancy) levels.
- Laundry consumption.

- Hours per patient day.

Cultural issues – to ensure we create an organisation with Pascas Health Sanctuary that is high performing, regularly benchmarked will be:

- Employee motivation.
- Communication within the hospital.
- How adaptable the health facility is to change.
- Client / patient focus.

Client satisfaction – to be benchmarked will be the views of the three key stakeholders that are critical to the success of the health facility:

- The Visiting Medical Officer (VMO) and health providers.
- The patient / client.
- The employees.

Other aspects that will be benchmarked are elements unique to the facility, including the medi-hotel.

In our pursuit for Best Practice, we will use benchmarking as a management tool to:

- Measure our hospital's performance in areas that are business critical (as provided in the examples above … clinical, operational, and strategic).
- Compare our performance level against other similar institutions throughout the world.
- And adapt these practices and strategies into Pascas Health Sanctuary in order to improve our performance levels.

BY-LAWS, RULES and REGULATIONS of the VISITING PRACTITIONERS and STAFF:

RESPONSIBILITIES

The Visiting Practitioners' Executive Committee shall serve as the Medical Advisory Committee required by the Private Hospital Act Regulations. It shall:

a. Monitor the overall quality, effectiveness, appropriateness and utilisation of services rendered to patients in the Hospital;
b. Make recommendations to the Management Committee relating to applications for appointment as a Visiting Practitioner and the granting of Clinical Privileges:
c. Participate in the planning, development and implementation of Quality Improvement Programs of the Hospital;
d. Assist in identifying health needs of the community and advise the Management Committee on appropriate services which may be required to meet these needs;
e. Advise the Management Committee on the acquisition and operation of facilities and equipment for the treatment, diagnosis and care of patients;
f. Review and advise on matters relating to the management of the operating suite with regard to, but not limited to, equipment and instrumentation, sterilisation, emergency procedures and use of drugs and anaesthetic gases;
g. Establish any ad hoc or standing sub-committee as required to review and evaluate specific aspects of patient care and Hospital services, or make recommendations to it in relation to applications for appointment, delineation of privileges or corrective action;
h. For each sub-committee established, identify its composition, provide for the appointment of a chairman and prescribe its terms of reference;
i. By resolution, dissolve any such sub-committee established;
j. Receive and act upon reports and recommendations of any sub-committees established;
k. Advise the CEO on the role and employment by the Hospital of Resident Medical Officers;
l. Provide continuing education responsive to the needs of the Visiting Practitioner Staff;
m. Maintain a permanent record of all proceedings and submit reports to the Management Committee including areas of patient care and services under review and summarising any corrective or preventive action taken or proposed to be taken;
n. Advise the Management Committee on such other matters as may be relevant to the proper and efficient function of the medical and other clinical services provided by the Hospital;
o. Make recommendation to the Management Committee on any new treatment or procedure proposed to be undertaken by any Visiting Practitioner; and
p. Report to the Director-General of Health any persistent failure of the licensee of the Hospital to act on the Committee's advice.

Best Practice Australia

301 Given Terrace, Paddington 4064 **Bs 61 7 3367 0613**

Best Practice Australia Pty Ltd is a privately owned research company specialising in employee surveys.

ν Established in Brisbane in 1992.
ν Operates Australia-wide and in New Zealand through its sister organisation, Best Practice New Zealand Ltd.
ν Has conducted surveys with over 350 organisations in the health, finance, public and other sectors.
ν Maintains a large database of organisational measures, benchmarks and workforce norms covering:

o Employee Satisfaction and Motivation
o Organisational Culture
o Employment Conditions
o Management Practices

ν Provides:

o Benchmarking analysis
o Statistical analysis
o Linguistic analysis
o Work unit and demographic analysis

ν Offers independent and unbiased advice. We only do surveys.

Glenn Parle
B.A. (Phil), M.B.A. (UQ)
Executive Director

The Australian Council on Healthcare Standards

safety, quality, performance

The Australian Council on Healthcare Standards (ACHS) is an independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through continual review of performance, assessment and accreditation.

Vision, Mission, Values and Goals

Vision

To be recognised nationally and internationally as the leading Australian organisation that independently assesses performance in order to promote and improve quality and safety in health care.

Mission

To improve the quality and safety of health care.

Values

1. Excellence
2. Leadership
3. Commitment
4. Integrity
5. Transparency
6. Team work
7. Consumer focus
8. Cultural responsiveness

Goals

1. to be the leading organisation in the health care industry providing products and services which include standards development, performance assessment, accreditation and education.
2. to develop and sustain collaborative links with key stakeholders.
3. to undertake research into quality improvement within the health care industry.
4. to promote and publish information in relation to quality in health care.
5. to maintain an effective internal system that enables business goals to be efficiently achieved.