Guideline

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Sexual Health Services (ACHS) - Accreditation Guidelines for NSW

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safety, quality, performance

Accreditation Guidelines for NSW Sexual Health Services

to complement ACHS EQuIP 3rd Edition Standards

2005

NSW HEALTH
Working as a Team

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Introduction

These *Accreditation Guidelines for NSW Sexual Health Services* cover many issues that are specific to sexual health care.

The aims of these guidelines are to:

- provide a comprehensive approach to improve performance and quality in sexual health services by identifying issues to be considered in the provision of those services
- use the ACHS Evaluation and Quality Improvement Program (EQuIP) standards which have a whole organisation approach to include elements of infrastructure that impact on service delivery in all services including sexual health
- give examples of quality improvement activities which are relevant to sexual health services
- assist those services that are conducting a self-assessment or preparing for an accreditation survey with ACHS EQuIP
- assist surveyors of sexual health services.

However the Guidelines can be used by sexual health services who are not members of EQuIP, as a quality improvement tool.

Background to development

In August 2002 The Australian Council on Healthcare Standards (ACHS) and Quality Management Services (QMS) were approached by the AIDS / Infectious Diseases Branch of the NSW Health Department to develop accreditation guidelines that meet the specific needs of sexual health services.

A series of discipline and location specific focus groups was held across NSW to establish stakeholder views and issues about the content of the accreditation guidelines. The focus groups had a structured approach to allow for correlation and cross comparisons with different variables such as rural and metropolitan or clinical and health promotion. Drafts of the Guidelines were then considered by the Department, the Sexual Health Accreditation Guidelines Working Group and more widely by the sector and stakeholders prior to being finalised in November 2003.

Guidelines for the Development of Sexual Health Services in NSW (1997) identifies the required components and functions of a sexual health service, and key strategies to achieve the aims of sexual health services. The aims stated in this document are:

- minimise transmission of sexually transmitted infections (STI)
- minimise morbidity from STIs
- minimise morbidity associated with sexuality, sexual function and relationship issues
- promote the maintenance and enhancement of sexual health
- increase access to sexual health services throughout NSW
- improve the quality of service.

Statewide priority populations are identified from time to time by the Health Department.

Sexual health services can include any or all of the following activities:

- care and treatment for STIs
- contact tracing
- sexual health promotion
- training, professional development and consultancy for health care workers
- research
- collection of surveillance data.

Services are delivered by multidisciplinary teams including:

- sexual health promotion workers
- sexual health physicians
- sexual health nurses
- sexual health counsellors
- peer workers.

It is recognised that there is considerable diversity in the way sexual health services are structured, organised and delivered.

Irrespective of the way in which the sexual health service is configured, the EQuIP functions, standards and criteria can be applied regardless of the size or setting.

How to Use the Guidelines

These *Accreditation Guidelines for NSW Sexual Health Services* have been written using the format of *The EQuIP Guide 3rd edition, June 2002*, and should be used in conjunction with the Guide.

The layout is as follows:

- Every EQuIP standard falls under a functional area. The functions are: Continuum of Care, Leadership & Management, Human Resources Management, Information Management, Safe Practice & Environment and Improving Performance.
- The EQuIP standard is at the top of each page. Standards express a desired outcome.
- Each standard has criteria which identify a result.
- Each criterion has elements which go from Little Achievement (LA) - Awareness, Some Achievement (SA) - Implementation, Moderate Achievement (MA) - Evaluation, Extensive Achievement (EA) - Benchmarking, and Outstanding Achievement (OA) - Leader. The elements describe the systems and processes that need to be in place for a sexual health service to be operating at a particular level of achievement. The elements are only described in *The EQuIP Guide 3rd Edition, June 2002*. Please refer to this document.
- In these Guidelines examples are written in the format in the EQuIP Self-Assessment Tool. At least one example of an outcome, an example of an activity which has been reviewed and changed stating the results, and an example of another activity planned for the future, are given. The examples in each category are not related to each other but provide suggestions for different activities to illustrate an outcome, a review and an action to improve. These sorts of activities would be expected to be seen in a sexual health service continually striving to improve. Please refer to *The EQuIP Guide 3rd Edition, June 2002*, pages 3-11 to 3-23, for information on self-assessments.
- Each EQuIP criterion is then listed with some dot points that suggest issues for sexual health services in relation to the criterion.
- For each standard some examples of quantitative measures and improvement activities are given, in addition to those in the generic guidelines in *The EQuIP Guide 3rd Edition, June 2002* - Section 4.

The examples in this document are a guide only; they are not intended to be regarded as complete or as ACHS compulsory requirements. The diversity of sexual health services will mean that some of the examples simply do not apply in all settings. Conversely there may be other relevant items that are not listed here.

EQuIP and Sexual Health Services

The ACHS Evaluation and Quality Improvement Program (EQuIP) provides a framework which sexual health services can use to achieve excellence. It is a quality management tool, which can help a sexual health service develop and maintain a systematic way of operating which is monitored and evaluated on a continuous basis with a view to the sexual health service becoming the best of its type.

The emphasis of EQuIP is on continuous improvement and the measurement and reporting of achievements and outcomes. The way in which this occurs is up to the individual sexual health service, and EQuIP enables a sexual health service to tailor its quality improvement activities to its own unique requirements. Function 6 Improving Performance is not included in these Guidelines as it is used only by surveyors to assist them to assess an organisation's performance. Organisations self-assess against the Improving Performance Standard 2.3 in Leadership and Management.

The guidelines have been provided to give more information and guidance on achievement of the standards at the criterion level. Please see Figure 1 for an example of a function's structure. This structure for the standards was developed to help the user obtain the greatest benefit. Details of the standards, criteria and generic guideline elements are in section 4 of The EQuIP Guide, 3rd Edition. These guidelines have not been developed to be all encompassing. The guidelines will often refer the reader to other guidelines for expert information.

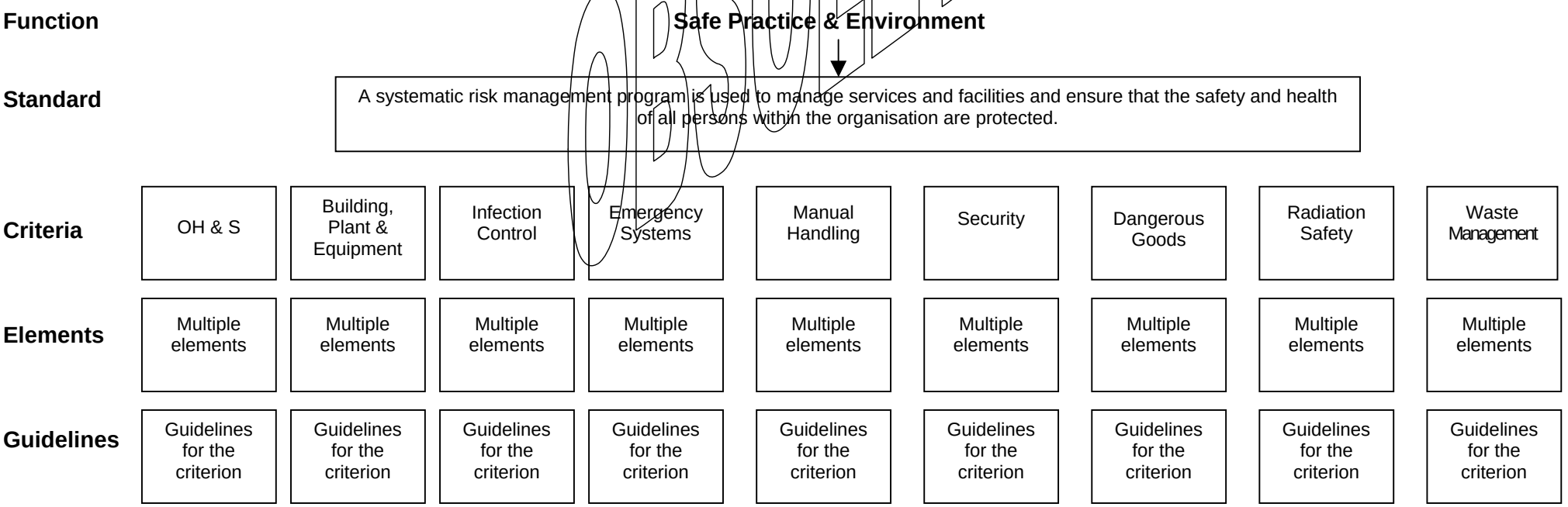


Figure 1 Example of a Function structure

Clinical Indicators

Using Clinical Indicators

Clinical indicator data can be used to identify trends in the quality of care in individual health care organisations, and compare performance across like organisations.

Assessing Internal Performance

Clinical care indicators are screening tools of health care quality. Each health care environment has its own framework for structure, process and outcome quality indicators. They serve as tools that, used in conjunction with other quality improvement methods, lead to improvements in quality of care. Clinical indicators are intended to highlight issues that may require further investigation. The effective use of clinical indicator data should result in demonstrable examples of improvements in quality of client care.

Benchmarking

Benchmarking is discovering and learning from differences. It is now considered an essential approach for achieving continuous improvement. Benchmarking focuses on comparing one organisation's current performance with the performance of similar organisations, identifying variation and implementing identified improvements in the process of care. Variations in outcomes between different health care organisations or professionals providing the same interventions create opportunities to learn how to improve the quality of service. The justification for benchmarking is that identifying and establishing best practices in structures and processes will lead to a reduction in unnecessary variation.

ACHS and Clinical Indicators

The ACHS has been involved in the development of clinical indicators in conjunction with Australian and New Zealand medical colleges, associations and societies since 1989. Both hospital-wide and discipline specific clinical performance indicators have been developed and are used by health care organisations to monitor the outcomes of care.

The ACHS currently has 20 clinical indicator sets covering 259 indicators. Taking advantage of the ACHS indicators may reduce the difficulties of identifying what indicators are to be used and what data are to be collected. Examples of the range of ACHS indicators are provided below.

An example of the range of ACHS indicators:

- Adverse Drug Reaction Indicators
- Infection Control Indicators
- Hospital-Wide Clinical Indicators eg Pressure ulcers, Readmissions
- Oral Health Indicators eg Unplanned return to the dental centre, Mode of treatment
- Hospital in the Home Indicators eg Client Safety and Selection, Program Interruption

Please refer to the relevant, yearly publication *ACHS Clinical Indicator Users' Manual* for further information on the ACHS indicators.

Please also refer to the quantitative measures under each standard in *The EQuIP Guide 3rd Edition, June 2002* and the quantitative measures under each standard in this tool.

Information regarding **discipline specific indicators** can be obtained by contacting:

The ACHS Performance and Outcomes Service:

Phone:	(02) 9281 9955
Fax:	(02) 9211 9633
E-mail:	pos@achs.org.au

Glossary and Abbreviations

The following definitions, abbreviations and commonly used acronyms are for use in the context of the ACHS EQuIP standards, criteria, elements, and the *Guidelines for NSW Sexual Health Services*.

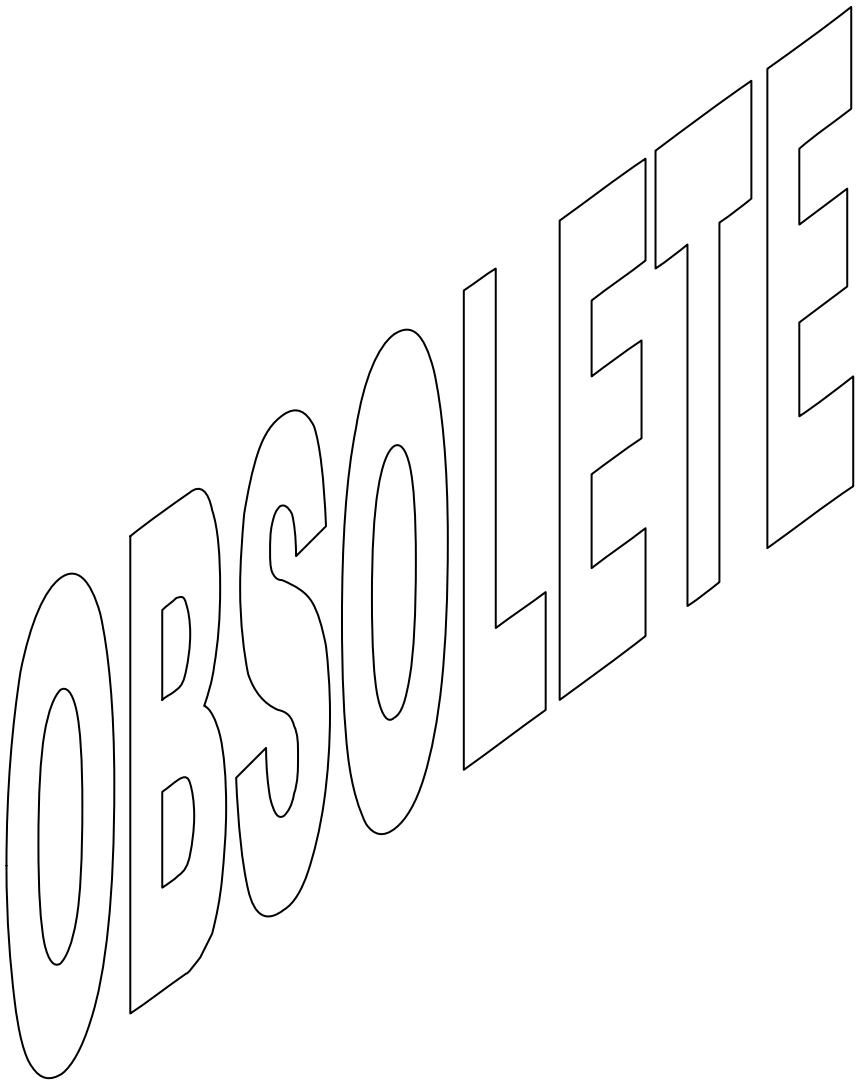
ACON	AIDS Council of NSW
agreement	a mutually agreed arrangement describing the scope for cooperative ventures between parties and documenting relevant responsibilities
AHS	Area Health Service
analysis	presentation of the essential features into simple elements, ie summary, outline or identification of the essence of an issue
AOD	alcohol and other drugs
ASHNA	Australian Sexual Health Nurses Association
Australian Standards	national standards developed by Standards Australia, eg *AS 4360 Risk Management*
BBV	blood borne viruses
benchmarking	the continuous process of measuring and comparing products, services and practices with similar systems or organisations both inside or outside the health care industry for continual improvement
best practice	the way leading edge organisations manage the delivery of world class standards of performance in all aspects of their operations. The concept of continuous improvement is integral to the achievement of international best practice.
CALD	culturally and linguistically diverse
CBO	community based organisation
classification system	a system of codes, from a set of defined categories, which are used to categorise activity in a consistent and systemised way
clinical indicator	a measure of the clinical management and outcome of care; a method of monitoring client care and services which attempts to 'flag' problem areas, evaluate trends and so direct attention to issues requiring further review
client	refer to definition for 'consumer / patient'
community	people who live in a defined geographic locality and / or who share a sense of identity or have common concerns
complaint	an expression of dissatisfaction with something
confidentiality	the restriction of access to personal information to authorised persons, entities and processes at authorised times and in an authorised manner
consent	in this document consent covers a number of different legal requirements: (a) The client must be informed in broad terms of the nature of any invasive procedure which is performed on the client. This consent operates as a defence to an action in the tort of battery or trespass to person.

	(b) The client must be informed of material risks inherent in the procedure or treatment. This is part of the duty of care owed to the client by an appointed medical practitioner who treats the client. (c) Consent to collection of health information, and to any use of that information or disclosure by the organisation to third parties, is required under Commonwealth and any applicable State or Territory privacy law requirements. (d) Informed financial consent of the client.
consumer / patient	people who directly or indirectly make use of health services[1]
continuity of care	the provision of care, coordinated amongst all care providers, in various settings, spanning all phases of the continuum of care
Continuum of Care	the cycle of care including access and entry; assessment; care planning, delivery and evaluation; and separation
coordinate	to bring together in a common and harmonious action or effort. Bring into order as parts of the whole
criteria	the measurable key components of a standard
data	unorganised facts from which information can be generated
data collection	a store of data captured in an organised way for a specific defined purpose
documentation	process of recording information in the health record and other documents that are a source of information. A written, tangible record of care and services provided
effective	producing the desired result
efficiency	ability to achieve desired results
elements	description of what is required to achieve the criterion. They provide prompts for improvement and best practice
evaluation	identification of the outcome of care and service
FPA	Family Planning Association
governing body	those persons ultimately responsible for governing the organisation. It may refer to a board of directors, owner / manager, management committee, or the board of an area health service, local health authority or network
HCV	Hepatitis C
HIV	human immunodeficiency virus
HPV	human papilloma virus
health record	term to cover client record, medical record, care record, health care record or record that documents care or service to a client
health care	services provided to individuals or communities to promote, maintain, monitor, or restore health. Health care is not limited to medical care and includes self care[2]
health care providers	staff or individuals who, in cooperation with the client, assume responsibility for all aspects of care in response to the diagnosis and needs of the client

IDU	injecting drug user
improving performance	continuous study and adaptation of processes in order to achieve desired outcomes and meet the needs and expectations of clients and other stakeholders
incident	an event or circumstance which could have or did lead to unintended and / or unnecessary harm to a person, and / or complaint, loss or damage
include(s)	a list that provides examples and is not limiting
indexing	the arrangement of data to allow retrieval and analysis
information	data elements that have been organised, analysed and provide a basis for decision making
information management	the process of planning, organising, analysing and controlling data and information. The management of information applies to both computer-based and manual systems
information technology	mechanical and electronic devices designed for the collection, storage, manipulation, presentation and dissemination of information
integrity	the characteristic of data and information being accurate and complete
mission	the purpose of an organisation
monitor	to check, observe critically, measure or record the progress of an activity, action or system on a regular basis in order to identify change
MOU	memorandum of understanding
MSM	men who have sex with men
multidisciplinary	care or a service given with input from more than one discipline or profession
NGO	non-government organisations
non-clinical information	information that is not direct, personal client information
NSEP	Needle and syringe exchange program
NUAA	NSW Users and AIDS Association
objective	the translation of the goals into specific, concrete terms against which results can be measured
OI	opportunistic infections
operational plan	short term plan that details how the strategic plan will be accomplished
outcome	results that may or may not have been intended that occur as a result of a service or intervention
parlour	brothel
pathway	a multidisciplinary plan of care that commences before or on admission and finishes at separation
PEP	post exposure prophylaxis

planning	to formulate a scheme or program for the accomplishment or attainment of an object
plan of care	plan based on data collected during client assessment. It identifies the care and resources needed by the client, describes the strategy for providing services to meet those needs, documents treatment goals and objectives and outlines the criteria for specific intervention
policy	a documented statement that formalises the approach to tasks and concepts which is consistent with organisational objectives
procedure	a set of documented instructions conveying the approved and recommended steps for a particular act or sequence of acts
process	a series of actions, changes / functions that bring about an end or a result
qualified	possessed of qualities or accomplishments which fit a person for some function or office
quality	the extent to which the properties of a service or product produces a desired outcome[2]
quality activities	activities which measure performance, identify opportunities for improvement in the delivery of care and service, and include action and follow-up
records management	field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposition of records[3]
risk management	the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse events[4]
safety	a state in which risk has been reduced to an acceptable level[2]
SHIP	Sexual Health Information Program
SOPV	sex on premises venues
staff	term which includes employed, visiting, sessional, contracted or volunteer personnel
standard	a statement of a level of performance to be achieved
STI	sexually transmitted infections
strategic plan	plan that is organisation-wide, that establishes an organisation's overall objectives
system	a group of interacting, interrelated or interdependent elements forming or regarded as forming a collective entity

1 Dept of Public Health, Flinders University, South Australian Community health Research Unit. *Improving health services through consumer participation*; Victoria: Consumer Focus Collaboration, 2000
2 Australian Council for Safety and Quality in Health Care
3 AS/NZS 4390 Records Management
4 AS/NZS 4360 Risk Management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FUNCTION 1: CONTINUUM OF CARE

STANDARD 1.1: CONTINUUM OF CARE

Consumers / patients have access to health care appropriate to their needs.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

- Six months following introduction of a number of strategies to assist client access eg providing a map, free parking, clear instructions on public transport, telephoning the client the day prior to appointment, late arrivals and 'failures to attend' had reduced from 14% to 3%.
- Following the development of a memorandum of understanding (MOU) with the mental health service, education programs for mental health workers, input to mental health consumer groups and sexual health outreach to community and in-client mental health facilities, the number of newly registered mental health clients increased from 2 in the previous 6 months to 19 in the current 6 monthly period. 16 of the new clients were treated for 1 or more STIs.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Community's awareness of services provided.	Advertising strategy - targeted media outlets specific to priority population groups.	• Increased use of facilities and services. • Clients increased by 63 from June to December last year.
Intravenous drug users as percentage of total clients.	Developed appropriate strategies with AOD service including emphasising proximity of clinics.	IDUs increased from 1% of total clients to 5% of total clients.
Percentage of clients from identified priority groups.	• Additional education of referrers about services provided. • Realignment of services with sexual health's identified needs. • Increased referrals to women's health and GPs.	Percentage of clients from identified priority groups increased from 54% of total clients to 74% in a 12 month period.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Develop Aboriginal and Torres Strait Islander specific information pamphlets and posters.
- Investigate the feasibility of outreach clinics being conducted regularly at the parlours with Thai, Chinese, Vietnamese and Indonesian sex workers.
- Develop a strategy for accessing young people at particular risk of contracting an STI including those who are homeless, in detention, Aboriginal, gay and lesbian, with a disability or a mental illness.

Criterion 1.1.1
The community has information on, and access to, services appropriate to its needs.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Where groups of potential clients are specifically identified as difficult to reach such as men who have sex with men but do not identify as gay, there should be multiple strategies to engage these individuals / groups and entry points that are acceptable and effective.
- There are flexible options for different priority groups such as drop in clinics, outreach clinics or sessions for youth.
- The use of Medicare cards may compromise privacy and some groups including priority groups such as young homeless people, backpackers and itinerant workers will not have a Medicare card.
- Services should be mindful of resource duplication when they are providing contraceptive and wellness checks other than where this activity is an entry point for identified priority access groups such as young Aboriginal people. Client population profiles should be regularly reviewed to ensure that they are actually representative of identified priority groups.
- Priority groups are clearly defined.
- The capacity of the sexual health service to meet the demand for services.
- Barriers (personal, social, geographic, financial, functional, structural, education, living conditions, cultural etc) to accessing services are identified and acted on, on an ongoing basis.
- Other health care services are aware of the sexual health service and intake criteria.
- The phone number of the sexual health service is easy to locate in the telephone book.
- Regular community geographic and demographic profiling for each service catchment area which is used to prioritise and plan for high priority groups.
- Consideration of cultural issues and client special needs eg culturally and linguistically diverse (CALD), Aboriginal people, mental health, disabled, single parents, low socio-economic groups, transgender people.
- Programs including health promotion and prevention activities, are culturally appropriate and meet the health care needs of special needs groups.
- There is a range of referral sources including for example self, GPs, acute hospitals, relatives and other agencies.
- Opening hours are appropriate - the implementation of strategies to extend the hours of service or offer service at hours suited to client groups such as working people, young people and sex workers.
- Referrers are satisfied with access to the sexual health service eg GPs, others.
- Health needs assessment strategies (focus groups, epidemiological data collections and comparisons with state / national data) are used to prioritise needs.
- Implementation of strategies to locate services as close to communities as possible.

Criterion 1.1.2
The organisation and its services can be located easily and physical access to the organisation is appropriate to sexual health needs.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- The service should be easy to find and accessible by public transport. However signage should be discreet so that individuals are not easily identified as sexual health clients.

- Outreach clinics are an essential part of access and service delivery.
- Gender specific staff should wherever possible be an available choice for clients, this can be particularly so for Aboriginal and CALD clients.
- The additional difficulties imposed by geographic distance in rural areas should be recognised by the provision of outreach clinics and regular visits or teleconferencing by local or metropolitan medical specialists. Consider instituting measures to counter the lack of specialist medical care and S100 prescribers.
- Reception and waiting areas are designated to maximise privacy and confidentiality.

Criterion 1.1.3
Access to the system of care is prioritised according to clinical need.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Priority is given to those diseases where there is greatest individual and social impact. Interventions should be focused on those diseases and strategies that are likely to improve or produce a change in health outcomes for individuals and communities. Health equity should be considered.
- There is likely to be a high rate of self-referral.

Examples of quantitative measures and improvement activities
There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size of the service. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures
- Number of inquiries about the location of the sexual health service
- Incidence of complaints by users about physical access issues including public transport
- Incidence of complaints by users about services not provided
- Level of client and referrer satisfaction with responsiveness of service, range of programs and hours of operation
- Percentage of services that are accessible and acceptable to high priority groups
- Percentage of users from high priority groups, eg specific CALD background groups, gay men, men who have sex with men, sex workers, injecting drug users, Aboriginal people eg percentage of total attendees represented by the high priority population
- Effectiveness of sexual health information strategies eg percentage of community aware of service
- Demand for a particular program provided by the service, eg number of referrals per month, attendances at particular programs
- Ability of the sexual health service to meet the demand eg proportion of clients waiting more that (x) days / hours between initial referral / contact and assessment or first service

Improvement activities
- Investigate appointment availability for particular services with development of strategies to increasing where possible
- Reduce delay between contact and first visits, especially for high priority clients

STANDARD 1.2: CONTINUUM OF CARE

A comprehensive assessment by competent professionals identifies the clinical, non-clinical and social needs of consumers / patients, as the basis for providing quality and safe care.

Criterion 1.2.1
The assessment system ensures consumer / patient needs are identified by competent professionals.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

Since the introduction of the standardised sexual health history assessment tool there has been a 15% reduction in repeat assessments with staff identifying a time saving of at least 1 hour per week and 12 less client complaints about duplication.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Adequacy of client assessment.	• Medical, nursing, and counselling staff trained in client assessment. • Consistent sexual history tool used across disciplines.	• 100% staff trained. • Saving of 3.5 hours per week for full-time staff in re-assessments as a result of more complete and comprehensive sexual history taking referrals.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Identify the incidence of variations between needs assessed and actual care provided.
- Educate staff on relevant evidence based protocols to assist client assessment including behavioural, social, and psychological risk factor assessment.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.
There are no specific issues for this criterion for sexual health services.

Examples of quantitative measures and improvement activities
There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures

- Percentage of client records which include fully completed sexual histories available for care planning
- Percentage of staff trained in sexual history taking
- Percentage of assessments with shared referral and assessment tools
- Percentage of clients who have had regular re-assessments
- Incidence of duplication of assessments
- Percentage of HIV care plans which include documentation of a combined health and social assessment.

Improvement activities

- Audit records to assess evidence of: completed referral information, consent documentation and client care pathways including goals for outcomes

STANDARD 1.3: CONTINUUM OF CARE

Consumer / patient needs for quality and safe care with desirable outcomes are addressed through the planning, delivery and evaluation of care.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

Employment of a specified sexual health promotion officer has resulted in greater take-up and involvement in sexual health promotion programs by the Health Promotion Unit and the Public Health Unit; local GPs report an increase in the number of their clients both requesting screening and returning for follow-up treatment.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Non HIV / AIDS related health and lifestyle issues for gay men.	• Increased the number and capacity of local GPs including the HIV S100 prescribers who see gay men by provision of an evening seminar and information packages. • Provided education and training for sexual health staff on gay male issues. • Developed links with local gay and lesbian group.	• Reduction in client complaints about inadequate care from 8 to 1 in a 6 month period. • There were 9 GP contacts with the sexual health service for further information following the seminar and 3 referrals. Previously there had been 1 contact and 16 referrals in 6 months.
Audit of care plans: proportion of clients with written care plans; % care plans with goals, strategies, time-frames, resources and responsibilities; % care plans goals achieved within desired time-frame; % of care plans developed in multidisciplinary case conference where desirable; % of care plans showing inconsistency with sexual health service's policies and procedures; incidence of care provision inconsistent with care plans.	Refresher for staff on writing care plans.	Increase to 95% compliance for all indicators except time-frame (78%).

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Audit of lengths of treatment against clinical pathways predictors.
- Cost effectiveness of changes in planning strategies eg introduction of a case management and / or shared care approach.

- Identify percentage of sexual health promotion program plans that are consistent with the identified needs of the community.
- Review of 'client-staff contract for service' and the number of visits required for routine infections.

Criterion 1.3.1
Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible results.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

Following a record audit of HIV / AIDS clients and subsequent increased support of clients with a history of non-compliance with medication, in-client admissions for long term clients reduced from 15% to 7% over an 18 month period.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Signing of care plan / contract by client and staff member.	• Care plans and contract made more accessible by staff. • Staff discussion re-emphasising the importance of working in partnership with client.	Three months later, 93% of all care plans / contracts signed by staff member and client.
Case conferences.	• Increased time allocation. • Client care modified related to case conferences.	• Better review of clinical care provided and opportunities for improved care for other clients with similar conditions. • All HIV / AIDS clients with chronic conditions now involved in a regular multidisciplinary case conference.
Frequency of review of care plans for clients receiving long-term services.	Service obtained up-to-date information for identified conditions about appropriate review periods and implemented over a 12 month period.	Some clients receiving more frequent reviews and other clients receiving less frequent reviews.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Identify the number of care plans / clinical pathways evaluated that led to improvements in clinical care.
- Identify the number and type of interactive client education sessions held to improve client understanding and involvement in treatment and prevention.
- Establish support groups where appropriate to encourage mutual support in a structured environment and engage clients in identifying self-care strategies.
- Identify appropriate health promotion programs to engage clients in the prevention / early detection of chlamydia.
- Work with local Council to develop health standards for local brothels.
- Establish and strengthen relationships with entertainment venues, gyms and sporting clubs, and sex on premises venues.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Client choices for medical / complementary treatment or no intervention at all should be respected and not prejudice ongoing access to care. Efforts should be made to establish relationships with key people who can act as links into diverse communities including Aboriginal, CALD, injecting drug users, sex workers. Ideally there should be staff employed who reflect the local population and communities.
- Particular issues around ensuring that women with HIV who are contemplating pregnancy options are not subjected to negative or punitive attitudes by staff for their choices.
- Policies and procedures should be developed from evidence based research to ensure a high and consistent standard of care across sexual health services. Interventions wherever possible should be based on research evidence.
- Care plans should contain flags or alerts where repeat testing or follow-up treatment is indicated or required.
- Extending the range of health workers that can undertake sexual health support activities such as training women's health nurses to take chlamydia and gonorrhoea swabs and acknowledging Aboriginal health workers who are trained to do venepuncture and take bloods where appropriate.
- Contact tracing must be undertaken whenever feasible in a manner sensitive to the individual and to the location, for example in a small rural township extra precautions may need to apply to ensure confidentiality is maintained.
- The service may need to consider a variety of arrangements for processing pathology according to geographic locations.
- A shared care model can enhance the treatment and well-being outcomes for clients with chronic health management needs including HIV clients and should be explored wherever applicable. Clients should be consulted about their preferences for a self-managed, specialist medical or shared care model.
- Staff who are involved in health promotion should include clinical access as part of any promotion or campaign planning.
- A clear relationship should exist between the health promotion programs and their contributions to improved health and social outcomes and previous promotions.
- Consideration should be given to recording and valuing the holistic and spiritual ways of working that lead to benefits for the client for example an Aboriginal person returning to their 'own people' and spiritual country and community.
- The organisation is committed to education to clients about understanding their infection, treatment regime and prevention strategies.
- Care is regularly reviewed especially for long-term clients.

- The care plan reflects the total care needs of the client.
- Clients are informed of any service limitations, boundaries and of their expected length of service.
- Care plans identify the most appropriate service (eg liver clinic, counselling, support group, medical specialist) and where a substitute service is provided due to the unavailability of the 'ideal' service (eg nurse, welfare worker).
- Care plans utilise recognised clinical management guidelines and current best practice.
- Services for client care are well coordinated across disciplines and other organisations.
- Care pathways and case management are used where multiple services are involved.
- There is interdisciplinary team collaboration in setting care goals, case conferencing and evaluation of care in complex cases.
- Education is provided to the client to enable them to manage their care independently.
- The relationship between health promotion programs and changes in health and social outcomes is identified.
- The sexual health service employs appropriate workers for high priority groups.
- The sexual health service uses clinical pathways as predictors of care outcomes.

Criterion 1.3.2
Care is evaluated by health care providers together with the consumer / patient and, when appropriate, with the carer.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- The features of successful health promotion programs are analysed and repeated where feasible eg summer safari and bush bus, chippers and pickers, drink coasters with a quiz on the back, key wallets etc.

Examples of quantitative measures and improvement activities
There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures
- Percentage of sexual health promotion program plans that are consistent with the identified needs of the community
- Number of accidents and incidents to clients, staff, visitors or contractors, which result from poor planning or failure to abide by the sexual health service's policies
- Percentage of deviations from accepted standards and codes of practice
- Incidence of changes in client behaviour after service interventions eg health promotion programs and other specific initiatives
- Evidence of use of validated objective measures to track client progress against goals
- Percentage of compliance with prescribed drug orders from record audits
- Incidence of client unplanned readmissions to hospital
- Analysis of program utilisation including over and under use
- Number of client feedback processes conducted
- Number of needs analysis reviews conducted
- Number and completion of consumer participation activities

- Original research conducted and published where available evidence is inadequate.
- Number of evaluated programs and services that have been adjusted to meet identified sexual health needs
- Gonorrhea notification rate
- Hepatitis A vaccination rate in gay male clients
- Accuracy and appropriateness of treatment
- Compliance with prescribed treatment
- Percentage of heterosexuals with high rates of partner change who are regularly tested for STIs

Improvement activities

- Measure cost effectiveness of changes in planning strategies eg by introducing a case management approach
- Audit clinical practice to confirm compliance with sexual health services agreed procedures eg management of Hepatitis C
- Monitor effectiveness of changes in clinical practice techniques
- Increase incidence of significant improvements following introduction of particular strategies
- Increase percentage of compliance with follow-up visits
- Reduce recurrence of infection
- Decrease new infections of chlamydia
- Increase opportunistic screening of young people and Aboriginal people for chlamydia
- Investigate measures for the success of counseling
- Increase availability of needle and syringe exchange.

STANDARD 1.4: CONTINUUM OF CARE

Consumer / patient and carer needs for ongoing care are addressed through the coordination of services and the provision of timely and useful information.

Criterion 1.4.1
Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

Incidents of re-entry to the sexual health service reduced from 20% to 12% following discharge planning with involvement of client.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Referrals to other services.	• Template to assist staff with referral letter writing. • Referral protocol updated. • Memorandum of understanding and formal agreements negotiated with referral agencies and GPs.	Over a 12 month period a reduction in the number of unsuccessful referrals (by 15%); increase in number of referrals (up 22%); increased client satisfaction (up 40%); decrease in number of re-visits and phone calls following discharge (by 8%).

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Improve links with community agencies and self-help groups involved with the service to improve support for clients.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Referrals to gynaecologists, nutritionists and liver clinics.
- Clients know what to expect from the other services and how to contact them.
- GP education and support is an important area of work for sexual health services. GPs can be assisted by clinical consultancy and referral information, phone advice and support, clinical attachments in sexual health, and small and large group education.

Examples of quantitative measures and improvement activities
There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information

or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Gude, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures

- Number of clients referred to other services for ongoing care
- Number of clients discharged to self-management
- Satisfaction of clients with information provided on discharge
- Satisfaction of clients with the timeliness of the discharge and the appropriateness of the ongoing services
- Percentage of referral arrangements which are unsuccessful, and reasons for same
- Number of staff follow-up activities with clients
- Number of occasions where there is a change in the level of involvement with other health services and other agencies eg NSEP, AOD, ACON
- Frequency of communication with GPs about the care of individual patients with HIV.

Improvement activities

- Reduce the number of revisits to the sexual health service for repeats of treatment for new infections
- Reduce the number of failures to complete treatment.

FUNCTION 2: LEADERSHIP AND MANAGEMENT

STANDARD 2.1: LEADERSHIP AND MANAGEMENT

The governing body leads the organisation's strategic direction and establishes an operational framework to ensure the provision of quality, safe services.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

- Following more involvement / consultation of staff in the planning process, 80% of strategic planning and sexual health service goals were completed on time, an increase of 50%.
- A memorandum of understanding signed with major referral and support agencies has resulted in a drop in inappropriate attendances within 3 months of 8% of total client attendances. The majority of these are now self-referred.
- Following a 25% increase in complaints about inadequate leadership and direction, questioning of staff found a duplication of tasks through insufficient communication between staff in different sites. The complaints have now reduced to 2% after staff meetings increased in regularity and for staff unable to attend personally, teleconferencing arrangements were made. Staff meetings are now held in different sites which has also raised the profile of the sexual health service with other related health services.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Linkages between strategic plan, business plan, budget, human resources plan and team work plans.	Consistent format for plans used by all; format requires direct linkage to strategic plan elements.	• All staff but one used the new format in the current planning cycle. • Performance indicators developed for all strategic goals.
Profile of sexual health service within area health service and access to governing body.	The sexual health service has formed an advisory committee with directors from the Public Health Unit, Women's Health, Aboriginal Health, Women's and Children's Health, Division of General Practice, AOD etc The sexual health service is now given the opportunity to present its activities and achievements to the governing body at regular intervals.	• The service received some additional funding. • A program to pilot a youth drop in service was approved with funding.
Structural separation between sexual health, HIV / AIDS and Hepatitis C staff.	• Regular meetings across the 3 services. • Secondments.	• More coordinated approach. • Joint projects. • More efficient use of staff time in all services.
Performance of outreach and specialist clinics.	• Assessment of operational efficiency and impact. • 2 clinics closed and one relocated.	• Increase in overall client numbers by 5% • 2 hour average increase in client contact per week by all staff.
Education services.	• Reintroduced involvement in general practice continuing medical education. • Increased number of clinical attachments available to undergraduate medical, social work and nursing students. • Monthly staff in-service sessions on clinical case presentations expanded to include other interested health service staff and GPs.	Increased number of referral points both into and out of the sexual health service.

Reviewed	Changed	Results
Performance of external contractors.	Performance of all contractors reviewed and feedback provided.	3 contracts not renewed because of poor performance re timeliness, cost and customer relations.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Increase percentage of funds allocated in accordance with organisation's strategic plan and sexual health service's work plans.
- Improve links between sexual health service and other areas of the organisation.
- Number of performance indicators in strategic plan which are achieved regularly and those that are at best practice level.
- Increase number of schools in the local area accessing the sexual health service for in-service updating of teachers implementing sexual health programs.

Criterion 2.1.1
The organisation provides quality, safe care through the planning and development of services and its pro-active response to internal and external challenges.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Planning forums and networks for health promotion include all relevant parties and stakeholders at the earliest possible stage to ensure that all perspectives are investigated and considered prior to the development of draft promotional materials and / or campaigns.
- All plans are informed by relevant local population health data.
- Decision making is informed by:
    - current health status and need
    - best available evidence on interventions
    - expert opinion
    - community preferences
    - current and likely future resources
    - legal framework
    - political environment
- Sexual health promotion is considered part of the core business of sexual health services. Whilst the service delivery model varies between sexual health services from health promotion officers on staff to non-sexual health specific health promotion staff in population and public health units, it is essential that there be collaborative and coherent sexual health promotion delivered to identified priority groups in the area.
- Where boundaries such as state borders or AHS boundaries may compromise continuity of care, the sexual health service should develop a memorandum of understanding to overcome any barriers to treatment and effective follow-up. There may need to be provision in these MOUs for client consent of shared information and transfer arrangements of records in the event of a crisis.

- Close working relationships within disciplines of the clinic and with NSEP, Public Health Units, Health Promotion Units, GPs, Divisions of General Practice, AOD (including acute detox), Women's Health, FPA, Mental Health, Bobby Goldsmith Foundation, Aboriginal Medical Service, local support and self help groups, NGOs eg AIDS Council of NSW, People Living with HIV and AIDS, Sex Workers Outreach Program, NUAA, supporting school teachers with the Talking Sexual Health package - training, support, professional development, referral networks, community links, community capacity building.
- There is consultation with members of priority groups and stakeholders about products and resources to ensure that they match client and community needs and build on strengths in preference to fear promoting messages.
- The use of regular monitoring and evaluation to support the improvement of products and services is encouraged. Regular searches are undertaken for updating knowledge about content or practices as well as attendance at conference and other learning forums. The service should be aware of and analysis relevant material and have them available at the service delivery sites. Systematic analysis includes regular communication with consumers and stakeholders to identify their needs and expectations to ensure a focus on consumer satisfaction. Time must be available to staff to engage in these activities.
- The organisation uses a design process that manages and adds to the quality and validity of its product or campaign by using relevant pre-testing and piloting to gauge impact, effectiveness and satisfaction. Evaluation results form the basis of further development or modification.
- In rural areas clients with Hepatitis C and HIV / AIDS are commonly seen by sexual health workers and may make up a larger percentage of clients than in metropolitan areas. This may need to be reflected in planning and recruitment for more complex care and maintenance of chronic conditions rather than on general screening activities and general health promotion campaign work.
- Regular review of local and area incidence and prevalence data is used to guide strategic, operational and human resource planning. Where there are significant variations in individual caseloads or population groups serviced from those identified as priority there should be a formal evidence based case made as a justification.
- Leaders actively promote the achievements and need for sexual health services as an important public health field and an emerging specialty. This includes representations for appropriate resources required to deliver effective sexual health services. This could include establishment of a high profile advisory committee with membership from relevant specialty fields and academic input.
- Relationships, partnerships and joint training / research programs with universities should be explored and further developed as part of workforce development, contribution to public health outcomes and to assist in raising the perceived profile of sexual health and sexual health services.
- The governing body provides resources for a sexual health needs assessment at regular intervals.

Criterion 2.1.2
Care and service are provided in accordance with legislative requirements.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

Following a lunchtime in-service for sexual health staff on the *NSW Children and Young People's (Care and Protection) Act 1998* the number of reports increased from nil in the previous 12 month period to 3 in the current period.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Audit of compliance with legislative requirements.	Relevant legislation put in a folder for easy access. Workshops conducted.	Staff report increased awareness of legislative requirements and changed practices as a result eg confidentiality, child protection reporting. Demonstrates an increased understanding of their legal responsibilities by staff.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Review of medication administration, documentation and medication errors in relation to legislative requirements.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Sexual health services must comply with relevant legislation including the *NSW Public Health Act* and with the range of policy documents issued by the NSW Department of Health. At the time of writing these include:
  - Notification of Infectious Diseases
  - Confidentiality of personal information
  - Informed consent to testing and treatment
  - Contact tracing
  - Counseling in screening for HIV
  - Access to pharmaceuticals
  - Management of people who risk infecting others
  - Protecting Children and Young People
  - Infection Control
  - Management of workforce exposures to BBVs
  - Management of Non Occupational Exposures (PEP).
- Implement processes to ensure that state and national health bulletins are used to update legislative requirements.
- Ensure staff are informed of new legislative requirements as they are proclaimed.

Criterion 2.1.3
Credible and transparent governance is assisted by formal structures within the governing body, and an operational framework within the organisation.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.
There are no specific issues for this criterion for sexual health services.

Criterion 2.1.4
A system for the delegation of authority and the management of external service providers supports safe and efficient business practices.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.
- There are formal agreements / contracts between the sexual health service and other agencies / individuals providing shared care to clients.

Criterion 2.1.5
Documented corporate, operational and clinical policies assist the organisation to provide quality, safe and efficient care and service.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

Two years after the sexual health service undertook a major project involving governing body members, staff, stakeholders and clients, to develop a comprehensive policies and procedures manual for the organisation, client satisfaction with the services provided increased from 62% to 84% and staff satisfaction from 51% to 88%. New clients also increased from 9 per month to 22.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Policies and procedures whose last date of review was prior to 1 July 1999, and any related policies and procedures.	• Updated in line with changes in legislation and to reflect best practice; all relevant staff were invited to comment on drafts. • Staff invited to education sessions on the revised policies.	• 15 of 22 staff attended the education sessions. • 92% of staff reported increased knowledge of the organisational policies and procedures.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Assess degree of staff knowledge of and compliance with service policies.
- Cross reference appropriate policies and develop system for regular review.
- Clinical policies are to be endorsed by the appropriate clinician(s).

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Documents that can be used as a resource include the NSW Department of Health HIV/STI Strategy and the Aboriginal Sexual Health Implementation Plan.

Examples of quantitative measures and improvement activities
There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures

- Frequency of governing body meetings and attendance rates of individual members
- Frequency of sexual health service presentations to the governing body
- Percentage of targets for business growth and finances met
- Percentage of funds allocated in accordance with the regional plan
- Percentage of program and service goals achieved including population health and health promotion programs
- Percentage of approvals for resource allocation for staff and equipment for new initiatives
- Percentage of management decisions made by delegated managers
- Frequency of sexual health service's strategic planning including review of structure
- Number of best practice guidelines implemented
- Percentage of contracts where there has been an improvement in the performance of the contractor
- Percentage of services carried out by contractors
- Percentage of cost overruns

Improvement activities

- Improve the range of skills of governing body members measured against 'ideal skills mix'
- Increase participation of contractors in evaluations
- Improve compliance with service policies
- Develop orientation program for contractors
- Complaints about sub-contractors are communicated to them
- Staff satisfaction monitored and improved on previous year's survey
- Evaluation of specific programs and services to determine achievement of improved population health outcomes.

STANDARD 2.2: LEADERSHIP AND MANAGEMENT

The governing body promotes the safety of all persons within the organisation by its pro-active approach to preventing and managing clinical and non-clinical risks.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

Increased awareness of governing body members and staff from training and policy development on ethical issues resulted in development of a conflict of interest register, increased number of clients referred to other team members, proposals for research forwarded to Area Ethics Committee.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Clinical risk management.	Appointment of a Clinical Risk Manager position.	Clinical Risk Manager has worked with sexual health clinicians to identify near risks and implement a strategy of prevention.
Staff initiated actions to manage risks.	• Staff discussion of risks to clients and education on how to rate the impact of the risks. • Procedures developed to enable staff to take immediate action when a risk is identified.	Staff initiated action to manage risks on 4 occasions compared to once in the ensuing month.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Introduce education on *AS/NZS 4360 Risk Management* approach including risk rating, to all staff.

Criterion 2.2.1

An organisation-wide risk management policy ensures that safety is considered in all activities.

NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

After the incident reporting system was reviewed to reduce the amount of information required and reporting of “near misses” was encouraged with staff involvement in review and action, reporting of “near misses” increased from 5 per month to 18, adverse events decreased from 8 per month to 2.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Relevance of risk management to staff.	• Staff discussed and agreed on top 5 risks to clients. • Protocols were reviewed to minimise these risks. • Staff discussion of incidents relating to these risks occurred at monthly staff meetings.	Staff compliance with the elements of the protocols increased from 80% to 100% after 3 months.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Management to review resources allocated to risk management activities.
- All staff to identify risks in their area, and strategies for reducing them to be developed into a service wide plan.
- Investigate a database to record incidents / accidents and provide reports to improve risk management of 'high' risk areas.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.
There are no specific issues for this criterion for sexual health services.

Criterion 2.2.2
A risk management system ensures that risks are minimised in all activities.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- The risk management plan must include planned responses to outbreaks of STIs.
- Issues of confidentiality are part of the risk management system.
- The risk management system is designed to identify system failures rather than fostering a culture of blame by focusing on individual practitioners, though responsibilities and accountabilities still apply.

Examples of quantitative measures and improvement activities
There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures

- Incidence of accidents, incidents, sentinel events, near misses related to client care and public health
- Occasions when inappropriate planning decisions result in resource shortages or adverse events
- Number of 'high risk' of aggression areas identified
- Number of medication errors reported to the Drug Committee

Improvement activities

- Analysis and trending of data on near misses, adverse events, sentinel events
- Increase staff ability to review systems rather than apportioning blame

STANDARD 2.3: LEADERSHIP AND MANAGEMENT

The governing body leads the organisation in its commitment to continuous improvement and the quality and safety of care and service.

Criterion 2.3.1
The organisation develops a continuous quality improvement system to demonstrate its commitment to improving performance in care and service delivery.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

After management and staff reviewed and acted upon trends in 6 performance targets for clinical and non-clinical performance for the service at monthly staff meetings, performance consistently met or exceeded targets, with staff pride in the service increasing from 42% to 88% of staff surveyed.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Level of a culture of quality in the organisation.	Quality improvement now a standing item on all governing body, staff and management meeting agendas.	Demonstrated improvements in client satisfaction in a number of areas.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Identify key performance indicators to benchmark internally and externally.
- Incorporation of quality improvement into operational plans.
- Quality committee to review feedback mechanism to ensure registered projects / initiatives are provided with feedback and that evaluation occurs.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- The organisation encourages continuous improvement through regular reflection and analysis of feedback and results. Clear and open communication and supportive teamwork assists group assessment and creative ideas and solutions.
- The sexual health service uses quality activities and projects to foster a closer working relationship with other service providers involved in providing care to their clients.
- Sexual health services need to address how they can best demonstrate their performance to external funding agencies while minimising duplication of effort.
- Sexual health services need to be innovative in finding a common time and place for staff working in different programs and locations to discuss issues of quality for the service as a whole.

Examples of quantitative measures and improvement activities

There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures

- Evidence of responses from the governing body to staff in regard to their reports and quality improvement initiatives
- Number of indicators that are achieved regularly and those that are at best practice level
- Number of occasions that quality improvement plans and achievements were noted in governing body minutes and acted upon

Improvement activities

- Improve care delivery and service performance by comparing and discussing performance indicators with similar services

STANDARD 2.4: LEADERSHIP AND MANAGEMENT

The governing body is committed to consumer participation as a strategy to assist the improvement of quality, safe care and service.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

One year after the commencement of a project aimed at improving client compliance with treatment plans, the consumer on the team reported that client satisfaction with the service had increased from 48% to 79%. The team also noted that follow-up attendance at appointments was 88% compared to 61% before the project began.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Membership of local Sexual Health Advisory Committee.	Increased size of committee by 3.	More adequate representation of priority communities and those who work with them.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Set up a working group to identify strategies to deal with clinical ethical issues.

Criterion 2.4.1
The organisation establishes mechanisms for involving consumers in planning, provision, monitoring and evaluation of the health service, to support improvement.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Sexual health services need to be creative in their thinking about consumer and community participation where clients may not wish to identify themselves, may be marginalised, may not perceive an STI as a key issue in their life, may only be able to manage day to day issues and be unable to participate in forums, focus groups etc.
- Sexual health centres use recognised tools and resources such as the *Community and Consumer Participation Audit Tool for Hospitals* to assist them to ensure good practice.
- Even where no ethics committee exists the service shows expertise in resolving ethical dilemmas.
- Policies and procedures for approving research protect clients' rights, ensure ethical considerations are addressed, and ensure validity of research methods.

Criterion 2.4.2
Information is readily available for consumers / patients so that they are informed of their rights and responsibilities.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

After an extensive re-write of all information relating to consent and education sessions on consent for all staff, in the following 12 months there were no instances when consent was not sought and 98% of clients were satisfied with the information and the consent process when surveyed 1 week after giving consent.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Complaints policy.	Complaints policy updated. Reoriented to a culture of welcoming complaints as an opportunity to make improvements. Streamlined complaints management procedures and time lines included and an increased range of remedies offered.	• Turnaround times for complaints processing decreased from 6 to 3 weeks after implementation of new procedures. • Trends in complaints are now reviewed quarterly by managers and staff and issues addressed as they arise.
Breaches of consumer confidentiality and privacy.	Training in the *Privacy Act* for all staff.	8/10 staff trained but feedback on training indicated need for a more plain English approach as staff reported their understanding of the issues as 6 on a scale of 10.
Consumer survey revealed 55% of clients were not able to identify any rights they had in relation to the service apart from confidentiality.	Poster on rights placed in waiting room; rights and responsibilities pamphlet updated; rights and responsibilities pamphlet given at every consultation.	Subsequent news sheet survey revealed 70% clients were able to identify at least 3 rights in their health care.
Strategies for obtaining client complaints / suggestions and acting on them.	• Suggestion box in reception area. • Notice board in reception area documenting progress if suggestion actioned.	Several good ideas have improved access, reduced waiting times, increased flow through of clients.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Include clients in the review of complaints trends and in the evaluation of the complaints process.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Confidentiality and privacy have particular importance in sexual health services where clients often feel that they might be stigmatised if their condition was known.

Examples of quantitative measures and improvement activities

There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures

- Frequency and cost of interpreter use
- Trends in number and type of complaints received by the sexual health service
- Incidence of compliments
- Number of improvements made after client feedback
- Number of ethical issues identified and referred to the ethics committee
- Percentage of ethical issues satisfactorily resolved
- Number of applications submitted to ethics committees for research projects
- Occasions when client requests to be seen by another worker of the service
- Occasions when clients advised of alternative practitioners / services available outside the service

Improvement activities

- Improve timeliness of addressing complaints
- Increase availability of information in relevant languages
- Increase client representation on sexual health services committees
- Reduce number of client complaints taken to the relevant Health Care Complaints Commissioner / Ombudsman because of improving internal complaints management procedures
- Increase percentage of clients who demonstrate an understanding of their rights and responsibilities
- Develop a complaints policy for internal and external stakeholders that identifies processes and time frames
- Trend compliments

FUNCTION 3: HUMAN RESOURCES MANAGEMENT

STANDARD 3.1: HUMAN RESOURCES MANAGEMENT

The management of human resources supports the delivery of quality and safe care and service.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

After an increase in the percentage of permanent staff and the introduction of 6 monthly performance evaluations for staff with pro-active resolution of issues raised, absenteeism reduced by 6%, turnover rates by 19% and overtime for full time staff decreased by 8%.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Incidence of reduction, cancellation or closure of services due to inadequate resources.	Human resources planning done in conjunction with annual planning.	No services reduced or closed down since introduction of new annual plan.
Orientation program.	Program updated; checklist introduced to identify that all orientation activities are completed.	98% of new staff have completed orientation program.
Provision of and access to staff development and training.	Staff development and training needs identified during professional supervision and performance appraisal, costed and included in annual budget as a line item.	2% total budget expended on staff development and training.
Industrial relations issues.	All staff given access to industrial legislation, award information, industrial advice and advocacy.	Decrease in time spent by managers in discussing industrial issues (approx 3 hours / month to 1).

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Identify strategies for recognition and acknowledgment of staff's work.

Criterion 3.1.1
Human resources planning supports the organisation's current and future ability to provide quality and safe care and service.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Teamwork and interdisciplinary collaboration are reflected in the organisational structure, skill mix and career paths.
- There are sufficient appropriately trained and qualified staff and the right skill mixes for the types of activities undertaken.
- The sexual health service uses strategies to attract occupational groups that are scarce.

Criterion 3.1.2
The recruitment, selection, appointment and continuing employment system ensures that the skill mix and competency of staff support safe practice and the provision of quality care and service.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

After the introduction of a formal system to regularly assess clinical skills in key activities, client complaints related to staff competency reduced from 15 per annum to 3 and there have been no reported incidents related to lack of appropriate skills.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Time frame for recruitment from time of identification of vacancy to start date of successful applicant.	Flow chart for recruitment identifying responsibilities for tasks drawn up; positions advertised as soon as resignation finalised.	Average time frame for recruitment reduced from 59 working days to 43 working days.
All job descriptions in the context of the human resources plan.	Job descriptions updated to reflect human resources plan for current and future needs and programs.	More targeted service provision; improved understanding by staff of their position's role and responsibilities.
Staff profile in relation to gender and ethnicity compared to client, high priority groups and local demographic data.	Targeted advertisement in local area and through ethnic media.	Staff from an Aboriginal or Torres Strait Islander background increased from 0-2%; males increased from 32-42%; from a CALD background increased from 5-13%.
Number of staff with a professional supervisor and number of sessions of clinical supervision.	Professional / clinical supervisor identified for all staff; regular appointments established.	All staff now have a mentor and discussions occur generally once every 2 months.

Reviewed	Changed	Results
Confidentiality of staff records.	• Managers reminded of their responsibilities re confidentiality. • New filing cabinets purchased. Access limited to 2 senior staff and a log system introduced.	There is now a record of when staff records are accessed and why and by whom.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Provide training in recruitment processes for staff, governing body members and external stakeholders who sit on recruitment panels.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Nurses have access and support to use standing orders for standard sexual health medication when no medical officer is available. Standing orders should be approved and reviewed regularly by a Drugs and Therapeutics Committee.
- All staff including managers are qualified and skilled to carry out their work safely and effectively.
- Expert personnel are available for consultation and advice.
- Recognition of life skills for community and peer workers.

Criterion 3.1.3
The performance management system ensures the competency of staff supports safe practice and the provision of quality care and service.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.
There are no specific issues for this criterion for sexual health services.

Criterion 3.1.4
The learning and development system ensures the skill and competency of staff support safe practice and the provision of quality care and service.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Mentoring options are explored including telephone mentoring and other related local providers.
- Mentoring and buddy systems and appropriate supervision by trained / accredited sexual health staff eg Australian Sexual Health Nurses Association (ASHNA) medical officers with recognised specialist qualifications or substantial experience.
- Staff have specific training in sexual health through a recognised training course and / or process, such as an appropriate workforce development program and observational visits.

- Consideration should be given to providing staff development in rural areas as well as metropolitan.
- Training addresses gaps in sexual health nurses competencies where identified eg ASHNA.
- Good outcomes for HIV infected clients are more likely where a doctor is managing a large case load of HIV infected clients.
- Training assists staff to effectively conduct systematic evidence reviews.

Criterion 3.1.5
Workplace relations support the organisation in achieving its goals.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.
There are no specific issues for this criterion for sexual health services.

Criterion 3.1.6
The organisation provides services that support staff to provide quality and safe care and service.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.
There are no specific issues for this criterion for sexual health services.

Examples of quantitative measures and improvement activities
There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures
- Percentage of human resources plan goals achieved
- Actual staff mix measured against ideal staff mix
- Instances where there are gaps in service provision due to inadequate or inappropriate staffing levels
- Incidence of reduction, cancellation or closure of services due to inadequate resources
- Staff satisfaction with workloads
- Audit of contracts and other employment records
- Occasions when staff are in acting positions
- Occasions and length of time when services are unavailable due to recruitment problems
- Percentage of managers with sound knowledge of the recruitment and selection process
- Incidence of current job descriptions and terms of employment in staff files
- Percentage of staff that demonstrate knowledge of their roles and responsibilities
- Incidence of breaches of security or confidentiality related to staff files
- Percentage of new staff that have completed their orientation program
- Number of staff that have had a performance management plan developed within (x) weeks of commencement

- Percentage of budget allocated to staff education and training
- Results of individual in-service program evaluations
- Frequency of staff skills audits
- Percentage of staff that have attended compulsory training programs
- Amount of study leave awarded per year
- Range of education opportunities and numbers of staff taking them up eg roster flexibility, exchanges with other services, paid study leave, secondments to other sexual health services
- Percentage of work hours used for training and development
- Budget for provision of library, journals, Internet access and evidence of use by staff
- Amount of funds awarded to staff to attend conferences, seminars and other training programs per year
- Staff satisfaction with education and training programs
- Number of client complaints related to staff competencies
- Number of staff initiatives and improvements introduced which were raised during performance reviews
- Frequency of meetings held with relevant industrial groups
- Percentage of conflicts resolved to the satisfaction of all parties
- Staff satisfaction with industrial issues management
- Percentage of staff utilisation of the employee assistance program

Improvement activities

- Improve the level of recognition of staff achievements
- Reduce absenteeism
- Increase compliance with industrial awards, principles, policies and procedures
- Increase productivity
- Increase percentage of staff with current, completed performance reviews
- Reduce incidence of unsatisfactory performance reviews
- Reduce work related injuries due to poor staff training
- Reduce amount of time lost due to industrial disputes

FUNCTION 4: INFORMATION MANAGEMENT

STANDARD 4.1: INFORMATION MANAGEMENT

Valid information sources support decision making and the identification of consumer / patient care outcomes.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

- Extension of access to written and Internet resources to clients has improved clients' knowledge of their diagnosis, treatment options and prevention strategies (as identified in client satisfaction surveys and clinicians' observations)
- Provision of photocopies of clients' file notes to the clients (for most recent visit) has resulted in an increase of medication compliance from 75% to 93%.
- Number of complaints related to breaches of privacy reduced from 15 to 1 following education on the *Privacy Act.*

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Unique identification for client records.	• One staff person was allocated time each week to ensure all information about the client was in the one record. • The system for uniquely identifying clients was reviewed with the assistance of an external expert. • Staff educated in the use of the system.	• All staff educated. • The first audit of the central index identified 23 clients with multiple identifiers.
Number of episodes of access to journals, books and Internet.	Identified staff member responsible for cataloguing and e-mailing lists of new acquisitions.	200% increase in episodes of access; reduction of library expenditure by $156 in the period because of cancellation of publications not used and increased Internet usage.
Policies on storage of sexual health clinical files.	Policy manual documented, education attended and policies implemented.	• Security of storage of clinical files dramatically increased. • Staff knowledge of correct procedures improved by 88%

Reviewed	Changed	Results
Records management system.	Advice from qualified health information manager.	Reduction in missing files from introduction of electronic and paper tracing system and increase in number of records accurately filed.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

List all data received from external entities, determine usefulness and develop a system for efficient distribution.

Criterion 4.1.1
Consumer / patient health records are a primary source of information to support consumer / patient care and safety, improving performance and for managing the organisation.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

After staff discussion about the importance of documentation in the client's record in the context of care continuity, partnership with the client, managing potential risks and litigation, the number of incidents related to inadequate documentation decreased to an average 1 per 2 months. There were also no complaints about follow-up in the following 4 months.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Clinical records comprehensively audited with particular attention to completed referral information, informed consent documentation, client care pathways including goals for discharge, fully completed sexual histories, and record of all members of the sexual health team.	Records policy requires consistency in record keeping methods across organisation. Publicise policy in orientation, staff update, Clinical Records Audit Report e-mailed or hard copy to all staff and managers.	93% compliance with requirements, an increase from 87% in the previous audit.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Decrease incidence of records damaged in transit to outreach clinics to nil.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Client records are stored safely to ensure confidentiality and easy access.
- Systems are in place to facilitate the location of client records at sites / clinics most frequently used by clients.

Criterion 4.1.2
Unique identification of consumers / patients ensures comprehensive and accurate information is used in care delivery.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Each client has a unique identifier which is recorded on a central database within the sexual health service.
- The sexual health service uses a recording system which complies with accepted standards and codes of practice and recognises the potential sensitivity of the material.

Criterion 4.1.3
Non-clinical information sources are maintained and monitored to enable safe management and for the organisation's goals to be met.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Sexual health promotion, capacity building projects and group activities are documented and made available for other staff to review or replicate (includes plan, resources used, numbers participating and evaluation).

Criterion 4.1.4
There are systems for records management that support the collection of information and that meet the organisation's needs.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- If pathology reports are regularly delivered electronically within a broader health service steps must be taken to ensure that sexual health results are not disseminated in this way to ensure client confidentiality.
- Consideration should be given to the tension between requirements for follow-up and contact tracing with a client's desire for anonymity.
- Ability for people to use aliases with identifiers such as date of birth etc.
- Consider a numbering system such as sequential number by practitioner rather than calling people by name in waiting rooms; whatever the system used should be by client preference.
- Laptops or palm pilots are utilised in outreach clinics so that data can be available but more easily protected.

- Consideration should be given to the appropriateness of integrating sexual health records into mainstream records systems and the client's consent sought. Particular attention should be given to the security of records in outreach and satellite services. The unique identifier system may need a firewall to protect the confidentiality of sexual health clients.

Criterion 4.1.5
Reference and research material is managed to support quality and safe care and service.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Staff have access to reference, research and evidence based materials.
- Mechanisms are in place to access expertise in information management (eg large health organisation, appointment of a health information manager, appointment of consultant).

Examples of quantitative measures and improvement activities
There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures
- Percentage of compliance with documentation requirements in record audits
- Incidence of lost records
- Incidence of records damaged during transit to outreach clinics
- Occasions when the same client has more than one record
- Percentage of records with all entries dated, signed and designation of person recorded

Improvement activities
- Eliminate occasions when records failed to meet medico-legal requirements
- Increase availability of information and reference material for staff
- Audit of client files to ensure staff have documented appropriate information on each client

STANDARD 4.2: INFORMATION MANAGEMENT

Information is created and is used to meet strategic and operational needs and to support quality and safety.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

Staff stated that 95% of their information needs have been met since the introduction of monthly reports about procedures, performance and staffing. Staff identified that information that is not available (5%) is of a minor nature and not related to core business.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Accuracy of surveillance data.	• Data base improved. • Staff training provided.	An audit identified an 8% improvement in the accuracy of surveillance data 6 months after the changes were made.
Timeliness of data submission to regulatory / funding bodies.	IT consultant familiar with sexual health systems improved data entry and reporting functions.	100% reports in past 12 months submitted before or on due date.
Reports to external stakeholders and time taken to produce.	IT expertise provided enhanced interrogation power of data.	Time to produce reports reduced on average by 3 hours per report because of reduction in manual counting; information able to be produced conforming with requirements of external stakeholders.
Analysis of data.	More detailed information on trends in performance, clinical and non-clinical.	Quality improvement projects increased from 2 per year to 8 and risk management activities from 1 to 4.
Financial and human resources data collection systems.	Report format streamlined; human resources information analysed and aggregated de-identified reports made available to governing body members, managers and staff.	Financial systems – 4 areas improved. Human resources – 1.4 staff recruited to provide missing skills in the service.
Review of effectiveness and efficiency of data collection techniques and data quality.	• Alterations in data collected and manner of collecting. • Staff training provided.	More useful and accurate data to inform service planning, delivery and evaluation.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Review and identify data required by legislation.
- Develop guidelines to guide the collection of data on STIs not currently notifiable.

Criterion 4.2.1
Data are organised to ensure availability, analysis and the creation of information.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Legislative and Health Department requirements for surveillance reporting and minimum data sets are used.
- Clinical classification data are monitored for compliance and are validated.

Criterion 4.2.2
Clinical classification provides health information to support internal and external service requirements.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Recognised data sets are used.
- Coding of client information is part of the sexual health service's operational activities. The coding is accurate and completed promptly.
- Coded data are used to identify trends.

Criterion 4.2.3
Data are analysed and used to support quality and safe care and service.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- A universally accepted and used data collection system with appropriate and ongoing training will provide more consistent and useful data with possibilities for benchmarking between services. Uniform data collection and analysis criteria that acknowledge the full range of health promotion and education activities are used. Appropriate weighting should be made to allow accurate cross comparison with rural and metropolitan centres – for time travelled, more complex cases and less access to resources. This system should also provide for local and timely data analysis not only provide a conduit to centralised data banks.
- Reports are available that inform managers / directors of the sexual health service's performance in a timely, simple and effective manner.
- Specific reports can be produced as necessary without having to reconfigure the system.
- The sexual health service seeks feedback from staff about the usefulness of reports and reviews their production and circulation regularly.
- The data can be used to benchmark aspects of the service with other sexual health services through the use of standardised data definitions and reports.
- Data are accurate and reflect a realistic picture of the sexual health service.

Examples of quantitative measures and improvement activities
There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures
- Cost, timeliness and accuracy of data collection and reports
- Incidence of duplication of data entry due to service systems or requirements of funding bodies
- Incidence of problems with delivery of services related to lack of information
- Satisfaction rates of report users with information provided
- Incidence of lost information due to poor indexing systems
- Representation of the sexual health service on data development and advisory committees

Improvement activities
- Improve speed and effectiveness of communication and access to data
- Improve the sexual health service's performance by improving timeliness and effectiveness of reports
- Improve quality and accuracy of reports
- Reduce incidence of inaccurate reports
- Reduce time taken to collect data and produce reports (either manually or electronically)

STANDARD 4.3: INFORMATION MANAGEMENT

Information technology (IT) enhances the organisation's ability to support care, safety, organisational goals and information management goals.

Example of outcomes relating to this standard. (Refer to Question 1 of the Self-Assessment Tool)

System downtime for the period decreased from 27 hours to 5 hours following a change in server provider.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
IT Plan against Strategic and Business Plans.	Aligned.	More efficient and better use of IT. The available IT better supports the sexual health service's work.
Expenditure on IT.	More support provided internally; IT Committee must sign off on all new purchases of hardware and software.	IT budget reduced by $1,284.
Staff competencies in use of IT.	Following skills audit, targeted training designed for all staff requiring IT.	Staff report increased confidence and more efficient use of time.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

- Monitor IT user satisfaction.
- Identify incidence of same data having to be entered more than once and duplicate sets of data, due to databases which are not linked.

Criterion 4.3.1
The organisation uses an integrated approach to plan, and appropriately use, information technology (IT).

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.
There are no specific issues for this criterion for sexual health services.

Criterion 4.3.2
Risks to the information technology (IT) systems are managed to minimise disruption.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.
There are no specific issues for this criterion for sexual health services.

Examples of quantitative measures and improvement activities

There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures

- Percentage of involvement of staff at all levels in planning the information technology systems
- Percentage of budget allocated to the introduction of technology
- Percentage of budget allocated to staff training in all relevant areas
- Staff satisfaction with education and training provided in use of information technology
- Percentage of achievement of sexual health service's information technology goals
- Costs of communication tools such as mobile phones, pagers, e-mail

Improvement activities

- Eliminate incidence of the same data having to be entered more than once and of duplicate sets of data
- Increase the number of skilled users
- Reduce the incidence of downtime due to system failure or lack of helpdesk support
- Improve compliance with software licensing requirements
- Review mobile telephone coverage and where appropriate implement satellite phones in 'black spot' areas
- Improve reporting and information management eg faster production of daily work sheets for outreach workers, improved appointment management, reduced duplication and recording errors

FUNCTION 5: SAFE PRACTICE & ENVIRONMENT

STANDARD 5.1: SAFE PRACTICE & ENVIRONMENT

A systematic risk management program is used to manage services and facilities and ensure that the safety and health of all persons within the organisation are protected.

Criterion 5.1.1

There is a system that identifies and manages occupational risks to ensure the health, safety and welfare of all employees, consumers / patients and visitors.

NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

- After consultation with staff who participated in updating the procedures relating to accidents and injuries at work and following subsequent education sessions, the number of days lost due to accidents and injuries decreased from 34 to 17 over a 6 month period.
- Staff satisfaction with the sexual health service's safety strategies increased from 72% to 92% over a 12 month period.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Workers compensation claims.	Staff compliance with OH&S procedures improved following consultation with staff and educational sessions.	Reduced insurance premiums.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Include OH&S prevention strategies in service planning activities.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- The service should consider advanced driver skills and safety courses for staff in rural areas driving long hours and distances.
- Staff routinely conduct risk assessments when first visiting clients at home or in community facilities.
- Policies, procedures and equipment are in place to protect staff whilst travelling or at remote sites including clients' homes (issues may include personal safety eg dog tethering during home visit, bush fire protection, remote area survival skills and contingencies for service provision during extreme weather conditions such as floods and cyclones, mobile phones not working).

Criterion 5.1.2
Buildings, plant, equipment and supplies are managed and operated to support safe practice and a safe environment.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

- A change in print paper supplier resulted in a $210 saving this financial year following consultation and feedback from staff regarding paper quality.
- Following a maintenance audit, turnaround times for non-urgent requests have reduced from 5 days to 2.5 days.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Assets.	Asset register completed allocating life expectancy to each asset.	Replacement planning documented for each asset.
Agreements with building owner.	Maintenance program for air conditioning agreed using industry guidelines.	Regular maintenance of air conditioning occurs.
Accidents and incidents related to the use of or failure of equipment.	Regular maintenance of equipment according to manufacturer's recommendation introduced.	Equipment life increased on average by 8 months compared to the period before regular maintenance.
Number and type of complaints about design and layout of work areas and client mishaps.	Establishment of workplace OH&S Committee.	Improved design and layout of work and client areas; all complaints addressed within 4 weeks.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Identify incidence of inappropriate supplies purchased and wastage rate of supplies.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- The equipment purchase policy includes selection criteria.
- The range of equipment required by the sexual health service is available.
- Ergonomics are considered in the use of examination couches and microscopes.
- Staff have access to fleet cars to enable them to deliver outreach services as required.
- There are sufficient fleet cars to cover service needs.
- Technical items are recalibrated regularly and maintained in accordance with the manufacturer's instructions.
- The turnaround time for replacement of damaged and replacement equipment in rural and remote areas is minimised.

- Motor vehicles are regularly maintained.
- The sexual health service provides appropriate facilities for the storage and transportation of equipment.
- Staff are qualified to use technical equipment.

Criterion 5.1.3
The infection control system supports safe practice and a safe environment.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

100% staff immunised against Hepatitis B following sexual health service offer of free immunisation.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Refrigeration temperatures of staff fridge following staff concern.	Fridge replaced after testing showed the inconsistency of temperatures could not guarantee safety of food.	Temperatures are all within the safe zone on routine monitoring of fridge temperatures.
Autoclave or single use equipment.	Introduction of corporate single use policy.	Increased costs but increased client and staff safety and compliance with legislative requirements.
Appropriate storage of vaccines.	Temperature audits of fridges and checking of expiry dates of vaccines implemented.	Appropriate storage of all vaccines. Wastage of vaccines decreased by 15%.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Review of infection control policies and strategies in line with current industry guidelines.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Sterile stock is stored appropriately and regularly monitored to ensure it remains sterile.

Criterion 5.1.4
The emergency management system supports safe practice and a safe environment.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

After increasing the frequency of fire drills, the purchase of additional extinguishers and the introduction of a fire safety video at orientation, the evacuation time decreased from 11 to 7 minutes.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Fire inspection report.	Management succeeded in having the report put on the Board agenda under the Risk Management item.	37 of the 42 recommendations addressed after 6 months with plans and time lines for the remaining 5.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Need to improve fire drills following a restroom not being checked at previous drill. Fire warden is currently undergoing more training.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Strategies are in place to deal with emergencies such as loss of power, petrol strikes, and natural disasters such as floods and cyclones.

Criterion 5.1.5
The management of manual handling risks supports safe practice and a safe environment.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

Manual handling injury claims, previously at 13% have decreased to nil following compulsory education of all staff on manual handling.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Difficulty in accessing supplies in storeroom.	New shelving installed.	All supplies accessible without step ladders and time to access supplies decreased by an average 3 minutes.

Reviewed	Changed	Results
Managers knowledge of manual handling.	Development of a Manual Handling for Managers education package and manual.	Improvement of manager's knowledge of their responsibilities in relation to manual handling improved by 25%.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Develop manual handling kit to form part of orientation package for staff and also for governing body members to raise their awareness. Include manual handling of office supplies.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Manual handling issues need to be considered in activities in the office, in transporting supplies and equipment as well as in outreach clinics and premises being visited.

Criterion 5.1.6
Security management supports safe practice and a safe environment.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

- Following the introduction of a contracted security service to undergo periodic night patrols the reporting of security related incidents has decreased from 6 to 2.
- Following Managing Aggressive Behaviour training for all staff the number of critical incidents involving aggression by clients towards staff reduced from 8 to 2 in a 12 month period.
- A 15% reduction in reporting of critical incidents involving staff safety has occurred in the 3 months since implementation of the policy of 2 staff attending potentially aggressive clients.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Incidence of office left unlocked overnight.	Implementation of lock up procedure.	Office now locked up every night.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Review security of reception during opening hours.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- The sexual health service provides centre-based and outreach staff with effective back-up at all times including mobile / satellite telephones with coverage in all catchment areas, duress alarms, use of security guards and other security strategies.
- There is a policy about entry / intake of clients where their environment or behaviour may cause staff safety to be compromised.

Criterion 5.1.7
The management of dangerous goods and hazardous substances supports safe practice and a safe environment.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

Following a review of all signage as part of the risk management program, there were no breaches of regulations identified in the subsequent 2 x 6 monthly audits.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Fumes from cleaning cupboard.	Introduction of system for handling and storage of cleaning chemicals following staff complaints of chemical fumes.	Chemical fumes have reduced markedly resulting in safer environment for staff.
Storage for spray paint cans at youth drop-in clinic.	Cans now stored in metal cupboard with appropriate Hazchem signage.	No access to cans without consent and supervision.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

It is envisaged that safety will improve following the implementation of an organisation-wide purchasing agreement for chemicals and the introduction of an organisation-wide policy for handling and storage of dangerous goods and substances resulting in uniformity of goods used and uniformity of storage.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- The sexual health service has appropriate secure areas for the storage of specimens, drugs, lotions, cleaning and other chemicals.
- The sexual health service has the appropriate protective gear for hot plates and gram staining.

Criterion 5.1.8
The radiation safety management system supports safe practice and a safe environment.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

This criterion is not applicable to sexual health services.

Criterion 5.1.9
The waste management system supports safe practice and a safe environment.
NB: The organisation needs to achieve a rating of MA or higher for this criterion to gain ACHS accreditation.

Example of outcomes relating to this mandatory criterion. (Refer to Question 1 of the Self-Assessment Tool)

Clinical waste disposal costs have decreased by 15% following an education program to all staff on waste stream management.

Example of reviewed activities. (Refer to Question 2 of the Self-Assessment Tool)

Reviewed	Changed	Results
Collection of waste paper.	Each office issued with collection box.	Paper sent for recycling increased from 2 to 4 bales per month.
Staff involvement in waste management initiatives.	Formation of waste management committee, meets 3 times a year.	See above. Also reduction of paper costs by introduction of reusable scribble pads, introduction of recycling of aluminium and glass waste.
Sharps disposal containers.	Converted to a small sharps container that is secured to the inside of car boot.	All sharps disposed of safely. No needle stick injuries reported in past 6 months.
Potential for recycling.	Recycling of cardboard, paper and aluminium cans introduced.	Entered Green Environment competition, increased morale.

Example of proposed improvement activities. (Refer to Question 3 of the Self-Assessment Tool)

Waste management committee to identify additional waste management strategies and staff education strategies.

In addition to the elements and generic guidelines for this criterion in *The EQuIP Guide 3rd Edition, June 2002* the following issues could be considered for sexual health services.

- Motor vehicles are maintained correctly and service routes are planned in a way which reduces travel time and minimises petrol consumption.
- The sexual health service uses timer switches and other power saving devices without compromising safety or the quality of the service.

Examples of quantitative measures and improvement activities

There is no requirement to monitor a specific number of indicators (quantitative measures). Sexual health services need to consider indicators and activities that relate to the services they provide and are appropriate for the size. Quantitative measures provide the information or data that can be used to develop improvement activities.

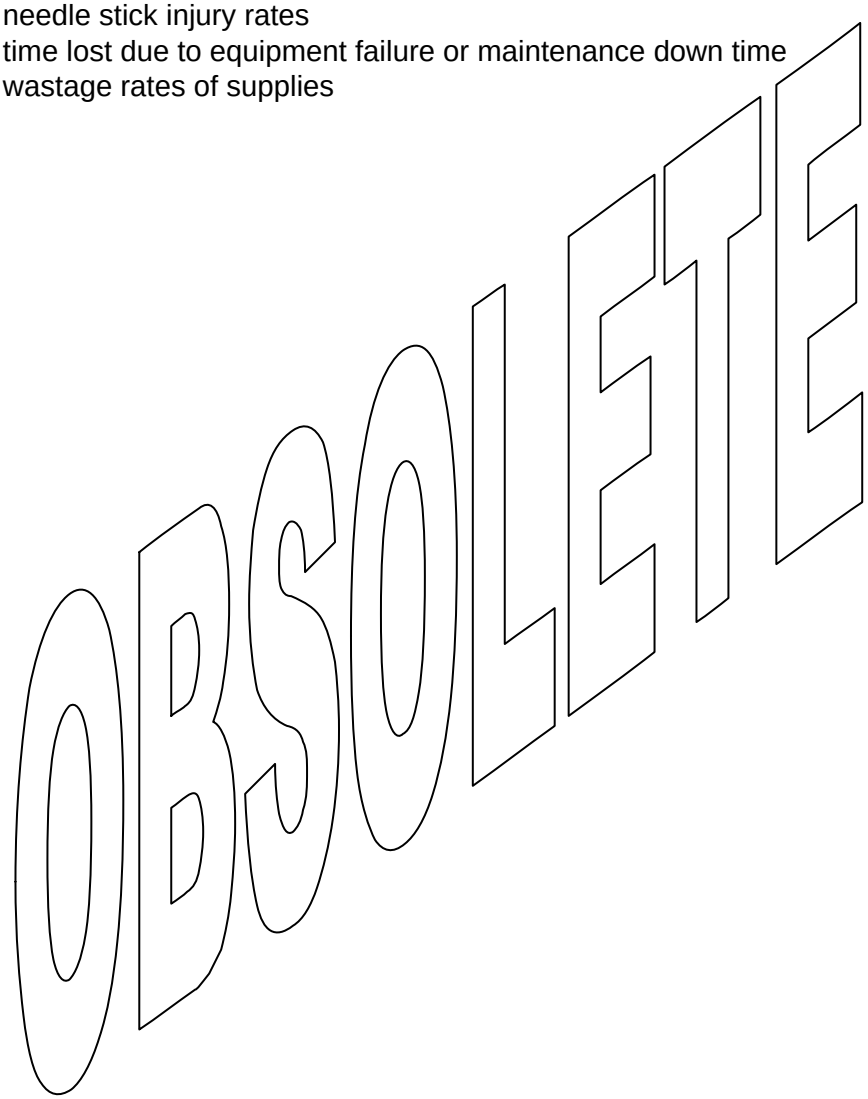
Please refer to the quantitative measures and improvement activities quoted for each standard within *The EQuIP Guide, 3rd Edition, June 2002* as well as those quoted below.

Quantitative measures

- Percentage of OH&S goals and targets met
- Staff satisfaction with sexual health service's safety strategies
- Outcomes of site inspections and audits
- Occasions of incident debriefing for staff
- Number of vehicle accidents and breakdowns
- Incidence of accidents and incidents related to design and layout
- Occasions of client mishaps / accidents when accessing service buildings
- Staff and client satisfaction with the design and layout of the service
- Lost time due to equipment failures
- Percentage of maintenance plan objectives met
- Percentage of budget allocation for purchase of equipment
- Percentage of staff involvement in purchasing decisions
- Number of accidents and incidents related to the use of or failure of equipment
- Staff satisfaction with the equipment provided
- Staff satisfaction with the equipment training provided
- Incidence of regular maintenance of equipment
- Incidence of equipment contractor / supplier breaches of contract
- Lost time due to breakdowns of plant or equipment
- Expenditure on repairs and replacements
- Results of microbiological testing of relevant equipment
- Staff satisfaction with infection control strategies
- Rate of staff compliance with infection control policies and strategies
- Outcomes of fire drills and fire inspections
- Cost of use of security services
- Number and type of incidents and accidents including assaults by aggressive clients dealt with at the service's premises or in outreach clinics or venues
- Number of breaches of security eg break-ins
- Changes in costs associated with waste disposal and energy consumption
- Percentage of staff involvement in waste management initiatives
- Staff and client satisfaction with waste and energy conservation strategies
- Number of complaints regarding cleanliness

Improvement activities

- Reduce lost time due to injuries caused by poor work environment
- Increase staff immunisation rates
- Reduce needle stick injury rates
- Reduce time lost due to equipment failure or maintenance down time
- Reduce wastage rates of supplies



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Feedback

The ACHS welcomes feedback on this tool. Should you have any ideas for improvement or suggestions for inclusion, please contact:

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