3 Recent developments in ensuring quality of care in health establishments in South Africa

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Improving the quality of care in health establishments has received significant attention in South Africa over the past few years. This chapter traces the development of the national core standards and sketches recent developments in ensuring quality of care in health establishments, particularly the steps taken to establish the Office of Health Standards Compliance (OHSC) as a public entity. The Office is mandated to protect and promote the health and safety of users of health services through monitoring, enforcing compliance with prescribed standards, and through the investigation and disposal of complaints. The authors suggest that the National Core Standards provide a useful mechanism for health establishments to measure their own performance. They further assert that the process has had important additional benefits in that it has introduced an awareness of the different dimensions of quality of care, objectively identifies and prioritises gaps, and allows facilities to measure their performance against other facilities within the district, provincially and nationally. The authors conclude that the establishment of the OHSC with powers to recommend needed changes and to enforce progressive sanctions constitutes a major opportunity to stimulate a culture of continuous quality improvement.

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i Office of Health Standards Compliance

Introduction

Improving the quality of health care has been an important objective of the South African Department of Health for a number of years,[1-4] especially given increasing concerns about progressive deterioration in this regard.[5] Sections 27 and 28 of the Constitution guarantee the right of all South Africans to access health care. The National Health Act (61 of 2003) (NHA) builds on the transformation of health care introduced in 1994, and presents the district health system as a vehicle for service delivery, improving quality and standards of health care in public and private sectors, human resource planning and development, and increasing universal access to health services.[6]

In recent years, there has been greater focus on health systems strengthening and capacity-building to ensure improved quality of health services and sustainability of the public health system in South Africa.[7,8] The Negotiated Service Delivery Agreement (NSDA) identifies strengthening health system effectiveness as an important output for the health sector, which will be achieved through re-engineering of primary health care, the strengthening of human resources, and improvement and standardisation of quality of care through the certification of health establishments.[2] This priority is mirrored internationally – as illustrated by extensive efforts to support and develop health system improvement strategies by organisations such as the World Health Organization (WHO), the World Bank, and major bilateral donors, such as the United Kingdom's Department for International Development (DFID), the United States President's Emergency Plan for AIDS Relief (PEPFAR), the United States Agency for International Development (USAID), and large private donors.[9]

Recent quality improvement initiatives have been largely unco-ordinated and minimally monitored, especially at a national level. In 2008, the Department of Health therefore embarked on an initiative to standardise, measure and enforce quality of care across all health establishments in South Africa. This was overseen by the establishment of the Office of Standards Compliance, a cluster in the Department of Health, based on provisions in the NHA and tasked with preparing for the establishment of an "independent quality management body".[3,10] Several quality assurance initiatives have been implemented in selected districts and facilities (such as the Council for Health Service Accreditation of Southern Africa (COHSASA) initiative), but this was the first time a co-ordinated, national approach had been developed in South Africa.

Underpinning these efforts, a set of National Core Standards (NCS) provided a benchmark for quality of care across South Africa, and has been the focus of a national development and dissemination process, together with countrywide training and support in using the standards to close identified quality gaps.[11] The NCS reflect the concerted effort being made to ensure that quality health care becomes an integral part of health system strengthening in South Africa.

The NCS set out what is expected and required to deliver decent, safe, quality care, and are accompanied by a set of measurement tools to assess compliance with these measures.

The NCS are structured into seven cross-cutting domains to reflect a systems approach, and define the scope or intent of assessing a health area where quality or safety might be at risk. Domains 1–3 relate to the core business of the health system while the final four refer to the support system that ensures that the former are delivered. These domains are further subdivided into sub-domains (Table 1) which comprise a set of standards with associated measurement criteria and measures.[11]

The Office of Standards Compliance: preparing for regulation

The Office of Standards Compliance was established within the Department of Health in 2008 and based its work on the provisions set out in the NHA. This office co-ordinated the development of the National Core Standards which, after several revisions, were finalised in 2010, ratified by the National Health Council and published and implemented across provinces from 2011 onwards.

In attempting to fulfil the purpose of the NCS, over the past five years, there has been a participatory process to develop standards appropriate to the South African context followed by a national dissemination and training initiative. An important aspect has been the provision of support to health facilities to apply the standards, and as such, the introduction of the NCS represents a landmark intervention to ensure that quality care becomes the norm in South Africa.

These standards essentially serve as a reasonably comprehensive set of guidelines for facilities on what is expected of them. Six areas of critical concern to patients, covering a sub-set of the full standards, have been identified as non-negotiable priorities, as follows:[11]

- **Values and attitudes** of staff, so that patients are treated in a respectful manner with due respect for privacy and choice (Domain: Patient Rights).
- **Reducing waiting times and queues** for administration, assessment, diagnosis, pharmacy, surgery and referral and transfer time (Domain: Patient Rights).
- **Cleanliness of hospitals and clinics**, including buildings, grounds, amenities, equipment and staff (Domain: Patient Rights).
- **Keeping patients safe and providing reliable care** by reducing adverse events resulting from care given, including operations and failures of the system and its workers through ignorance, inadequate inputs, systems failure or negligence (Domain: Patient Safety, Clinical Governance and Care).
- **Preventing infections from being passed on in hospitals and clinics**, specifically hospital-acquired infections (Domain: Patient Safety, Clinical Governance and Care).
- Ensuring that **medicines, supplies and equipment are available** and that patients get their prescribed medicine on the same day (Domain: Clinical Support Services).

Over the past few years, these priorities have become the central focus for quality care and are widely known. They are gradually being mainstreamed into general management practices through inclusion in budgeting processes, recruitment and performance management, and in planning and monitoring of delivery.

Although the focus in this introductory phase has been predominantly on the public sector, the standards are intended to be universally applicable, and to extend to the private sector. To this end there has been extensive engagement with private health sector bodies and personnel, and the standards were piloted within private health care facilities and adapted to be applicable to both private and public health facilities.

Compliance has been voluntary, and as yet there are no specific sanctions for health facilities that fail to meet the standards. The NCS do, however, represent a major advance towards compliance monitoring, in that they provide a framework to consolidate the essential pillars of what is meant by quality health care in the South African context: reliable implementation of evidence-based interventions that contribute to expected clinical results and a service that meets users' expectations of "care".

Table 1: Domains and sub-domains of the National Core Standards

Domain	Sub-domain
Domain 1: Patient Rights The domain of Patient Rights sets out what a hospital or clinic must do to make sure that patients are respected and their rights upheld, including getting access to needed care and to respectful, informed and dignified attention in an acceptable and hygienic environment, seen from the point of view of the patient, in accordance with Batho Pele principles and the Patient Rights Charter.	• Respect and dignity • Information to patients • Physical access • Continuity of care • Reducing delays in care • Emergency care • Access to package of services • Complaints management
Domain 2: Patient Safety, Clinical Governance and Care The Patient Safety, Clinical Governance and Care domain covers how to ensure quality nursing and clinical care and ethical practice; reduce unintended harm to healthcare users or patients in identified cases of greater clinical risk; prevent or manage problems or adverse events, including health care associated infections; and support any affected patients or staff.	• Patient care • Clinical management for improved health outcomes • Clinical leadership • Clinical risk • Adverse events • Infection prevention and control
Domain 3: Clinical Support Services The Clinical Support Services domain covers specific services essential in the provision of clinical care and includes the timely availability of medicines and efficient provision of diagnostic, therapeutic and other clinical support services and necessary medical technology, as well as systems to monitor the efficiency of care provided to patients.	• Pharmaceutical services • Diagnostic services • Therapuetic and support services • Health technology services • Sterilisation services • Mortuary services • Efficiency management
Domain 4: Public Health The Public Health domain covers how health facilities should work with non-governmental organisations and other healthcare providers along with local communities and relevant sectors, to promote health, prevent illness and reduce further complications; and ensure that integrated and quality care is provided for their whole community, including during disasters.	• Population-based service planning and delivery • Health promotion and disease prevention • Disaster preparedness • Environment control
Domain 5: Leadership and Corporate Governance The Leadership and Governance domain covers the strategic direction provided by senior management, through proactive leadership, planning and risk management, supported by the hospital board, clinic committee as well the relevant supervisory support structures and includes the strategic functions of communication and quality improvement.	• Oversight and accountabiity • Strategic management • Risk management • Quality managment • Effective leadership • Communications and public relations
Domain 6: Operational Management The Operational Management domain covers the day-to-day responsibilities involved in supporting and ensuring delivery of safe and effective patient care, including management of human resources, finances, assets and consumables, and of information and records.	• Human resource management and development • Employee wellness • Financial resource management • Supply chain management • Transport and fleet management • Information management • Medical records
Domain 7: Facilities and Infrastructure The Facilities and Infrastructure domain covers the requirements for clean, safe and secure physical infrastructure (buildings, plant and machinery, equipment) and functional, well managed hotel services, and effective waste disposal.	• Buildings and grounds • Machinery and utilities • Safety and security • Hygiene and cleanliness • Linen and laundry • Food services

Source: National Department of Health, 2011.[11]

Core standards for other health services (e.g. Emergency Medical Services) are still to be developed.

Office of Health Standards Compliance

The past three years have seen the development and finalisation of the legislative provisions in the amendment to the National Health Act for the establishment of an independent Schedule 3A Public Entity as a quality regulator, namely the new Office of Health Standards Compliance (OHSC – to be distinguished from its NDoH precursor, the Office of Standards Compliance or OSC). This Office is mandated to protect and promote the health and safety of users of health services through monitoring, enforcing compliance with prescribed standards, and ensuring the investigation and disposal of complaints. With the promulgation of the Amendment Act in September 2013, concrete steps have been taken to establish the Office as a public entity in 2014.

In terms of the National Health Amendment Act (12 of 2013), the OHSC is empowered to fulfil functions that include:[13]

- advising the Minister on the norms and standards that will be prescribed for the national health system;
- inspecting and certifying health establishments as compliant or non-compliant with prescribed norms and standards and holding the authority to withdraw certification for non-compliance;
- investigating complaints in relation to the national health system;
- monitoring indicators of risk to provide early warning of serious breaches of norms and standards, and reporting serious breaches to the Minister;
- making recommendations for intervention by national, provincial or municipal health departments or health establishments (including private establishments) in order to achieve compliance with norms and standards;
- publicising information relating to norms and standards;
- recommending quality assurance and management systems for the national health system to the Minister;
- collecting information relating to norms and standards from establishments and users; and
- maintaining records of all its activities.

Extensive preparatory work has been done towards the establishment of the Office as a separate legal entity. Table 2 identifies the key activities undertaken by the OSC towards the creation of an independent unit, the OHSC, with a summary of progress made in 2013.

Table 2: Key activities towards the development of the Office of Health Standards Compliance

Key activity	Progress to date
Establishment of a competent inspection team	• The first team of 30 inspectors was engaged and trained by the Office of Standards Compliance. Four team leaders were sent on a study tour to the United Kingdom Care Quality Commission. The inspectors continue to receive ongoing in-service training.
Development and refinement of the assessment tools	• The inspectors have conducted 833 "mock" or training inspections of public health establishments in order to test tools and procedures for future regulation. Several tools have been developed to ensure clarity and consistency in interpretation of assessment criteria, and to ensure reliability of results.
Assessment and analysis of compliance with standards	• The NCS enables the assessment and comparison of quality – across facilities within districts, across districts within provinces, between provinces – and can thus compose a national picture of the state of quality of care in South Africa. • Analysis of 833 mock inspection reports to date shows mixed results. While some hospitals are meeting standards and providing quality care, others (including some of the better-resourced public health establishments) fall short on some essential measures. Of the 833 inspected health establishments, 47 were re-inspected, with some showing improvement and others remaining unchanged.
Testing the universal applicability of the standards	• Assessing the applicability of the assessment tools to different health settings – primary health care, Community Health Centres and hospitals – is an important part of the introduction of the NCS. • Many clinics, which are the foundation of primary health care, are barely able to meet 50% of the NCS requirements. This has led to an in-depth review of what can be reasonably expected of a clinic in terms of accountability for the care they provide, as well as further refinement of the measurement tools as a whole. • Extensive work has been done to test the applicability of the standards in the private sector.
Baseline assessment	• A sub-set of the NCS covering only the "six priorities" served as the basis for the Health Facilities Baseline Audit conducted by a consortium led by Heath Systems Trust (HST) in all public hospitals and clinics during 2011 and 2012.[14] • This audit provided baseline information on the gravity of the quality deficits in a number of provinces (although no province was found to be at the required level) and served as an impetus for more intensive quality improvement interventions.

Improvement work

The NCS provide a framework for quality assurance. An integral part of compliance with norms and standards is the identification and closing of deficits which is done by means of the assessment process. To support this, the OSC has encouraged a model of continuous quality improvement, whereby a gap or problem is identified, the problem is analysed to identify both the cause and possible remedial action, and the Plan-Do-Study-Act (PDSA) model is applied to evaluate, rethink, refine and ultimately scale up the corrective intervention.[15-17]

A number of different initiatives have been implemented over the past two to three years to support implementation of the NCS and to ensure that their intent is realised, namely to improve the quality of basic care provided to patients throughout the country at all levels of care. Given that this is a very new initiative and is breaking new ground in many ways, much emphasis has been placed on raising awareness and disseminating knowledge through seminars, workshops and more formal training activities. As awareness has grown and as the implications of the functions and powers of the future OHSC have become clearer, the focus is now shifting towards concrete efforts to introduce corrective action in order to make the system work more effectively and efficiently for better quality.

Initial training and awareness creation

An important aspect of igniting the implementation of the NCS was an intensive national training programme, run from February 2011 to August 2012, targeting hospital management and district teams across all nine provinces. The purpose of the training was to orientate senior leadership, secure buy-in and commitment, and highlight the importance of skills development on how to conduct an assessment and take remedial action. The training methodology involved on-site use of the assessment tools and provided managers with the opportunity to assess and benchmark their own health establishments.

The training focused on the NCS, and prioritised teamwork. Teams were encouraged to identify those gaps that were easily solved and effect immediate remedies, and then to engage in more formal quality improvement activities to close significant gaps. It was thought that by focusing on attaining rapidly achievable results, the teams would be encouraged to continue addressing other, more daunting quality gaps. The response from many management teams was indeed that "these are things we know about – we should have been doing them all along". Where formal teams were needed, these often worked better when supported by provincial and district quality co-ordinators, managers and personnel from the NDoH Office of Standards Compliance.

Problem-solving approaches were used to ensure that the root causes of problems were identified.[16] The primary aim was to transfer skills and make positive changes in healthcare processes to achieve favourable outcomes in relation to quality, using the PDSA model.[17,18] One of the unique features of this model is the cyclical nature of designing and assessing change, which is achieved through small and frequent PDSA cycles (rather than large and slow ones), used to test impact before changes are made system-wide. The PDSA cycle starts with determining the nature and scope of the problem, the changes that can and should be made, devising a plan for a specific change, and identifying who should be involved, what should be measured to understand the impact of change, and where the strategy should be targeted. This model leads to the development of detailed and specific improvement plans at facility level. These measures are far more effective at making change happen than the generic statements of intent "for all hospitals in the district (or province)", which are typically confused with a plan (or even regarded as implementation).

Facility Improvement Teams

In order to respond constructively to the Baseline Audit findings, implement the NCS in preparation for the unfolding implementation of National Health Insurance, expedite rapid, high-impact quality improvement activities, and ensure that all key departments were actively involved in this process, the NDoH established Facility Improvement Teams (FITs), which were activated in February 2012.[19] The FITs comprise senior, multi-disciplinary national staff and are led by Cluster Managers. Four districts were identified at the time as pilot sites to test both quality improvement methodologies and the FIT model, using the very first validated baseline audit results. The teams were formally introduced in the respective provinces by the Director-General of Health, and thereafter were able to provide support to the district and province to close the gaps identified during the Baseline Audit study. The FIT teams were later expanded to cover eight provinces and ultimately all 11 National Health Insurance pilot sites.

The introduction of FITs at the national level as part of the improvement strategy has strengthened communication between different departments at national, provincial and district levels, since the standards cut across all the units, and solving problems and blockages that lead to poor quality requires a team approach if it is to succeed. Some provincial departments were able to replicate the model of establishing FIT teams at provincial or district level. Facilitating meetings at district level has allowed for comparisons of the improvements that were taking place at the facility level, and teams and senior management in respective districts were able to escalate challenge scenarios appropriately. The FIT model used problem-solving approaches through identifying root causes in a collective brainstorming, which proved to be surprisingly creative. Overall, enhanced local support has been the primary result of the synergy of approaches, as partners are able to guide and support the district and facilities more effectively toward compliance with the NCS. Standards used as a framework together with systems improvement methods have allowed teams to focus efforts on critical areas needed to gain maximum results while maintaining focus on quality services.

However, concerns have been expressed as to the slow pace of change and the sustainability of the model, and the fact that the underlying contributory factors have not always been clearly identified and addressed. In a recent refinement therefore, the NDoH has been focusing intensively on a small number of clinics in order to bring about real improvement, while identifying and developing the support systems and inputs needed to achieve full compliance and improved quality in these "ideal clinics". The learning from these PDSA-type exercises will enable more rapid scale-up, while also quantifying more accurately the real impact of system weaknesses and resource constraints.

Using inspection reports and feedback to improve the quality of care

While the inspection teams are acutely aware of the need to remain objective and not become directly involved in "fixing things", as the mock inspections unfolded it became clear that the presence of the inspectors on site was a critical opportunity for learning on the part of those being inspected. In developing procedures and the training of inspectors, the inspectorate has therefore developed an assessment methodology that is designed to explain the intent of each standard being assessed, and how the measurement and corresponding criteria contribute to achieving compliance and improved quality. The assessment process itself and the underlying reasons for non-compliance are communicated in detail to every unit manager during the inspection, ensuring that they understand what is required of them to correct current practices and achieve compliance.

Another critical opportunity for the inspection process to contribute to change and improvement is during the feedback of the findings. The OSC encourages provinces and districts to attend the final feedback session of an establishment, during which the overall results and the areas of greatest concern or risk, as well as how the local management perceives the problems and solutions are communicated. In these sessions, it has become very clear that many of the weaknesses and gaps are indeed within the capacity of local management to solve, requiring a much greater degree of initiative and a sense of responsibility on their part than is often the case in practice. However, there are other instances in which local managers' hands are effectively tied – often because they do not have the authority to solve problems or ensure that others solve them.

The OSC has been focusing on a process of collecting basic information on all establishments that they inspect, in order to have more complete data on the degree to which workload and capacity are indeed markedly different across establishments showing different levels of compliance.

In addition, the OSC has been trying to encourage a higher level of engagement at the feedback sessions, whereby provincial senior management can reflect on their results and how they compare with other provinces. It is critical in these sessions that accountability is fairly accepted and shared, and that the fora do not result in blame-shifting. Such sessions should constitute an important opportunity for managers as a collective to identify and recognise success and effort, and to ensure that all the establishments for which they are responsible receive the kind of support and oversight they need and deserve (for example, in development of policies and procedures; sharing of contracts to enable monitoring; sharing of best practices; improving referrals). It is also critical that the high-risk areas identified as non-compliant (for example, those relating to emergency and resuscitation procedures) are corrected as a matter of urgency.

Scaling up and mainstreaming of the NCS

Despite prior efforts, the need to scale up training and dissemination of the NCS and accompanying materials was identified as an ongoing priority. In February 2013, a Primary Health Care (PHC) seminar involving nearly 300 district managers and support staff was used to catalyse a series of provincial workshops, where trainers were to be trained to assist with cascading information and skills targeting frontline workers, with the support of partners.[19] The provincial workshops were organised by the provinces, and the OSC team conducted the training for managers and other frontline workers to understand key quality concepts, principles and models, and to ensure skills development for relevant staff to pave the way for subsequent training of the frontline workers.

To ensure that the standards achieved are sustained and that improvement work becomes an ongoing process at facility level, the OSC has recommended that training on the NCS and the six priority areas be built into the provincial induction and orientation programmes of new staff. The OSC has also re-trained data capturers following revision of the NCS measurements based on input from provinces, and a revised database guide was also used as a practical guide during capturing of self-assessment data.[20] In the longer term, it is critical that the knowledge and skills required to achieve quality care should form part of basic training curricula, as well as of human resource management systems in general.

Quality improvement (QI) work is continuous and cross-cutting. The OSC therefore needed to engage other stakeholders and was able to mobilise additional support from non-governmental organisations (NGOs) working with provinces to support health system strengthening activities, in many cases funded by the US government. The OSC held several meetings with NGO partners to gain an understanding of their mandates, and to co-ordinate QI activities which maximised use of resources and understanding of the work of the OSC in order to effectively support QI activities at provincial, district and facility level. The NGOs were able to support the provincial departments with scaling up the training of frontline workers and dissemination of the NCS. It was important for the NGO partners to be involved in these endeavours, as they work closely with the facilities, in particular the primary health care clinics, on health systems strengthening and specific related actions and processes. Ongoing feedback from the NGOs has also been very helpful in ensuring continuous improvement regarding the work of the OSC.

Development of tools and guidelines

The implementation of the standards framework and six priority areas has highlighted gaps in different areas within health establishments. It is crucial that the measurement of quality does not become an end in itself, and that assessments are followed by intensive, carefully monitored quality improvement processes. The OSC has developed a set of training toolkits and a number of key guides to support provinces in complying with the standards.

The toolkits consist of a number of PowerPoint slide-sets and have been developed to support decentralised training and dissemination of information needed to operate at scale, and to ensure that similar standardised information is being communicated in a consistent and accurate manner by different trainers across the country.[21] The toolkits are updated and revised periodically as the situation evolves, and are designed so that users at any level can select the type of information and detail that is important for them. These materials thus support a multi-pronged communication strategy designed to secure buy-in from provincial, district and facility-based leadership and management, and to equip them with the correct information to relay to and train their counterparts. This entails a cascaded

approach whereby leadership and management (from national to provincial, district, sub-district, facility and frontline worker levels) are able to brief their staff about implementation of the NCS and associated quality improvement initiatives. The toolkit approach also provides up-to-date information on the legislative structure, including an overview of the legislative process leading up to the establishment of the independent OHSC, the legal framework, the NCS, the importance of compliance as a legal requirement, and the need to support training on the implementation of the NCS so that personnel understand the assessment process and tools.

The toolkits are accompanied by posters and key guidelines. Critical guidelines focus on quality improvement, self-assessment and the database which, when used together, provide managers with the knowledge and approaches needed for continuous assessment of their own performance and the appropriate methodologies for effecting change. The Quality Improvement guide demonstrates that, in practice, the process is about improved management and effective problem-solving. It sets out in simple language how a number of different methodologies and approaches share similar basic principles and can be used by managers and teams to improve quality of care.

Current work in progress

Major efforts have been invested in the process of reviewing the current NCS in preparation for the regulation of the norms and standards. Consultation with internal and external stakeholders included a focus on updating the standards with recent policy developments, re-wording and re-writing for greater clarity, and assessing their applicability to various types and levels of health establishments. The inspectors, in addition to ongoing mock inspections, have commenced the process of developing and piloting standard operating procedures, compliance procedures and revised measurement tools based on their broad experience.

The OHSC has continued to receive requests for support and guidance from the provinces. In March 2014, the OHSC together HST conducted District Health Management Team feedback meetings in four districts with completion of a questionnaire on the whole inspection and follow-though process by the participants. This feedback will be used to inform future support and guidance to health establishments, districts and provinces. The OHSC met with NGOs supporting health system strengthening initiatives in the provinces to share experiences and align efforts with respect to ensuring compliance with standards, with support from HST.

Conclusion

The NCS provide a useful mechanism for health establishments to measure their own performance. This process has had important additional benefits: it has introduced an awareness of the different dimensions of quality of care, it objectively identifies and prioritises gaps, and it allows facilities to measure their performance against other facilities within their district, province and nationally. Ongoing self-assessment enables management and staff to monitor improvements, assess changes made across each unit within a facility towards consistent positive client experience and delivery of quality service throughout the system, and ensure that gains are sustained.

The knowledge and establishment of the OHSC as a new regulator with powers to recommend needed changes and to enforce progressive sanctions constitutes a major opportunity to stimulate and strengthen a culture of Continuous Quality Improvement. This combined approach of quality improvement and assurance bolsters the health system as a whole to become more effective and responsive in making a real difference for patients and users of health services. In reality, this outcome is what National Health Insurance is designed to achieve for everyone in South Africa.

A case study:

The Benedictine District Hospital Risk Management Strategy

In implementing the standards, some health establishments have done well and have captured the process they followed to achieve this. The OSC has identified an example of best practice in relation to implementation of a specific methodology that can aid in improving quality and addressing shortfalls, namely that of risk assessment as implemented at Benedictine Hospital in Nongoma, KwaZulu-Natal. The experience presented below illustrates how a hospital can develop its own approach to improvement:

The objectives of the project were to:

- design, develop and integrate a risk management system into the management process at Benedictine Hospital;
- use this system as a vehicle for implementation of the National Core Standards; and
- monitor implementation of the National Core Standards.

Process

A baseline National Core Standards audit was conducted by Health Systems Trust for the National Department of Health in July 2011 and Benedictine Hospital scored 76% (24% non-compliant).

We worked on the assumption that all public and private hospitals need to comply with the National Core Standards to meet the requirements for National Health Insurance (NHI). Any standard with which Benedictine Hospital did not comply was classified as an "extreme risk". This drew on a process of risk management already started in 2010 (by our partners, the Centre for Rural Health, with the Benedictine Hospital's management team, the district managers, and the principal of the Benedictine nursing campus). Gaps identified were entered into the Risk Register, and action plans were developed, implemented and monitored. The Risk Register is a live electronic document that generates serial reports on the prevailing status of all risks in the database, and is used by the designated risk manager supported by a risk management committee.

Another mock inspection was conducted in July 2012, and the results showed that the hospital had improved its score to an 81% overall score (19% non-compliant). The leadership and corporate domain for the CEO scored 91%. The risk manager held regular meetings with lead managers with regard to progress on action plans and monthly updates of the Risk Register. In May 2013, a self-assessment process was conducted and the score had increased to 86%. To date, there are 58 risks on the live Risk Register which are divided into categories.

Using the approach of a risk management system has benefited Benedictine Hospital in that it has facilitated the review of the National Core Standards in a methodical way, enabled selection of risks for action, allowed for continuous monitoring of progress on key risks, and ultimately led to impressive compliance with National Core Standards.

Source: Office of Standards Compliance, 2014.

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