SLHD Policy

SLHD Quality Audit Reporting System (QARS) Implementation	
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Related MOH Policy	N/A
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Applies to	All SLHD Staff
Clinical Streams	**All Clinical Streams**
Tier 2 Sign Off	7 July 2016, Director, Clinical Governance and Risk, SLHD
Date approved SLHD Policy Committee	8 September 2016
Author	Clinical Quality Manager, CGU, SLHD
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Replaces	N/A

Version History	
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1. Introduction

Sydney Local Health District (SLHD) is committed to the delivery of effective and evidence based healthcare. High quality, consistent and validated audit tools support this objective.

SLHD has elected to use the Clinical Excellence Commission's Quality Auditing Reporting System (QARS), which is a web based audit hosting platform. The platform will house compatible audit tools that will be used at a District and Facility level.

The implementation of QARS ensures compliance with National Safety and Quality Health Standards, EQuIP, NSW Health Directives, other regulatory agencies directives and promotes clinical and service excellence.

This policy is in line with SLHD's Strategic Goals:

- for our Patients to have equitable access to safe, high quality patient centred care;
- for our Staff to be highly skilled, committed, accountable and valued;
- for our Staff to work in safe, respectful, healthy and productive workplaces;
- for our Services to be innovative, sustainable and evidenced based;
- for our Service to be efficient, high quality, safe and appropriate;
- for our Service to be accredited and recognised for excellence.

2. The Aims of this Policy & Procedure

This policy and accompanying procedure aims to achieve the following:

- outline the process for development of QARS audits;
- outline a process for SLHD Audits to be signed off;
- outline process for Service and Facility-level Audits to be signed off;
- reporting of Service or Facility level audits to the SLHD QARS Committee.

3. Risk Statement

SLHD Enterprise Risk Management System (ERMS) Risk # 32 - Governance for Safety and Quality in Health Service Organisations:

- Published QARS audits that are not supported by evidence, best practice, and/or align with current policy or legislative requirements;
- Published QARS audits are to be appropriately approved.

4. Policy Statement

Audits are important tools to support the implementation of new policy or practice, support evidence of action, and as an aide to quality improvement.

SLHD will only develop audits for inclusion into QARS where no equivalent Australian Commission for Safety and Quality and NSW Health audit exists. Audits for inclusion into QARS are to be developed on two fronts, one as the primary standard audit applied across the District and secondly, stand-alone Facility or Service level audits. Audits in QARS will be developed with an emphasis on collaboration across District, Facilities and Services.

Where a mandatory NSW Health audits exists, SLHD will adopt in whole that audit tool for use.

Audits in QARS must be approved and published in accordance with the process set out in this document in order to ensure transparency of process, quality improvement, clinical excellence and adequate governance oversight.

5. Scope

This policy applies to all SLHD staff, in particular those staff with the responsibility to develop and review NSW Health and/or SLHD policy documents, involved with compliance with National and ACHS Standards and hospital/service accreditation. This policy excludes audits that are developed and used by the SLHD Internal Audit Unit.

6. Resources

Clinical Quality Manager, SLHD
Nursing Manager, Clinical Practice SLHD
Quality Audit Reporting System (QARS) Committee, SLHD
Clinical Excellence Commission
Quality Audit Reporting System

7. Implementation

The implementation of the QARS program will require a change management approach, particularly as this new processes will take time to become established.

- The SLHD QARS Committee will oversee and endorse the initiation and approval of all SLHD wide audits.
- Nominated Facility Administrator/s of QARS will work to identify unnecessary duplicates and/or out of date audits, and identify opportunities for District-level audits in consultation with the SLHD QARS Committee.
- Current SLHD audits will be reviewed by the QARS Committee in order to consolidate unnecessary, duplicate audits.
- Introduction of the QARS System will include education and training and access rights to staff as follows:
    - education at facility level will be provided by Facility Administrator/s as required and with assistance from SLHD QARS committee as requested;
    - education at District level will be provided by members of the SLHD QARS Committee or the Clinical Excellence Commission (CEC);
    - access rights at District will be through the Clinical Quality Manager or Nurse Manager, Clinical Practice and for Facility level through the Facility Administrator/s.
- There will be ongoing review and loading of audits into the QARS system at facility and district levels.

8. Key Performance Indicators and Service Measures

- All audits to be submitted into QARS for SLHD will have been endorsed by the SLHD QARS Committee.
- All audits to be submitted in QARS for Facilities will have been endorsed by the relevant Manager or local committee.

9. Procedures

A consistent process is necessary in order to ensure SLHD QARS Audits are based on a national standard or statutory requirement, are collaborative, validated, and reduce duplication. Appendix 1 provides an overview of the process to be followed when developing new or updated QARS Audits in SLHD.

9.1 SLHD QARS Audit Initiation

All new SLHD Audits for inclusion in QARS must be approved for development through the QARS Committee. The *SLHD QARS Audit Development Application Form* should be used for submissions (*appendix 2*).

Facility-level QARS audits approved should be noted in a monthly report, to be provided by the Service/Facility to the SLHD QARS Committee. If the SLHD QARS Committee notes the proposed audit may give rise to duplication, and/or would more appropriately sit as a District-level audit, a representative of the Committee will liaise with the Facility/Service to identify an appropriate solution.

9.2 Development

There is no standard format for an audit tool. SLHD recognises audits developed by NSW Health and its agencies, or by external organisations and can adopt in whole these audits if suitable. Appendix 3 provides an example of how to develop an audit.

Consultation, as set out in the *SLHD QARS Audit Development Application Form* should be undertaken during the audit's development. Audits will not be endorsed unless evidence of appropriate consultation is provided.

9.3 Endorsement

The *SLHD QARS Audit Development Application Form* should be signed off as follows:

- District Audit – Tier 2 Director
- Facility or Service Audit – General Manager
- Clinical Stream Audit - Clinical Director

QARS SLHD audits: are to be endorsed by the SLHD QARS Committee. The audit should be submitted to the SLHD Clinical Quality Manager for final review by the SLHD QARS Committee. The Clinical Quality Manager or designated SLHD QARS Committee member will work with the author to progress any final amendments.

QARS Facility or Service-level audits: are to be endorsed by the General Manager, followed by endorsement from the appropriate local committee (or responsible person). All audits endorsed at a Facility or Service level are to be reported on a monthly basis to the SLHD Clinical Quality Manager for the information of the SLHD QARS Committee.

QARS Ward-level audits: are to be endorsed by the NUM or designated Ward Administrator. The Facility Quality Manager or designated QARS Administrator should be consulted prior to any publication to ensure there is no duplication.

9.4 Publication

Once approved by the SLHD QARS Committee, the SLHD Clinical Quality Manager or Nursing Manager, Clinical Practice SLHD will arrange for publication of **all** SLHD level audits.

Facility/service audits will be loaded into QARS by the local Quality Manager or designated Facility Administrator.

Ward level audits will be loaded into QARS by the NUM or QARS Ward Administrator.

There will be audit tools used within SLHD and at Facility/Service level that will not be compatible with loading into the QARS system or require the use of an independent database system. These audit tools will be authorised and published accordingly.

9.5 Reviews

In order to ensure that SLHD Audits are up to date and responsive to current requirements, SLHD Audits should be reviewed at least every five years by the audit author.

Minor revisions to SLHD Audits can be made with the agreement of the SLHD Clinical Quality Manager or Nursing Manager, Clinical Practice SLHD where these revisions do not impact the scope or implementation of the audit. In requesting revisions, audit authors must provide a clear rationale and/or evidence for the change. All revisions will be noted in the 'revision history'.

Where changes are major, that is requiring a significant change in scope or implementation, the audit will be referred to the SLHD QARS Committee for consideration as to whether the audit should be formally placed under review.

9.6 Naming Conventions

Depending on level of access, QARS allows users to create their own questionnaires and audits. The naming of these is to be standardised so that the system retains its utility. Audits are to be placed under the relevant National Standard.

General Principles:

- avoid use of punctuation (no underscores or quotation marks);
- use title case followed by lowercase;
- separate_each_word_with_an_underscore_space;
- avoid unfamiliar acronyms;
- numbers of standards and actions to include two numerals at each level (i.e. write action 3.4.1 as 03.04.01);
- use approved abbreviations, e.g. SLHD, RPAH

SLHD naming:

District_Target of Audit_Standard Number_Name

e.g. SLHD_All_01.17_Rights_and_Responsibility

Facility/Service naming:

Facility/Service_Target of Audit_Standard Number_Name

e.g. Balmain_Nursing_08.06.02_Skin_Inspections

If the questionnaire/audit is related to EQuIPNational Standards then the word EQuIP should be placed in front of the Standard number. Example:
RPAH_All_EQuIP12.02.01_Provision_of_Care. This will distinguish from any new National Standards that may be developed in the future.

9.7 Access to QARS

You can access the system using your employee ID and Staff Link password. Once you have logged in you will be directed to the Homepage which displays a wide range of icons. Access to the icons is based on your user role. There are four levels of user access and your user role will be allocated by:

- SLHD Level – Clinical Quality Manager or Nursing Manager, Clinical Practice, SLHD;
- Facility/Service Level – Quality Manager or Facility/Service Administrator; and
- Ward Level – Nursing Unit Manager or QARS Ward Administrator.

9.8 Action Plans in QARS

If the audit compliance rate has not met the target rate, an action plan needs to be completed. The Manager of the relevant Service/Facility or Ward must ensure that action plans are completed.

10. Consultation

Balmain Hospital; RPAH; CRGH; Canterbury; Oral Health; AC&R; Community Health; Tresillian; District Nursing and Midwifery; Workforce Services; Drug Health Services; Mental Health Services

The SLHD QARS Committee was convened to collaboratively develop a revised framework. Co-Chaired by the Director, Clinical Governance and Risk and SLHD Director of Nursing and Midwifery, membership of the group was as follows:

SLHD Clinical Quality Manager, CGU;
Nurse Manager, Clinical Practice, SLHD Nursing & Midwifery;
Patient Safety & Quality Manager, SLHD Drug Health Services;
Quality and Risk Manager SLHD Mental Health Service;
Quality & Patient Safety Manager, Canterbury Hospital;
Quality and Clinical Risk Manager, Community Health;
Quality Manager, Balmain Hospital;
Acting Director, Patient Safety and Quality Unit, RPAH;
Director of Allied Health, SLHD;
Operational Nurse Manager, Mental Health;
Manager, Innovation, Partnerships and Quality, CEWD;
Quality and Safety Manager, Tresillian;
Director Web Services, IM&TD;
Clinical Quality and Risk Manager, Concord Hospital;
Quality and Risk Manager, Oral Health;
Quality and Risk Manager, Community Health;
Work Health & Safety Coordinator, SLHD

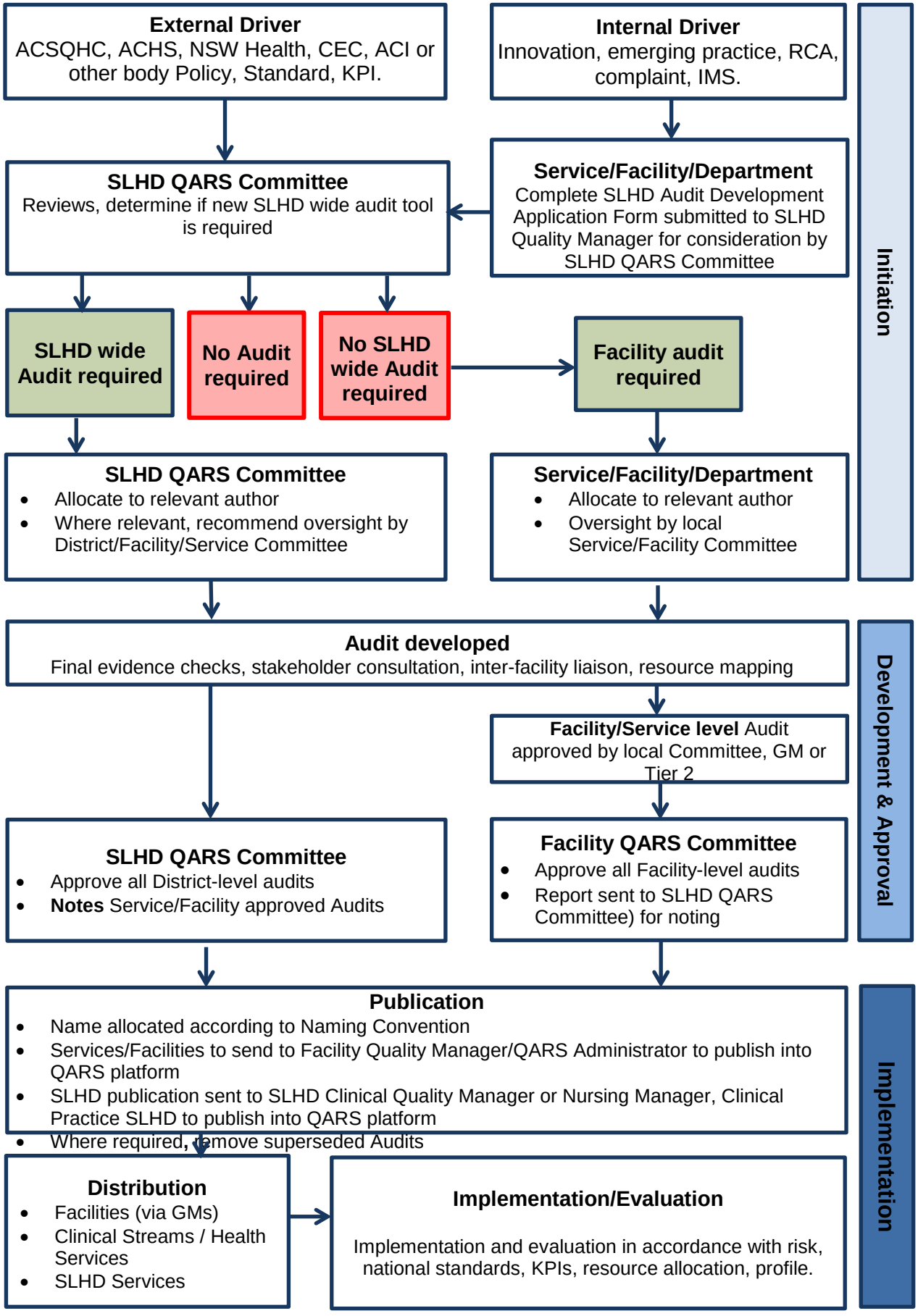
11. Links and tools

Link to SLHD Clinical Governance Unit, QARS: http://intranet.sswahs.nsw.gov.au/cgu_slhd/

Link to CEC QARS Database: QARS Database (http://qars.cec.health.nsw.gov.au/)

Clinical Excellence Commission QARS website: http://qars.cec.health.nsw.gov.au/

Appendix 1: Audit Process Flow Chart



Appendix 2: SLHD QARS Audit Development Application Form

PART A *To be completed for:* *1) Proposed new audit tools* *2) When updating current audit tools*	
Audit Title	
Audit Scope *	☐ **SLHD wide audit**
	Facility/Service-level audit: ☐ **RPA** ☐ **Canterbury** ☐ **Drug Health Services** ☐ **Community Health Services** ☐ **CRGH** ☐ **Balmain** ☐ **Mental Health Services** ☐ **Oral Health Services** ☐ **Tresillian**
Reason for the Audit *Why is the audit necessary?* *What is the aim of the audit?* *What data will the audit tool collect?* *What evidence do you have to support this?* *What will be done with the results?* *Who will be responsible for collection?* *What is the frequency of the audit?*	SLHD Audits are systematic, independent and documented process for obtaining evidence. This section should provide reasons/rationalize why an audit is required to be developed. Demonstrate why the audit is necessary and the evidence you have to support this.

Resources *What additional resources will be required to implement this audit?*	
Communication, Education and Training *Outline how the audit will be communicated, and what (if any) training is required.*	
Related documents *Will this audit require the creation of any new policies or review of other documents?*	*(Provide hyperlinks to relevant documents where possible)*
Consultation	**Audit proposed by:** *Name, position, email, phone*
	List all staff, committees and other groups who will contribute to, and are stakeholders in, the development of this audit:

PART B - SIGN OFF *For use by Services, Facilities or Departments when proposing a **new** audit or reviewing an **existing** audit*		
Approval	1. Facility Quality Manager	Date:
	2. Tier 2 / Clinical Director / General Manager	Date:

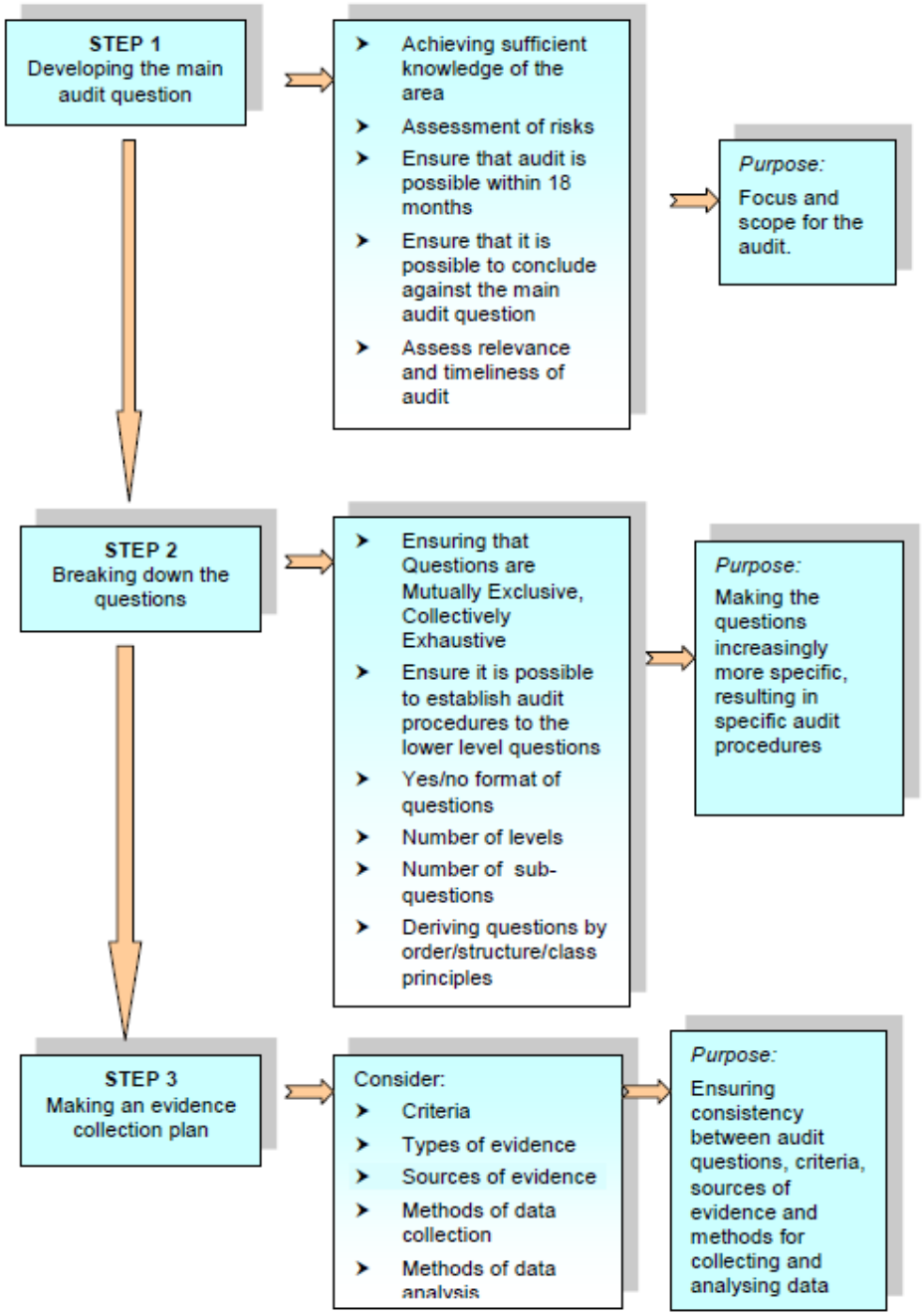
PART C *For use by the SLHD QARS Committee*	
Date Reviewed by QARS Committee	
Recommendation	☐ **SLHD wide audit required - Refer to Lead Author.** ☐ **Facility level audit required – Refer to Lead Author.** ☐ **No audit required.**
Allocated to	
Supporting comments	

Appendix 3: Example of How to Develop Audit Questions

Sufficient knowledge of the area and an initial set of topics to start the process of developing the audit questions, will typically be arrived at through activities such as desk research, meetings with auditees, brainstorming and/or more structured creative thinking.

3-step process — The process can be conducted in three steps, which is explained in the following 3 sections: Step 1: Developing the main audit question; Step 2: Breaking down the questions; and Step 3: Making the evidence collection plan. Below is a brief overview over this process.

Overview over the process



Adopted from: European Court of Auditors, Audit objectives Guidelines, October 2013