

# Consumer and community participation self-assessment project Acute Services 2002–03

## Summary

April 2004

Centre for Clinical Effectiveness

Monash Institute of Health Services Research  
in collaboration with the Health Issues Centre

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## Centre for Clinical Effectiveness

Monash Medical Centre, 246 Clayton Rd, Clayton Victoria 3168

<http://www.med.monash.edu.au/healthservices/cce>

## Affiliations

Southern Health, Monash Institute of Health Services Research, Monash University

## Executive directors

---

Jeremy Anderson, CCE, MIHSR    Meredith Carter, HIC

---

Tony McBride, HIC    Don Campbell, MIHSR

---

## Project team

---

Wendy Allen    Project manager

---

Dr Charin Naksook, Health Issues Centre    Project and policy officer

---

Ms Gillian Halliday, Health Issues Centre    Project and policy officer

---

## Members of the project reference committee and others who contributed to committee meetings

Jeremy Anderson	Centre for Clinical Effectiveness, MIHSR
Liz Baillie	Bendigo Health
Robyn Batten	Southern Health
Merdith Carter	Health Issues Centre
Lee-Anne Claverino	Peninsula Health
Philip Cornish	Bayside Health
Kay Currie	Centre for Clinical Effectiveness, MIHSR
Marie Ellis	Austin Health
Jon Evans	Western Health
Anne Hastie	Western Health
Lyn Jamieson	Peninsula Health
Jackie Kearney	Department of Human Services
Chris Larsen	Peninsula Health
Tony McBride	Health Issues Centre
Claire Murphy	Southern Health
Anne Oakley	consumer representative
Sue O'Sullivan	Department of Human Services
Christine Petrie	Bayside Health
Mark Petty	Austin Health
Sandy Robinson	National Resource Centre for Consumer Participation in Health

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# Executive summary

## Background

From 2001 all metropolitan health services were required to establish community advisory committees and develop community participation plans. The Department of Human Services recommended that audits of consumer participation be undertaken to inform their development. This project took place from March 2002 to November 2003, and sought to:

- identify current levels of consumer and community participation (primarily in acute services)
- provide baseline data
- identify organisational capacity for change
- Identify factors preventing further development of consumer and community participation in public health services.

## Objectives

The objectives of this project were to:

- assist the conduct of consumer and community participation self-assessments in acute settings (other, non-acute services were also included, where resources permitted)
- evaluate the draft audit tool for hospitals (available from the National Resource Centre for Consumer Participation in Health)
- provide information about consumer participation to the Department of Human Services, all health services and their community advisory committees
- recommend refinements to the tool and self-assessment process, and identify action required for further development of consumer and community participation in public health services.

## Methods

### Participating health services

Five health services participated in this project (in alphabetical order): Austin Health, Bayside Health, Peninsula Health, Southern Health and Western Health. These are de-identified in this document, and referred to as H1, H2, H3, H4 and H5 – not necessarily in order of site visit or the above list.

Respondents included middle managers of units, wards and departments, from a range of clinical and professional disciplines.

## Data collection and analysis

The project collected these data:

- semi-structured interviews – on the organisational context, staff attitudes, perceptions and beliefs (314 responses)
- self-assessment tool data – twelve questions on current and planned consumer participation activities (309 responses, which was a 97 per cent response rate)
- evaluation data on the self-assessment process and tool (307 responses).

Qualitative analysis was conducted on all data – individual, aggregated and comparative, across the five health services.

## Findings

### Attitudes to consumer and community participation

Most respondents (94 per cent) at all five health services indicated that they had an understanding of what was meant by consumer and community participation; that there was a range of processes by which staff could engage with consumers and the community to bring about beneficial outcomes for all stakeholders. These responses indicated very positive support for the philosophical underpinnings of consumer participation, that is, that the public health system should be responsive to and shaped by input from those who use it or might use it. The terminology however, was open to a range of interpretations, in particular, the term ‘consumer’.

### The acute services context

The nature of the work and the type of patient in an acute setting was perceived by more than half of the respondents (54 per cent) to influence the type and amount of consumer participation that could take place. A small number reported that consumer participation was a concept with limited application in their clinical area. Comparisons between acute, sub-acute and chronic settings were made, with the general consensus that there was less time in an acute setting to engage with patients and their carers than in non-acute areas.

### Current consumer participation activities

Collaborative decision making for individual consumers (patients, their families and carers) in acute and sub-acute settings was most likely to occur in family and patient meetings, where care, treatment and discharge options were discussed, needs stated and plans developed.

The most common consumer participation activities in all health services were provision of information to, and seeking information from, consumers. Few respondents evaluated the *effectiveness* of consumer participation.

## Evaluation of the self-assessment tool and process

The process involved staff from a range of disciplines and raised awareness of consumer participation across all health services. Most respondents (93 per cent) perceived the results to be of benefit to their unit or department, and identified ways to improve their current activities.

## Further development of consumer participation

Most respondents indicated that further development of consumer participation activities would be resourced through existing staff roles in the organisation, with some indication that additional time would be required. Only respondents from one health service explicitly stated that substantial additional resources were required to undertake further activities at the organisational level. These included resources for:

- planning and implementation of consumer participation activities
- policy development
- training and education for all stakeholders
- evaluation of current consumer participation activities
- payment for consumers to cover costs of participating
- funding for translations, printing and document production costs.

Additional resources identified by respondents included:

- commitment from Department of Human Services and senior health services management
- staff education and training in consumer participation theory and practice
- dedicated time
- skilled staff
- consumer availability and willingness to participate
- funds.

The full range of resources identified as required for the development of consumer participation are listed in the tables in the Recommendations section below.

## Reporting on consumer participation activities and outcomes

The five health services were at various stages in the development of a systematic organisational approach to consumer and community participation when the survey was undertaken. In their own ways, all were developing strategies to meet the needs of their local communities. All focused mainly on community participation via consultation with their community advisory committees (CACs). Consumer participation was addressed by some through strategies detailed in their community participation plans (CPPs), or through involvement in individual consumers or consumer groups in special projects or programs.

### *Organisational culture*

All health services incorporate aspects of consumer and community participation into their mission, vision and values statements in order to promote this as an integral part of the organisational culture.

### *Policies*

Consumer and community participation policies had yet to be developed in all of the health services – except for one health service, which had included a policy statement in its CPP. It is not known whether the intention was to communicate this policy to all relevant staff across the organisation, or if it was intended only for those who received a copy of the plan.

### *Skill levels*

Designated staff in all health services had the skills necessary to further develop consumer and participation activities, including the CAC support staff, community integration manager, quality personnel and other senior management. Training for other (general clinical) staff across the organisations was not routinely offered, except for areas such as complaints and clinical risk management, multicultural awareness, privacy requirements and using patient satisfaction monitors. Further staff education could be developed and offered on consumer participation theory and practice.

### *Program/clinical division level (ward, unit and department level)*

Two health services implemented their CPPs as an organisation-wide approach. This was achieved by involving program and clinical service unit directors in developing consumer participation strategies for their respective areas.

### *Structures and processes*

All health services were well underway in the development of organisational structures for community participation, including:

- full-time and part-time staff positions to support the CACs
- routine reporting to the community and consumers (for example, through quality of care reports).

Areas for attention included incorporation of consumer participation aspects into position descriptions and performance appraisals. This needs to be linked to acquisition of relevant skills.

# 1 Recommendations

The project team and reference committee jointly developed the following recommendations based on the findings from this project. These recommendations are listed by context, and are prioritised within each category. A summary table of the requirements for consumer participation activities based on the recommendations has also been included for easy reference.

## 1.1 State-level requirements

### **Universities**

If consumer participation is to become part of routine delivery of care and service, clinicians must be educated in theory and practice in the universities. It is recommended that consumer and community participation concepts be incorporated into curriculum development in all health care faculties in Victoria, and delivered as a routine component of health care education and training.

### **Department of Human Services**

#### *Education and training*

There was an identified need for education and training for hospital staff on all aspects of consumer participation as a shorter-term interim measure, and as part of the change management processes. Development of staff training modules (or other forms of professional development) on consumer participation should be funded by the Department of Human Services, because the department can provide a much-needed resource to health services.

Similar responses from all five health services indicated that the benefits from this would be wide ranging. Training should include:

- theories
- background of the 'consumer movement' and 'consumer and community participation'
- evidence
- practical ways to engage with consumers and the community in various settings.

Health service respondents indicated they would like staff skilled with knowledge and expertise in consumer participation. Funding should be made available for a range of roles to act as facilitators in further developing the skills of hospital staff. This could include funds for project workers and representatives from community advocacy groups and peak bodies to deliver training and in-services for hospital staff.

### *Consumers' views*

This self-assessment tool and process did not provide a means to assess the *effectiveness* of consumer participation activities. As with any other aspect of care and service delivery, effectiveness can only be determined if three factors are taken into account and incorporated into proposed changes. Consumer participation activities should meet these criteria:

1. best available evidence to support change in practice
2. clinicians' experience and knowledge
3. patient preferences.

This project only provided health services' views. To augment the small amount conducted to date, funding for further research is required on the extent of, and ways in which consumers and the community in Australia want to participate in health services. <sup>1</sup>

### *Defining consumers*

A substantial proportion of the respondents (43 per cent) regarded *anyone* who used their services as being their consumer, including other health care staff (internal and external to the health service) and suppliers. The Department of Human Services could assist health services by providing a clear definition of who actually was regarded as the 'consumer' of health services.

Adopting the term now used in EQuIP, 'consumer/patient' could help focus the definition on the patient as consumer. The terms 'carer' and 'community' require further clarification, so that standard definitions can be developed and promoted among health care staff in hospitals. The department should engage with representatives from all health services and the general public for further discussion on the type of language used in this field. Using one generic term (for example, 'consumer') might not be appropriate, and different contexts could require different terminology. <sup>2</sup>

### *Re-assessment of tools*

The purpose of the self-assessment tool should be reassessed. A clear message from the data was that for some, this process duplicated annual quality reporting processes such as EQuIP. Respondents wanted to see a condensation of all quality assurance activities, consistent formats and reduction of processes undertaken.

The tool was said to be useful for conducting an initial organisational stocktake of consumer participation activities. Beyond this initial step, incorporation of the self-assessment tool and process into an existing quality process, namely EQuIP, should be given further consideration. This would require negotiation by Department of Human Services with the Australian Council for Health Care Standards (ACHS). A consumer participation resource tool could be developed similar to the existing EQuIP resource tool for community services.

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<sup>1</sup> For example Johnson, A. and Bament, D., 2002 Improving the quality of hospital services: how diverse groups of consumers prefer to be involved, *Australian Health Review* 25(6): 194-205

<sup>2</sup> For example terms used in acute settings, to denote the person in the bed may differ from chronic or sub-acute settings and so on.

## 1.2 Health service-level requirements

### Commitment

Respondents from all health services indicated strong 'willingness to change', as detailed in the sections 'Perceived benefits of self-assessment' (Part B) and 'Usefulness of these results' (Part D). This needs to be encouraged and supported by management through resources to assist services to translate plans into action. This should further develop the capacity of their organisations to engage in a meaningful way with consumers.

Staff willingness to change was also accompanied by a desire to improve the quality of services and care delivered to consumers. Many respondents described ways that improvements could occur at their local level – if they were given the necessary support. Practical support from health service boards and management is required to enable further systematic development of effective consumer participation methods and activities.

Respondents also had multiple interpretations of the term 'community', such as connotations of community service providers, rather than the general public. Each health service needs to make more explicit who they viewed as their communities (in the context of 'community participation') and promote this to staff. Hospitals could benefit by further developing links with peak consumer and advocacy bodies in the community, for example, through working collaboratively in special projects or joint committees.

### Human resources development

Information and training sessions and materials should be made available to health service staff from all disciplines (medical, nursing and allied health) on relevant theory and research methods used in consumer participation, including, for example:

- focus groups
- facilitating skills
- survey design and analysis
- evaluation methods
- program planning
- community development.

Such training could be delivered to designated staff, such as those in units or departments holding quality portfolios.

Designated support personnel in the health service are also needed to provide further advice and support to staff on an individual basis, for example:

- a consumer and community participation liaison officer
- a community development officer
- staff with a quality portfolio.

Elements of consumer participation could be incorporated into staff position descriptions according to the degree and type of consumer contact they have.

## Supporting structures, policies and procedures

Many respondents spoke of the need to formalise their current consumer participation activities. Standardised methods for capturing information could be developed at an organisational level to help develop comprehensive information systems on consumer and community preferences. These efforts could also be coordinated at the clinical program level. Within programs, information flows could be mapped in order to identify areas that combined to provide the overall hospital experience for the patient, and these areas could coordinate their consumer participation efforts. One example is the path followed by elective surgery patients, which could cover several of these areas:

- preadmission
- day surgery
- operating theatre
- surgery
- anaesthesia
- recovery
- wards
- discharge lounge.

Evaluation and feedback processes could be developed, with the aim of capturing the overall experience for the consumer, rather than each individual unit covering their discrete area.

Communication of existing policy needs improvement, as do structures and processes in organisations, in order to provide department, unit and ward staff with guidance and a frame of reference. This might include organisation of a dissemination plan to inform staff of the existence of consumer and community participation plans and any relevant committees, such as CACs, cultural diversity committees and community consultative committees.

A consumer and community participation section on each health service's intranet could be developed (or enhanced). The dissemination plan could be placed in this section of the network and all relevant staff notified of its location. As some staff might not regularly access the computer network, management should consider alternative methods of communication, for example, presenting information sessions on consumer participation at general staff forums, articles in staff publications or posters in accessible places.

An organisational consumer participation framework, guidelines or toolkit could be developed and made available on the intranet and in print. A unit or working group could be established to undertake periodic review and update in both formats. The printed information should be distributed to all departments and staff libraries. A toolkit might contain:

- the resource guide: improving health services through consumer participation
- the checklist on consumer and community participation activities (based on the resource guide, which presents a condensed view)
- examples of what was happening in the health service in consumer and community participation (for example, findings from this project and other relevant projects)

- case studies of successful consumer participation activities, including contact details for further discussion or mentoring sessions
- details of the health service protocol for involving patients or other consumers in a consumer participation activity (for example, whether staff have to seek ethics committee approval, relevant informed consent and privacy policy information)
- information on available professional development programs in consumer participation, both internally and externally (if possible, an email alert system could be developed to notify staff when relevant programs would run)
- details of consumers available to take part in focus groups or other activities
- contact details of organisations with a consumer participation focus (for example, the National Resource Centre for Consumer Participation in Health and the Health Issues Centre).

## Evaluation standards and protocols

Health service management should help units and departments to develop routine methods for reporting on their consumer participation activities, for example, through quality planning or in annual quality of care reports.

Activities that evaluate consumer and community participation (such as undertaking self-assessments and the future of the tool, or a modified version) should be incorporated into regular ward, department or divisional review processes.

## 1.3 Recommendations for modification and improvement of the self-assessment tool

Until the concepts from this tool are incorporated into other existing quality reporting, these recommendations aim to improve the self-assessment tool's effectiveness, processes and outcomes.

All respondents expressed the need to give the project team additional information and documentation in order to make sense of the responses given in the tools. The usefulness of this tool for this was not as apparent as it might be for units or department levels.

Respondents from two health services did not complete the 'improvements' columns to the extent that the other health services did. One group indicated that they were relative novices in this field, and that much of their planned activity was yet to be fully implemented. They expressed the need for time to monitor and assess the impact of this first, before they could suggest further improvements. Another group did not believe that undertaking this exercise was of significant benefit to the organisation at that time, because they believed that consumer and community participation was well underway across the health service. They said that using this exercise as a method of documenting baseline information was duplicating work conducted in the previous year. They were more interested in determining the *effectiveness* of their consumer participation activities, however this tool does not cover this area.

This self-assessment tool did not properly or adequately capture particular areas in all health services, including:

### *Special research projects*

All health services conducted specially funded projects that were developed and coordinated at an organisational, rather than at a unit or department level. For example, one health service’s clinical support systems colo-rectal project and patient education materials project (PEP) were two successful projects that incorporated a substantial consumer participation component, however, neither was documented in the organisational-level tool.

### *Public relations, philanthropy and fundraising*

Public relations staff expressed difficulties making questions in a ward-level tool relevant to their work. This area should be included as part of the organisational-level self-assessments, as these units engage with the community and individuals at an organisational level.

### *Consumers on research and ethics committees*

Specific questions could be developed for the organisational level tool, which ask about the level and type of involvement.

## 1.4 Summary of recommendations for improving the self-assessment tool

**Table 1 Suggested enhancements to the self-assessment tool**

Further refinement of the core concepts	For example, the questions on ‘allocation of resources’ and ‘organisational consumer policies’.
Improved terminology	<ul style="list-style-type: none"> <li>▪ brevity and clarity of terms</li> <li>▪ clarification of terms</li> <li>▪ development of shared meanings</li> <li>▪ use of plain English examples.</li> </ul>
Piloting the revision	<ul style="list-style-type: none"> <li>▪ with health service staff who have never used the tool before.</li> </ul>
Baseline information	<ul style="list-style-type: none"> <li>▪ to accompany any self-rating scales included in the tool.</li> </ul>
Layout and design	<ul style="list-style-type: none"> <li>▪ staff indicated preferences for a portrait format, or a table in landscape format (the portrait format better approximates the most recent version of the EQulP workbook; the table/landscape layout is based on a superseded version of EQulP)</li> <li>▪ increased space for writing responses (however, it would look longer)</li> <li>▪ options for staff to complete the tool in hard copy or electronically</li> <li>▪ encouragement to use an electronic version, as this can be customised to suit.</li> </ul>

### Terminology

The adoption of common terminology is particularly important. Inconsistent language use can create problems for staff with different professional or academic backgrounds. Terms can be interpreted differently by staff with different backgrounds. Use of the term ‘consumer/patient’ in future revisions of the tool would make it consistent with current EQulP terminology.

## Improvements suggested

Respondents suggested how they might alter the tool or process of self-assessment if they repeated this exercise in the future, including:

- allowing more time to do it
- making questions more specific to individual areas (for example, by having a 'ward-only' tool)
- addressing specific areas identified in the tool, or using one section at a time
- incorporating corresponding educational components and training for staff
- including elements about staff roles and responsibilities
- focusing on how to implement changes based on feedback
- making the wording more simple
- removing the resource column
- condensing the whole tool
- keeping the format and adjusting the questions
- using the same questions, but workshopping them differently.

## Problems identified with the tool

Just under one-third of all respondents (32 per cent) said that they would *not* use the tool again in the future. A typical response was that they had already had a similar process in place for business or quality planning, and this tool was not relevant; or that they had done as much as they could in the available resources. About fifteen per cent of one health service's respondents, and several at other health services, indicated that this process duplicated the work they already did for EQuIP.

Other reasons for not using the self-assessment tool again included that:

- it was a time-consuming process
- respondents did not see the benefit of the process in general
- it was of no relevance to their unit
- lack of adequate support.

Other problems included:

- the perceived irrelevance of some questions to the area of service
- the time required for completing the tool.

Positive effects of the self-assessment tool could be enhanced by:

- being more concise
- using plain English and avoiding ambiguity

- making the questions more focused
- reducing repetitiveness between questions
- providing more explanation and examples
- keeping the design and format simple
- allowing more time to complete the process.

## 1.5 Recommendations for improvements to individual questions at departmental/unit level

### ***Question 1: Are organisational consumer policies reinforced as part of department/ward management processes?***

This question was taken from the original draft audit tool, without changes. The answers received indicated that it met a very broad interpretation. It might have been less confusing if the question asked about 'network-wide consumer participation policies', if this was the intended focus. The question might not have been relevant to management at this level, unless organisational-level consumer participation policies actually existed.

### ***Question 2: Has the department/ward identified who their consumers are***

Having Question 2 as a separate question in the tool did not result in information beyond listings of who used their services. Future revisions of the tool might excise this question.

### ***Question 3: Has the department/ward identified the purpose, and mechanisms for involving consumers in planning and decision-making?***

This question could have caused confusion, because it seemed to ask for two different answers. Less than half the sample provided an answer to both parts. Compared with the findings from Question 1 of the semi-structured interviews (Part B), more comprehensive answers were given in the interview format than were documented in the self-assessment tool. This was particularly apparent in the responses to the question on the 'purpose' of consumer participation; these were the 'outcomes' responses in Section 3.4.

This question should be worded much more simply. There could be two separate questions, similar to those asked in Part B: 'What do you understand is meant by "consumer and community participation"?' and 'Do you currently do any consumer and community participation activities in your area?'

Some respondents indicated that they thought that the terms 'purpose and mechanisms' referred to something very specific, rather than merely asking them why they thought consumer participation should take place and how they went about it.

### ***Question 4: Does the department/ward have a community participation plan in place? How will the effectiveness of this plan be evaluated?***

It became clear to the project team that the wording and capitalisation in Question 4 was inappropriate. The question was modified for this tool revision because the one it was based on in the draft audit tool was thought to repeat Question 3. The term 'community participation plan' (CPP) was included in this tool revision after discussions with the project

reference committee. It was suggested that the term be consistent with the CPPs developed by health services in conjunction with their CACs.

The responses provided very little new information in addition to those in Question 3. It is recommended that this question be dropped from future revisions to the tool.

***Question 5: Are there strategies to involve consumers in decision-making about care processes, and service improvement at the department/ward level?***

This question asked for two separate answers, and was not answered comprehensively by the majority of respondents. It could be worded much more simply, but as it duplicated Question 3, it might be deleted.

***Question 6: Are resources allocated at a departmental/ward level for enabling consumer feedback and participation in decision-making?***

Some respondents said they had difficulty interpreting this question, in particular, knowing what resources were being referred to. Some questioned whether it meant time and staff, or if it was asking about specific funds available. Due to different interpretations of the question, some said they did not have the resources to do this work, or that it was part of their normal roles, while others said that they did have resources to do this work, and listed staff roles and routine processes used in the ward or department. This illustrated that staff have different perceptions of the same things.

This question provided little new information beyond that which was given in Question 2.3 and Question 2.5. Several respondents said to refer back to 2.3, 2.4 and 2.5 when answering this question, and added no further information.

***Question 7: Have consumers participated in the development and evaluation of care pathways and consumer education/information resources?***

This question was included from the original draft audit tool with no modification. As noted earlier, this was a poorly designed question, being in two parts. It was not clear why these consumer participation activities were singled out as a separate question in the original tool. In addition, the term 'care pathways' should not have been used, as it is a proprietary name. Little new information was gained from responses to this question, and it is recommended that it be deleted from further revisions to the tool.

***Question 8: Does the performance review of staff consider attitude towards, and achievements in, consumer participation in care processes and service improvement?***

Performance reviews were not standard management practice in all areas surveyed, nor did all respondents manage staff. This question might not be relevant at this level, at this stage. It could be left out of further revisions to the tool until training interventions are commonplace in all health services.

***Question 9: Are staff supported to attend staff development programs about consumer participation, and consumer policy issues?***

Many respondents did not answer the question completely, or might have preferred to give some answer, rather than none. This question might have been expressed better, and be reworded in future revisions. In addition, this question can only return meaningful data once professional development is widely available.

It appeared that most respondents understood this question as only asking whether they had links with other areas in the health service. However, the intention was to ask whether they had processes for gauging consumer satisfaction with continuity of care. Only one-quarter of the respondents listed ways that consumers were able to provide, or had provided, feedback on continuity of care.

***Question 10: Are links and feedback mechanisms in place with other departments/wards to ensure consumer satisfaction with continuity of care?***

This was a long question. Three-quarters of the respondents appeared not to comprehend its intent. The question requires rewording, and a clearer and more explicit focus on consumer satisfaction with continuity of care.

***Question 11: Does the department/ward have effective working relationships with key services and support/community groups associated with the consumer profile of their department/ward? Are staff aware of the key consumer issues for these groups, and do they have processes in place to jointly address these issues?***

The majority of respondents only answered the first part of this three-part question. The two sections on 'issues' and 'processes to address issues' should be dropped from further revisions to the tool.

The question needs to be worded more simply, and needs to be made distinct from the previous one. It needs to be explicit in asking about relations with community-based services and groups.

***Question 12: Does the department/ward report on their consumer participation activities and outcomes?***

This question could be left as it is, or alternatively, all reporting of consumer and community participation could be incorporated into the EQUIP process, which means that a separate tool and process is needed. The substantial additional information on their services and consumer participation activities responses could have been contained in the twelve questions, but it appears that respondents had difficulty knowing what information to provide in answer to which question.

## 1.6 Requirements for further development of consumer participation

Table 2 Summary of requirements for further development of consumer participation

Institution	Action	Identified key stakeholders
Tertiary education	Incorporation and delivery of consumer and community participation concepts into curriculum development and health care education and training in all health care faculties in Victoria.	Collaboration of key stakeholders, including universities, governments professional colleges and associations, health services, and peak consumer organisations.
Department of Human Services	Education and training: <ul style="list-style-type: none"> <li>education and training for hospital staff regarding all aspects of consumer participation</li> <li>funding for professional development in consumer participation.</li> </ul>	The Department of Human Services presently funds the Health Issues Centre to conduct training of staff within health services.  Health services and their staff need to prioritise within professional development plans.
	Consumers' views: <ul style="list-style-type: none"> <li>funding for projects to assess how consumers and the community want and are able to participate in health services.</li> </ul>	Department of Human Services, health services and peak consumer organisations.
	Shared identification of consumers: <ul style="list-style-type: none"> <li>definition of who is the 'consumer' of health services</li> <li>terminology to be consistent with ACHS term 'consumer/patient'.</li> </ul>	Department of Human Services to work in collaboration with peak consumer organisations and health services staff and consumers.
	Re-assessment of tool: <ul style="list-style-type: none"> <li>consistent formats</li> <li>streamlining of processes</li> <li>possible incorporation of the self-assessment tool and process into an existing quality processes (ACHS).</li> </ul>	Collaboration of all stakeholders, including ACHS.
Health service level	Developing commitment: <ul style="list-style-type: none"> <li>encouragement and support by management, through resources to help translate plans into action</li> <li>practical support from health service boards and management</li> <li>explicit identification by each health service of who they view as their communities (in the context of 'community participation')</li> <li>support for improvements at a local level</li> <li>links with peak and advocacy bodies in the community.</li> </ul>	Health services management, boards, CACs and peak consumer and advocacy organisations in health.
	Human resources development: <ul style="list-style-type: none"> <li>information and training sessions and materials should be developed for health service staff from all disciplines</li> <li>designated support personnel</li> <li>incorporation of elements of consumer</li> </ul>	Health services human resources managers and other management personnel, in consultation with CACs and consumer participation experts — internally and externally.

Institution	Action	Identified key stakeholders
	participation into staff position descriptions.	
Development and implementation	<p>Supporting structures, policies and procedures:</p> <ul style="list-style-type: none"> <li>▪ formalised current consumer participation activities</li> <li>▪ standardised methods for capturing information</li> <li>▪ evaluation and feedback processes</li> <li>▪ improvement in communication of existing policy structures and processes</li> <li>▪ development (or enhancement of) a consumer and community participation section on health services' intranets</li> <li>▪ information sessions on consumer participation at general staff forums, articles in staff publications or posters in accessible places</li> <li>▪ development of an organisational consumer participation framework, guidelines or 'toolkit', on the intranet and in print.</li> </ul>	<p>The Department of Human Services, health services, the community and CACs need to work together to develop and share their resources, reduce duplication and promote collaboration.</p>
Evaluation	<p>Evaluation of the effectiveness of consumer participation activities:</p> <ul style="list-style-type: none"> <li>▪ assistance from health service management to help units and departments develop routine methods for reporting on their consumer participation activities</li> <li>▪ development of activities evaluating consumer and community participation</li> <li>▪ incorporation of these activities into regular ward, department or divisional review processes.</li> </ul>	<p>Development and implementation of evaluation of the effectiveness of consumer and community participation.</p> <p>Health service management, NRCCPH and CAC, with the support of the Department of Human Services.</p>



Appendix 1 Audit tool parts 1 and 2

**CONSUMER & COMMUNITY  
PARTICIPATION  
SELF ASSESSMENT PROJECT:  
ACUTE SERVICES 2002-2003**

**SELF ASSESSMENT TOOL  
Part One: Organisational Level**



## **Consumer and Community Participation Self-Assessment Project: Acute Services 2002-2003**

### **Background and Definitions<sup>3</sup>**

Community and consumer feedback and participation is increasingly regarded as an important component in decision-making for health service managers and providers. There are various methods and models that can be used to involve the community and consumers. There is no one right way of enabling the community or consumers to participate. It is important that a hospital clearly identifies whom their community and consumers are, and what the purpose and mechanisms are for involving them. It is also important that community and consumer participation is part of an overall organisational strategy, and is seen as part of care processes between providers and consumers.

**Consumer:** Users or potential users of a health service, including their families, friends and carers.

**Community:** Refers to a group of people in a geographical location (locality of the health service/ hospital and/or catchment area) or who have characteristics in common (eg culturally determined, a disease-oriented group, or an interest group etc.).

**Participation:** The processes of involving consumers and community members in decision-making about their health care, health service planning, policy development, setting priorities and quality issues in health service delivery. The degree of participation can range from low degrees (e.g. information giving and information seeking) to higher degrees (e.g. consultation and partnership). For some examples of consumer and community participation, see the Checklist.

**Purpose of the Self Assessment Tool<sup>4</sup>:** The Self Assessment Tool is designed to assess the level of organisational commitment to consumer participation principles and to document policies, processes and activities currently in use in health services and hospitals. The Self Assessment Tool does not measure the effectiveness of these activities which needs to be done as a separate process. The Self Assessment Tool can be used by organisations to determine:

1. The level of organisational management commitment to community and consumer participation;
2. The range of activities being implemented at organisational and departmental/ward levels; and
3. Where to go next and the resources required.

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<sup>3</sup> Based on definitions used in *Improving health services through consumer participation: A resource guide for organisations*, Consumer Focus Collaboration, 2000, Dept Health, Flinders University, SA Community Health Research Unit

<sup>4</sup> This tool has been modified from the National Resource Centre for Consumer Participation in Health's *Draft Community and Consumer Participation Audit Tool for Hospitals*

## How to Use the Self-Assessment Tool

How you use this Self Assessment Tool will depend on how your hospital or department is structured and the resources you have available. The following list presents some examples of how you might use the Tool to gather the information you need.

- Planning workshop for managers
- Round table discussion involving all staff
- Agenda item at staff unit meeting
- Suggestion box in a shared staff area
- White-boarding activity in a shared staff area
- Set up a Self Assessment Committee or team with a range of staff to collect all data
- Other methods may suit your department

However you choose to use the Self Assessment Tool, it is important that you determine beforehand why you are undertaking the self assessment and how you want to use the results. It is equally important that you clearly describe and justify your method.

## Rating the Activity

This is a self-rating scale and has been adapted for this Project from the EQuIP format.

LA	Little achievement	EA	Extensive achievement
SA	Some achievement	OA	Outstanding achievement
MA	Moderate achievement	N/A	Not applicable

## What to do with the Information

For the purposes of this project, the Project Team will collate and analyse the data. Once the information is gathered from the organisational and department/ward self assessments, it will be analysed and then reported to senior management, staff and consumer groups who have been involved in the self assessment to enable them to determine where the organisation is positioned with regard to its commitment to, and activity in, community and consumer participation. The results can be used to identify the organisation's strengths, as well as any gaps and limitations. The organisation will then be able to assign priority to where the management efforts need to be directed if it chooses to develop an organisational approach to community and consumer participation.

**PART ONE: ORGANISATIONAL LEVEL**

No.	Criteria	If Yes, what you have/do currently	Self Rating	What could you do or improve? Action Required and expected Outcomes	Resources required (eg staff roles, timelines, finance etc)
1.1	<p>Has community and/or consumer participation been incorporated into the organisation's:</p> <ul style="list-style-type: none"> <li>• Vision &amp; Mission</li> <li>• Values</li> </ul>				
1.2	<p>Has the organisation clearly identified who their:</p> <ul style="list-style-type: none"> <li>• Community, and</li> <li>• Consumers are?</li> </ul>				

1.3

Has the organisation clearly identified the:

- Purpose, and
- Mechanisms

for involving community members and consumers in decision-making at different levels?

No.	Criteria	If Yes, what you have/do currently	Self Rating	What could you do or improve? Action Required and expected Outcomes	Resources Required (eg staff roles, timelines, finance etc)
1.4	Do the Strategic directions and plans of the organisation reflect <u>identified</u> consumer needs?				
1.5	Does the organisation have a Community Participation Plan in place?  How will effectiveness of this Plan be evaluated?				

1.6

Does the organisation have key consumer policies in place, such as:

- ◆ Consumer rights and responsibilities
- ◆ Complaints
- ◆ Consumer access to information
- ◆ Consumer participation?

No.	Criteria	If Yes, what you have/do currently	Self Rating	What could you do or improve? Action Required and expected Outcomes	Resources Required (eg staff roles, timelines, finance etc)
1.7	Are staff education programs in place to support the implementation and maintenance of these consumer participation policies?				

<p><b>1.8</b></p>	<p>How do consumers find out about:</p> <ul style="list-style-type: none"> <li>◆ Their rights and responsibilities</li> <li>◆ How to make a complaint or commendation</li> <li>◆ Accessing information</li> <li>◆ Information about how they are able to participate in the organisation?</li> </ul> <p>Are these processes monitored and evaluated?</p>				
<p><b>1.9</b></p>	<p>Have training and education programs been provided to enable consumers and community members to participate effectively?</p>				

No.	Criteria	If Yes, what you have/do currently	Self Rating	What could you do or improve? Action Required and expected Outcomes	Resources Required (eg staff roles, timelines, finance etc)
1.10	<p>Are there leaders, champions, or staff delegated with the responsibility for consumer participation?</p> <p>Are they easily identifiable within the organisation? How?</p>				
1.11	<p>Have organisational resources been allocated to support the incorporation of community and consumer views into strategic and service planning and review?</p>				

1.12

Are consumer participation principles incorporated into job and position specifications?

Are these principles part of staff performance appraisal and staff recognition processes?

No.	Criteria	If Yes, what you have/do currently	Self Rating	What could you do or improve? Action Required and expected Outcomes	Resources required (eg staff roles, timelines, finance etc)
1.13	Does the organisation recognise the contribution/s made by consumers?				
1.14	Does the organisation report on their consumer participation activities and outcomes?				

Further Comments:

**CONSUMER & COMMUNITY  
PARTICIPATION  
SELF ASSESSMENT PROJECT:  
ACUTE SERVICES 2002-2003**

**SELF ASSESSMENT TOOL**  
Part Two: Department/Unit/Ward Level



## Consumer and Community Participation Self Assessment Project: Acute Services 2002-2003

### Background and Definitions<sup>5</sup>

Community and consumer feedback and participation is increasingly regarded as an important component in decision-making for health service managers and providers. There are various methods and models that can be used to involve the community and consumers. There is no one right way of enabling the community or consumers to participate. It is important that a hospital clearly identifies whom their community and consumers are, and what the purpose and mechanisms are for involving them. It is also important that community and consumer participation is part of an overall organisational strategy, and is seen as part of care processes between providers and consumers.

**Consumer:** Users or potential users of a health service, including their families, friends and carers.

**Community:** Refers to a group of people in a geographical location (locality of the health service/ hospital and/or catchment area) or who have characteristics in common (eg culturally determined, a disease-oriented group, or an interest group etc.).

**Participation:** The processes of involving consumers and community members in decision-making about their health care, health service planning, policy development, setting priorities and quality issues in health service delivery. The degree of participation can range from low degrees (e.g. information giving and information seeking) to higher degrees (e.g. consultation and partnership). For some examples of consumer and community participation, see the Checklist.

**Purpose of the Self Assessment Tool<sup>6</sup>:** The Self Assessment Tool is designed to assess the level of organisational commitment to consumer participation principles and to document policies, processes and activities currently in use in health services and hospitals. The Self Assessment Tool does not measure the effectiveness of these activities which needs to be done as a separate process. The Self Assessment Tool can be used by organisations to determine:

1. The level of organisational management commitment to community and consumer participation;
2. The range of activities being implemented at organisational and departmental/ward levels; and
3. Where to go next and the resources required to implement improvements.

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<sup>5</sup> Based on definitions used in *Improving health services through consumer participation: A resource guide for organisations*, Consumer Focus Collaboration, 2000, Dept Health, Flinders University, SA Community Health Research Unit

<sup>6</sup> This tool has been modified from the National Resource Centre for Consumer Participation in Health's *Draft Community and Consumer Participation Audit Tool for Hospitals*

## How to Use the Self Assessment Tool

How you use this Self Assessment Tool will depend on how your hospital or department is structured and the resources you have available. The following list presents some examples of how you might use the Tool to gather the information you need.

- Planning workshop for managers
- Round table discussion involving all staff
- Agenda item at staff unit meeting
- Suggestion box in a shared staff area
- White-boarding activity in a shared staff area
- Set up a Self Assessment Committee or team with a range of staff to collect all data
- Other methods may suit your department

However you choose to use the Self Assessment Tool, it is important that you determine beforehand why you are undertaking the self assessment and how you want to use the results. It is equally important that you clearly describe and justify your method.

## Rating the Activity

This is a self-rating scale and has been adapted for this Project from the EQUIP format.

LA	Little achievement	EA	Extensive achievement
SA	Some achievement	OA	Outstanding achievement
MA	Moderate achievement	N/A	Not applicable

## What to do with the Information

For the purposes of this project, the Project Team will collate and analyse the data. Once the information is gathered from the organisational and department/ward self assessments, it will be analysed and then reported to senior management, staff and consumer groups who have been involved in the self assessment to enable them to determine where the organisation is positioned with regard to its commitment to, and activity in, community and consumer participation. The results can be used to identify the organisation's strengths, as well as any gaps and limitations. The organisation will then be able to assign priority to where the management efforts need to be directed if it chooses to develop an organisational approach to community and consumer participation.

**PART TWO: DEPARTMENT/WARD LEVEL**

No.	Criteria	If Yes, please list what you have/do currently.	Self Rating	What could you do or improve? Action Required and expected Outcomes	Resources required (eg staff roles, timelines, finance etc)
2.1	Are organisational consumer policies reinforced as part of department/ward management processes?				
2.2	Has the department/ward identified who their consumers are?				

**2.3**

Has the department/ward identified the:

- Purpose, and
- Mechanisms

for involving consumers in planning and decision-making?

No.	Criteria	If Yes, please list what you have/do currently.	Self Rating	What could you do or improve? Action Required and expected Outcomes	Resources required (eg staff roles, timelines, finance etc)
2.4	<p>Does the department/ward have a Community Participation Plan in place?</p> <p>How will the effectiveness of this plan be evaluated?</p>				
2.5	<p>Are there strategies to involve consumers in decision-making about:</p> <ul style="list-style-type: none"> <li>• Care processes, and</li> <li>• Service improvement</li> </ul> <p>at the department/ward level?</p>				

2.6

Are resources allocated at a departmental/ward level for enabling consumer feedback and participation in decision-making?

No	Criteria	If Yes, please list what you have/do currently.	Self rating	What could you do or improve? Action Required and expected Outcomes	Resources required (eg staff roles, timelines, finance etc)
2.7	Have consumers participated in the development and evaluation of Care Pathways and consumer education/information resources?				
2.8	Does the performance review of staff consider attitude towards, and achievements in, consumer participation in care processes and service improvement?				
2.9	<p>Are staff supported to attend staff development programs about:</p> <ul style="list-style-type: none"> <li>• Consumer participation, and</li> <li>• Consumer policy issues?</li> </ul>				

2.10	Are links and feedback mechanisms in place with other departments/wards to ensure consumer satisfaction with continuity of care?				
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No.	Criteria	If Yes, please list what you have/do currently.	Self Rating	What could you do or improve? Action Required and expected Outcomes	Resources required (eg staff roles, timelines, finance etc)
2.11	<p>Does the department/ward have effective working relationships with key services and support/community groups associated with the consumer profile of their department/ward?</p> <p>Are staff aware of the key consumer issues for these groups, and do they have processes in place to jointly address these issues?</p>				
2.12	Does the department/ward report on their consumer participation activities and outcomes?				

**Further Comments:**

## Appendix 2 Background to the project

This Project is a quality assurance programme, funded by the Department of Human Services (DHS), Effectiveness Unit, with the primary purpose of facilitating the conduct of self assessment of consumer and community participation activities in Acute Services across five metropolitan Health Services. Collaboration has been formed between the participating Health Services: Austin & Repatriation Medical Centre, Bayside Health, Peninsula Health, Southern Health and Western Health and the Research Team which is composed of staff from the Health Issues Centre (HIC) and the Centre for Clinical Effectiveness (CCE) from the Monash Institute of Health Services Research (MIHSR).

This Project arises from our appreciation of two issues:

Strong feedback from participants at the dissemination seminars for ***Well-Written Health Information***, our DHS-funded project on evidence-based consumer health information, that consumers need both ***clinical*** and ***service*** information.

The mandatory requirements outlined in DHS's ***Community Advisory Committee Guidelines*** to monitor consumer and community participation in health services and to evaluate the effectiveness of Community Participation Plans. The establishment of the Community Advisory Committees (CACs) is a statutory requirement for Health Services. **The self assessment of consumer and community participation activities is a non-statutory requirement of Community Advisory Committees and is a key initial step in developing a strategic Community Participation Plan.**

The ***Draft Community and Consumer Participation Audit Tool for Hospitals***, developed by the National Resource Centre for Consumer Participation in Health, a modification of which will be used in this Project, was designed to identify organisational and unit/department capacity for consumer participation, including facilitating factors, barriers and achievements. The Tool also identifies areas for future direction and development.

### **Aims of this Project**

Determine present levels of consumer and community participation within Acute Services through the application of the Self Assessment Tool. Management in Acute Services will assess the current situation in their area.

Evaluate the effectiveness of the Self Assessment Tool and usefulness in establishing baseline data on consumer participation activities.

Identify organisational supports and barriers that influence consumer participation

Provide useful information to each Health Service and their Community Advisory Committees and to the Department of Human Services

Facilitate information-sharing across health services, acknowledging that consumer participation is part of an emergent systematic process that has broad-ranging organisational and consumer benefits.

### **Executive Sponsorship**

The Chief Executive Officer (CEO) at each Health Service has provided executive sponsorship to this Project. Each CEO has nominated specific health service staff at each site to collaborate with Project staff while on-site.

### **Project Methodology**

A Reference Committee including representatives of all participating Health Services and consumer representation has been established to oversee and monitor progress and scope of the Project.

The Project Team will assist all Acute Services managers in conducting self assessments of consumer participation activities. The Team will spend, on average, 8 weeks at each site during which time they will collate and commence analysis of the data from the self assessments and provide preliminary reporting and feedback.

Initial stages at each site will incorporate, where possible, information sessions for staff followed by semi-structured interviews with all Unit Managers and Department Heads in Acute Services. The purpose of the initial interview is to discuss application of the Self Assessment Tool within the individual context of each unit and how this can be best conducted. Interviews should take approximately 30 minutes.

The Project Team will give presentations on the Project to all the Community Advisory Committees.

The senior-level organisational component of the self assessment can be conducted as a planning workshop under the facilitation of the Project Team, if required. This level of the self assessment should include all Health Service executive staff and senior Acute Services managers.

Managers at unit/department/ward level will be encouraged to include the views of all their staff when conducting the self assessment. A range of methods can be used to collect the necessary information.

It is anticipated that working on the self assessment process with a combination of internal and external staff will promote ownership and independence which will help to address potential barriers, use staff time effectively and provide data which is useful to the Health Service and their Community Advisory Committee.

Project staff will conduct an evaluation survey on the effectiveness of the Self Assessment Tool which will be administered to each manager when the completed Tool is collected. It should take approximately 15-20 minutes to complete the questions.

An interim report documenting the processes involved and findings from the baseline self assessment will be provided to each Health Service and to DHS. Final data analysis and reporting will be done on completion of all on-site activity in the second part of 2003.

## **Definitions**<sup>7</sup>

**Consumers:** Users/potential users of a health service and their friends, family and carers.

**Community:** A group in a geographical location (e.g. hospital locality and/or catchment area) or a group who share common characteristics (e.g. culturally determined, disease-focused, interest group).

**Participation:** The processes of involving health consumers and communities in decision-making about their own healthcare, health service delivery, policy development, setting priorities and quality issues in the delivery of health services. The degree of participation can range from lower (e.g. information giving and seeking) to higher degrees (e.g. consultation, partnership).

## **Evidence**

While there is considerable evidence of consumer participation in health services, it is often random or has evolved in an ad hoc manner. For example, participation may have involved specific disease groups with strong consumer voices, or been motivated by requirements of accreditation, rather than systematically developed and applied across health services as an essential component of the continuum of care.

Evidence now suggests that increased consumer participation in systems planning and delivery can lead to improvements in the quality, safety and accessibility of health care systems and can improve individual and community health outcomes.

While evidence continues to emerge there are a number of facilitating factors that are known to be essential for development and application of effective consumer participation strategies in health service organisations. These include:

Management commitment to consumer participation principles

Supporting organisational structures, policies and processes

Human resources development

Evaluation standards and protocols

Staff skilled in effective communication and exchange of quality information

Similarly, a number of barriers to consumer participation have been identified in the literature. These include:

The limited capacity of organisations to engage with diverse communities and cultures

Service provider attitudes

Models of care that discriminate or focus on the problem rather than the person

Limited capacity to convert feedback into systems change

These barriers can lead to a circular process that results in reinforcement of beliefs and services which are resistant to change.

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<sup>7</sup> Based on definitions in *Improving health services through consumer participation: A resource guide for organisations*, Consumer Focus Collaboration, 2000, Dept. Health, Flinders University & SA Community Health Research Unit

### **Benefits of Self Assessment**

Conducting self assessment through an audit is a process with many positive aspects for the organisation and their consumers and communities. These benefits include the following:

It is an educational process for healthcare professionals

Staff development takes place

Potential for improvements can be identified

Clinical standards may be set which incorporate consumers' perspectives, knowledge and feedback

Good practice can be identified

An audit cycle may be developed leading to continuous improvement processes

It is unlikely that evidence collected by the Self Assessment Tool will be sufficient, in isolation, to bring about changes in attitudes or capacity, as has been shown in other areas of turning evidence into practice. Research has suggested that at least two other factors need to be considered in order to bring about effective change:

The beliefs and values of the participants, both healthcare professionals and consumers

The social and organisational context in which the implementation occurs.

### **Further information on Consumer and Community Participation:**

The National Resource Centre for Consumer Participation in Health

<http://www.participateinhealth.org.au>

The Health Issues Centre

<http://home.vicnet.net.au/~hissues>

Consumers' Health Forum

<http://www.chf.org.au>

### **Further information on the Consumer and Community Participation Self Assessment Project:**

Wendy Allen, Project Manager,

Centre for Clinical Effectiveness

Email: [wendy.allen@med.monash.edu.au](mailto:wendy.allen@med.monash.edu.au)

Charin Naksook, Research and Policy Officer,

Health Issues Centre

Email: [c.naksook@latrobe.edu.au](mailto:c.naksook@latrobe.edu.au)

## Appendix 3 Methods and strategy checklist for consumer and community participation activities

The following is a list of possible strategies and methods that may be used to promote and enable consumer participation in your organisation. **The list is not exhaustive** and is designed as a prompt/tool to assist you in identifying current and planned processes for improved consumer and community participation within your context.

- **Publications, media releases and displays**  
(Written information on how consumers can participate)
- **Information to consumers about services and treatments**  
(Written/oral information explaining treatment pathways and outcomes)
- **Patient charters**  
(Written patient rights and customer guarantees)
- **Consumer participation policy**
- **Access policies and processes**
- **Planning documents**
- **Seminars and conferences**
- **Public meetings and forums**
- **Consumer advocates/consultants**  
(Organisation employs person to consult with consumers and advocate on their behalf for service improvement)
- **Discussion papers**
- **Strategies for recruiting consumer representatives**  
(Includes clear objectives and processes for finding and selecting consumer representatives)
- **Human resource development for consumer participation**  
(Job design, recruitment, orientation and training to support development of staff skills for developing and maintaining consumer participation)
- **Consumer friendly administrative procedures**  
(Reviewing and reforming administrative communication with consumers)
- **Consumer councils and reference groups**  
(Made up of consumers who advise the organisation. Structure and role prescribed by the organisation. Input to whole of organisation)
- **Consumer representatives on committees**  
(Informing, training and supporting consumer representatives. Clarifying their roles and terms of reference for the committees they sit on)
- **Complaints handling**  
(Response to consumer feedback and complaints. Useful because it assists identification of areas for service improvement)
- **Surveys**  
(e.g. identifying consumer needs)
- **In-depth consumer interviews**  
(Extended, usually semi-structured face-to-face, one-to-one interviews)
- **Focus groups**  
(Semi-structured interview with small groups)
- **Evaluation of services/Feedback forms/Suggestion boxes**
- **Hotlines and phone-ins**

- **Input into needs assessment processes**  
(Cyclical planning process where input maybe requested by the organisation or by use of standing committees with consumer representatives)
- **Workshops**
- **Health promotions and campaigns**
- **Project groups**  
(Instigated by organisations to advise on specific issues or to guide a project)
- **Facilitating mutual support groups**
- **Community development**  
(Support and partnership with consumers about their own issues with a focus on process as well as outcomes)
- **Community control**  
(Community elected board of management)

**Other methods:**

- **Develop your own methods for developing and enhancing consumer participation activities within your context. You need to know who the different group of consumers are that you wish to engage with, what objectives you all want to achieve, and what the best method will be for achieving your objectives.**

## Appendix 4 Semi-structured interview schedule for use with unit/department managers in acute services

Name/Position: \_\_\_\_\_ Dept/Health Service: \_\_\_\_\_ Date: \_\_\_\_\_

What, in your understanding, is meant by 'consumer and community participation' in health services? (What do you call the people who use your services?)

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Do you think your staff members share these views?

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Do you currently have consumer/community participation activities/policies in your department?

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Do you think that Acute Services would do consumer/community participation activities differently to the rest of the organisation? If so, in what ways i.e. what is it about the Acute Services context that necessitates things being done differently?

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Have you done anything like this Self Assessment before? If so, please explain.

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What would you like to get out of doing this Self Assessment? What do you see are the benefits? What types of information would be of most use to you in your role?

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What do you think will be the most effective method of using the Self Assessment Tool within your context?

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What do you think are/would be the most effective forms of consumer/community participation activities within your part of the Acute Services sector? Why?

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Do you foresee any difficulties for your department /unit in doing this Self Assessment?

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# Appendix 5 Evaluation of the self-assessment tool & process<sup>8</sup>

Name<sup>9</sup>/Position: \_\_\_\_\_ Dpt: \_\_\_\_\_ Health  
Service: \_\_\_\_\_ Date: \_\_\_\_\_

How did you go about the self assessment in your area? What process/es did you use for getting the self assessment information? (eg designated staff, formed an audit team, agenda item at staff meeting, and so on)

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What was your overall impression of the Self Assessment Tool as a method of gathering information on, and assessing levels of, consumer/community participation activities in your area?

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Was the Tool easy to use? If you had any difficulties, what were they?

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Did undergoing this self assessment process stimulate staff thinking about consumer/community participation activities and processes?

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<sup>8</sup> Adapted from the National Resource Centre for Consumer Participation in Health's evaluation survey

<sup>9</sup> All responses will be anonymous when reported on

Did you identify any gaps in the questions asked in the Self Assessment Tool? If so, what were they?

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Were there any unnecessary questions in the Self Assessment Tool? If so, which ones?

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Was there any wording of the questions that you thought could be improved? If so, could you specify the question number and suggest alternative wording?

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Was the format, including the rating scale, easy to follow and use? If not, what suggestions would you make to improve it?

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---

Would your hospital/unit/department use the Self Assessment Tool in the future? Would you use any sections differently? If so, please describe?

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Who would be the most likely person(s) to co-ordinate future self assessments and use the Self Assessment Tool? (eg. Quality Manager, Strategic Planner, Unit Managers, Designated Staff etc)

---

---

Would the results of the self assessment be useful to your hospital/unit/department? How would the results be used? Who would be the most likely person(s) to implement change based on the results?

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Has using the Tool and undergoing the self assessment process resulted in any improvements to your current activities in the areas of consumer/community participation?

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Has undergoing this self assessment process identified what the most effective methods of consumer/community participation might be for your area?

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Any other comments on the Self Assessment Tool and/or processes of self-assessment? How much time did you spend completing the Tool (inc. discussion, thinking time, documenting, typing up etc.)

# Appendix 6 Memorandum of understanding

**DRAFT**

## Memorandum of Understanding

Between



**Centre for Clinical Effectiveness**  
**Monash Institute of Health Services Research**

**&**

**Name of Health Service**

**for**

## **Consumer & Community Participation**

### **Self Assessment Project: Acute Services 2002-2003**

**Month 2002/3**

#### **Brief Description of Centre for Clinical Effectiveness, Monash Institute of Health Services Research, Melbourne, Australia.**

The Monash Institute of Health Services Research was established as a joint initiative of Monash University and the Southern Health Metropolitan Health Service in response to the rapidly changing nature of the organisation and delivery of health care in Australia. The increased emphasis of health systems on health promotion, preventive care, accountability and consumer-centred health practices implies a requirement for new types of strategic and applied research initiatives. The Institute addresses these issues by exploring areas such as health intelligence and knowledge management, consumerism, quality and cost of care, and the best ways to organise health systems now and in the future. The Institute is composed of a diverse range of Centres, each a leader in their field, one of which is the Centre for Clinical Effectiveness (CCE).

The Centre for Clinical Effectiveness aims to enhance patient outcomes through the clinical application of evidence-based research. It undertakes teaching and research activities, and answers requests for evidence from the staff of Southern Health.

Brief Description of Health Service:

[Insert]

**Brief Description/Title of the project:**

**The Consumer & Community Participation Self Assessment Project** is a quality assurance programme, funded by the Department of Human Services, with the primary purpose of facilitating the conduct of self assessments of consumer and community participation activities across Acute Services in five metropolitan Health Services. Collaboration has been formed between the participating Health Services (Austin and Repatriation Medical Centre, Bayside Health, Peninsula Health, Southern Health and Western Health), and the Project Team which is composed of staff from the Health Issues Centre (HIC) at LaTrobe University and staff from the Centre for Clinical Effectiveness (CCE) at the Monash Institute of Health Services Research (MIHSR). All participants in the project view this as an opportunity to share information in order to build upon each other's experiences in the emergent processes of developing systematic strategies for consumer participation.

Staff from CCE and HIC will provide advice and consultancy services to Acute Services staff from the Health Services who will conduct assessments of all current and planned consumer participation activities. Acute Services staff will use a modified version of the National Resource Centre for Consumer Participation in Health's (NRCCPH) *Draft Community and Consumer Participation Audit Tool for Hospitals* to gather data. CCE and HIC staff will provide educational briefings on Consumer Participation issues and will analyse and report back on the data to each individual site.

CCE and HIC staff will also conduct an evaluation of the effectiveness of using the Tool towards the end of each site visit.

Description of services to be provided:

	Key Issues	How achieved or measured	Person(s)/ organisation responsible	Expected date of completion dd/mm/yyyy
1.	Support from all relevant unit and department managers and staff	CCE project manager to gain executive sponsorship for project at CEO level.  Health service liaison staff to facilitate introductions to all relevant staff in Acute Services and to provide an overview of organisational structure to CCE/HIC staff	Project manager  Health service Liaison staff	
2.	A realistic assessment that project objectives are achievable by those involved	Objectives clearly stated with timelines, deliverables, persons responsible named. See attached work-plan.	All	
3.	Clear description of the desired change and who will be: <ul style="list-style-type: none"> <li>affected</li> <li>involved</li> </ul>	Identification, documentation and analysis of CP activities. Heightened awareness of CP activities by Acute Services staff and consumers of Health Service.	All staff Health service CAC members	
4.	Clearly defined and realistic outcome measures	Development of clear definitions of terms for self-rating scales so that common understandings exist when using the Self Assessment Tool across all Health Services.  Co-operation and participation of all Acute Services staff at Health Service to ensure comprehensive coverage.  At the start of the project, minor modifications to Tool, where required.  At the conclusion of the project, recommendations for further refinements of Tool for application across all clinical areas on an iterative basis.	CCE and HIC staff  Health Service staff  CCE, HIC and Health Service staff to reach agreement prior to changes made.  CCE and HIC	
5.	Commonly understood expectations on: <ul style="list-style-type: none"> <li>communication strategy</li> <li>meeting times/frequency</li> <li>deliverables</li> <li>content of report(s)</li> <li>format of report(s) &amp; final presentation</li> </ul>		All	

6.	Opportunity for both parties to the agreement to view/approve all documents involving or naming them		All	
7.	Conflicts of interests stated openly and noted.		All	
8.	Opportunity to co-author and co-develop publications. Manuscripts viewed by authors prior to submission. Appropriate citation in presentations and publications.	Consensus	All	
9.	Opportunity for involvement in discussions of study design/ methodology.	Participation in Reference Committee and other meetings.	All	
10.	Provision of work space on-site at <b>Health Service</b>		<b>Health Service liaison staff</b>	

#### Staff Profiles

Wendy Allen, Project Manager

Centre for Clinical Effectiveness

Monash Institute of Health Services Research

Monash Medical Centre, Level 1, E Block

246 Clayton Rd, Clayton VIC 3168

Ph: 9594 7533 Email: [wendy.allen@med.monash.edu.au](mailto:wendy.allen@med.monash.edu.au)

Mobile: 0410 301 946

Charin Naksook, Research Officer

Health Issues Centre Inc.

Level 5, Health Sciences 2,

LATROBE UNIVERSITY VIC 3068

Email: [c.naksook@latrobe.edu.au](mailto:c.naksook@latrobe.edu.au)

Telephone: 9479 5827

Health Service Staff:

[INSERT NAME and CONTACT DETAILS]

#### 1. Dispute Resolution:

Each of the parties shall use its best endeavours to co-operatively resolve a dispute. The collaborative nature of the Project should encourage full and frank discussions in the event of any disagreement occurring. In the unlikely event that an unresolvable dispute should occur, notices in writing must be given by the party claiming dispute and the dispute shall be referred to **The Department of Human Services or an agreed independent arbiter**, for resolution in the first instance.

#### 2. Termination of Agreement:

The **Health Service** and the **Centre for Clinical Effectiveness** may terminate this agreement at any time by giving one month's prior notice in writing.

**3. Non-Disclosure Agreement:**

I/we \_\_\_\_\_  
agree that I/we will not, without prior agreement of all Project Stakeholders, communicate, publish or release information acquired or created by me/us in connection with this work, except to CCE, or for the purpose of the consultants' performance of the work. No organisation or individual will be identified in any external publications.

Signed \_\_\_\_\_

Date \_\_\_\_\_

**9. Additional Information:**

*Project Manager:*

The Project Manager, Wendy Allen, is the lead contact person for this project. She represents the Centre for Clinical Effectiveness and will be available at all reasonable times for consultation regarding this project, and any matter specified in this agreement.

**Signed by** **Health Service Director, [INSERT NAME]**

Signed by Centre for Clinical Effectiveness Monash Institute of Health Services Research Director

## Appendix 7 Database structure

The databases used for collation of the self-assessment data were created in Microsoft Access 2000. This was composed of three relational databases:

1. Audit Tool;
2. Comments;
3. Audit Questions.

Data needs to be entered into the first two databases before entering data into the Audit Questions database. Each of these two databases has been linked by a one-to-many relationship with the Audit Questions database.

The structure of the three databases is as follows:

Table 1: Audit Tool Database

Field Name	Data Type	Description
AuditTool♣	Number	The unique identifier for each Audit Tool
HealthService	Text	The name of the health service
Ward/Unit	Text	Name of ward/unit/department/project
DeptType	Text	Type of ward/unit/department eg. surg, renal, day surgery etc.
Division	Text	Clinical service unit or division where ward/unit/dept is placed within the organisation
ServiceSite	Text	Name of health service campus where ward/unit/department is located
Position	Text	Job role/position of person responsible for completion of audit
Date	Date/Time	Date on which completed audit tool is collected (Formatted to dd/mm/yy)

♣ Primary Key

Table 2: Comments Database

Field Name	Data Type	Description
AuditTool♣	Number	Unique identifier for each Audit Tool
Comments	Memo	Further comments

♣Primary Key

Table 3: Audit Questions Database

Field Name	Data Type	Description
AuditData♣	Number	The unique identifier for each data entry
AuditTool	Number	The unique identifier for each audit tool
QuestionNo	Text	The question number as it appears on the audit tool
CurrentActivities	Memo	What we have/do currently
Strategies	Text	Types of strategies used (0-7)
Rating	Text	Self rating EQUiP score (Formatted to only accept 2 letters and will automatically capitalize these)
Outcomes	Memo	Action required/expected outcomes
Resources	Memo	Resources required

♣Primary Key

Data types and definitions used in these databases are:

**Text:** Text and/or numbers up to 255 characters

**Memo:** Length text and/or number combinations up to 65535 characters

**Number:** Any numeric data that could possibly be used in calculations

**Date/Time:** Date and/or time entry. (Formatted as dd/mm/yy in database)

Other Issues:

Descriptions of how strategy categories (0-7) are applied to the data collected in current activities is provided in the attached strategy checklist. A zero, '0', was entered when no strategies could be identified in the data.

**NR** refers to 'No Response' and was entered wherever data was not provided.

**NA** refers to 'Not Applicable' and was only entered where this was already written by the respondent in the audit tool.

# Appendix 8 Areas included

## Austin Health

### Cancer and Neurosciences

Breast Care Liaison Nurse	Neurology Liaison Nurse	Radiation Oncology
Cancer Support Nurse	Neuropsychology	Recovery
CATs team	Occupational Therapy	Social Work
Day Oncology	Oncology	Volunteers co-ordinator
Epilepsy Liaison Nurse	Palliative Care	
Neurology	Projects	

### Cardiac and Thoracic

Bowen Ward, VSSR	Cardiac Surgery Liaison Nurse	Respiratory Lab Liaison Nurse
Cardiac and thoracic Surgery, Cardiology	Coronary Care	Thoracic Medicine
Cardiac Surgery	General Respiratory Medicine	Thoracic Surgery Liaison Nurse

### Specialist Surgery

Central Dialysis, Satellite Dialysis and Repat Dialysis Unit	General Medicine (Medical Units 1 and 3)	Nephrology
Dialysis Training Unit	Medical and Planning Unit	Paediatrics
		Renal

### Specialist Surgery, Gastro and General Surgery

Endoscopy	Orthopaedics/Plastics	Spinal, VSSR
ENT/Ophth/Ortho/General Surgery	Peri-Op Liaison Nurse and Manager	Urology, Gynae, Max, ENT & General Surgery
Liver Transplant, Gastro, ENT & General Surgery	Quality co-ordinator	Vascular/Gastro Surgery
Liver Transplant Co-ordinator	Specialist Surgery, Gastro and General CSU Director	

### Other

Anaesthesia	Operating Rooms
Emergency Department	Patient Services and Multicultural Health Services
Intensive Care Unit	Pharmacy

## Peninsula Health

### Integrated Care

Allied Health Rosebud  
Social Work/Response Assessment Discharge (RAD) Team

Post Acute Care

### Medicine and Critical Services

Breast Care Nurse Consultants	Intensive Care Unit (ICU)	Ward 5G South (Stroke)
Diabetes Educators	Respiratory Nurse Consultant	Skin Integrity Nurse Consultant
Coronary Care	Ward 5F North (Respiratory/High Dependency)	Stomal Care Nurse Consultants
Cardiac Angiography		
Day Oncology	Ward 5F South (Coronary Care)	
Dialysis		

### Surgery, Operating Theatres, Day Surgery, Endoscopy

Day Surgery	Short Stay/Admission Departure Lounge	Ward 5G North (Orthopaedic)
Endoscopy	Waiting Lists Manager	Ward 4G South (General Surgical)
Operating Theatres Frankston	Ward 4G North (Surgical/Gastro)	

### Women's, Children's and Adolescent Health

Maternity Services Frankston	Paediatrics	Special Care Nursery
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### Rosebud Hospital

Emergency Department Rosebud	Medical (Walker) Ward Rosebud	Surgical Ward Rosebud
Maternity Rosebud	Operating Suite Rosebud	

### Other

Aged Care and Rehabilitation (Mt Eliza Centre)	Hospital In The Home (HITH)	Pre-Admission Clinics
Emergency Department Frankston	Pharmacy Clinical Pathways Co-ordinator	Radiology

## **Southern Health**

### **Acute Allied Health**

Audiology	Speech Pathology	Occupational Therapy (Clayton and Dandenong)
Interpreting Services (Clayton and Dandenong)	Podiatry	Nutrition and Dietetics (Clayton and Dandenong)
Physiotherapy (Clayton and Dandenong)	Social Work (Clayton and Dandenong)	

### **Critical Care**

Operating Theatres (Clayton, Dandenong and Moorabbin)	Intensive Care Units (Clayton and Dandenong)
Pre-admission (Clayton and Dandenong - anaesthetics)	

### **Medicine**

Emergency Departments (Clayton and Dandenong)	Acute Medical Care Unit	Palliative Care (Clinical Nurse Consultant, McCulloch House)
Chemotherapy Day Unit	Body Composition	
Respiratory (44 North)	Medicine (32 North, 44 South, Lion's Ward, Ward 2, West 4)	
Diabetes Educator	Endoscopy	

### **Other**

Hospital in the Home	Pharmacy
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### **Specialty**

Coronary Care	Neurosciences (54 South, 54 North)	Dialysis (Cranbourne and Moorabbin)
Cardiac Unit (32 South)	Nephrology (Haemodialysis, Peritoneal, Transplant, 34 South)	
Dandenong Heart Unit		

### **Surgery**

Day Surgery (Cranbourne)	Ward 1, Ward 3, 34 North, 33 South)	Stomal Therapy
Surgical Units (West 3, North 1, North 2, Surgical Unit 1,	Designing Care Project	

### **Rehabilitation & Aged Services**

DARP, HARP, West Ward 2, South 2, South 3, South 5, South 6, North 3, East 1, Biala Ward.

### **Women's & Children's**

Maternity Services (Clayton - 52 North, 52 South, Maternal Foetal Medicine, Clinic D/Collaborative Pregnancy Care), Dandenong – Post natal and Moorabbin – Birth Centre and Ward 4)

Delivery Suite (Clayton and Dandenong)  
Breast Care and Breast Screen Project  
Paediatric Renal (42 North)  
Paediatric (41 North)

Newborn Services/Neonatal Intensive Care Unit  
Play Education/Therapy  
Medical Therapy Unit  
Special Care Nursery  
Children's Ward

### **Bayside Health**

#### **Acute Allied Health**

Nutrition  
Occupational Therapy  
Orthotics/Prosthetics  
Oto-Neurology/Audiology

Pastoral Care/Chaplains  
Pharmacy  
Physiotherapy  
Speech Pathology

Social Work  
Volunteers

#### **Cardiovascular and Respiratory**

Heart Failure Centre  
Heart Lung Replacement  
Ward 2F (Cardio-thoracic)

Ward 3C (Acute Cardiac Unit)  
Ward 3 West (Cardiology and General Medicine)

Ward 5 East  
(Respiratory/Cystic Fibrosis)

#### **Community and Ambulatory Services**

Alfred@Home (Hospital in the Home)  
Ambulatory Care Australia (Research Projects)

Better Care for Older People (BCOP) Project  
Disease Management Unit  
E-Health

Mobile Assessment and Treatment Services (MATS)  
Rapid Assessment Service (RAS)

#### **Medical Specialties**

Access Information Centre, Infectious Diseases  
Alcohol and Drug Liaison  
Cancer and Blood Diseases Services  
Cancer Support Nurse

Health Educator, Infectious Diseases  
HIV Services Co-Ordinator (included Ward 7 West, Fairfield House and HIV Palliative Care)  
Palliative Care/Fairfield House

Ward 4C (Endoscopy and Gastroscopy)  
Ward 7 East (Cancer)

## **Musculo-Skeletal**

Hyperbaric Service  
Intensive Care Unit

Ward 2D (Trauma and  
Orthopaedics)

Ward 6 West (Burns and  
Plastics)

## **Neurosciences/Medicine**

Alfred/CGMC Dialysis unit  
Diabetes Nurse Co-ordinator  
Emergency Department  
Ward 1F (Alfred Dialysis Unit)

Ward 3 East (Neurosurgery)  
Ward 3 West (Professorial  
General Medical Units A and  
B)  
Ward 4D (MADU/Medihotel)

Ward 4 East (Renal, Neuro,  
stroke, Endocrine)

## **Public Affairs**

The Alfred Foundation

Public Affairs, The Alfred

## **Sandringham and District Memorial Hospital**

Emergency Department  
Dietetics  
Hospital in the Home (HITH)  
Occupational Therapy  
Operating Suite  
Orthopaedic Preadmission

Pharmacy  
Physiotherapy  
Quality Co-ordinator  
Radiology  
Social Work  
Volunteer Co-ordinator

Ward F2 (Medical)  
Ward F3 (Maternity)  
Ward F5 (Dialysis)  
Ward G2 (Surgical)  
Ward G3  
(Orthopaedic/Neuro/ENT)

## **Surgical**

Anaesthetics  
Stomal Therapy

Ward 2 East (Preadmission/Day Surgery)  
Ward 6 East (Surgical)

## **Western Health**

### **Ambulatory Services**

HARP Projects  
Hospital in the Home (HITH)

Outpatients  
Paediatric Outpatients

### **Clinical Support Services**

Pharmacy

Radiology

## **DASWest (Drug and Alcohol Services)**

DASWest, Adult Services

DASWest, Youth Outreach Services

DASWest, Residential Services

## **Emergency and Critical Services**

Emergency Department, Sunshine Hospital

Intensive Care Unit

Emergency Department, Western Hospital  
Footscray

Ward 2A (Cardiac Care Unit)

## **Medicine**

Acute Care of the Elderly  
(ACE)

Rapid Assessment Medical  
Unit (RAMU)

Ward 2D (Infectious Diseases,  
Respiratory and Thoracic)

ACE, Gynaecology and  
Surgery.

Ward 1 West (Endocrinology,  
Nephrology, Drug and  
Alcohol, Rheumatology)

Ward 3 East (General  
Medicine, ENT)

Day Oncology

Ward 2C (Stroke, Neurology)

Oncology

## **Peri-operative Services**

Day Procedure Unit and  
Preadmission, Sunshine

Operating theatres, Western  
Hospital Footscray

Waiting lists, Sunshine

Day Procedure Unit, Western  
Hospital Footscray

Pain Nurse Consultant

Waiting lists, Western Hospital  
Footscray

Operating theatres, Sunshine

Preadmission Clinic, Western  
Hospital Footscray

## **Public Affairs**

Public Affairs

Volunteer Program

## **Surgery**

Continuity of Care Co-  
ordinator

Rapid Assessment Surgical  
Unit (RASU)

Wards 3A and 3B  
(Orthopaedics, Plastics,  
Geriatric Orthopaedics)

Intensive Care Unit (ICU)  
Liaison Nurses

Stomal Therapy Consultant

Wound Care Consultant

Orthopaedic Clinical Co-  
ordinator

Ward 1 East (General Surgery)

Ward 2 West (Cancer, Gastro  
Surgery)

### **Sub-Acute and Allied Health**

Allied Health in Women's and Children's Health

Community Rehabilitation Centre, Sunshine

Community Rehabilitation Centre, Williamstown

Home Rehabilitation Service

Geriatric Evaluation and Management (GEM), Sunshine

Geriatric Evaluation and Management (GEM), Williamstown

Neuropsychology

Nutrition

Occupational Therapy

Palliative Care

Physiotherapy

Podiatry

Rehabilitation

Secure GEM

Social Work

Speech Pathology

### **Williamstown Hospital**

Day Procedure Unit

Lower West (General Medicine and Surgery)

Operating Suite

Upper West (Maternity and Surgery)

### **Women's and Children's Health**

Children's Ward

Maternity Wards

Shared Care Co-ordinator

Pregnancy Day Stay & Maternity Outreach Support Services

Maternity Educators

Paediatric Consultant

Special Care Nursery

## Appendix 9 Typical time allocation for site visits

<p>Week 1</p>	<p>Met with Directors of Acute and Sub-Acute Services to discuss the project and determine which units should be included. These Clinical Divisions included a range from:</p> <ul style="list-style-type: none"> <li>• Sub-Acute and Aged Care</li> <li>• General and Specialist Medicine</li> <li>• Women's and Children's Health</li> <li>• Peri-operative/Admissions</li> <li>• Public Relations</li> <li>• Clinical Support Services</li> <li>• Surgery</li> <li>• Emergency and Critical Care</li> <li>• Pharmacy</li> <li>• Drug and Alcohol Services</li> </ul> <p>Met with Chief Executive Officer, and the Chief Operations Officer.</p> <p>Met with the Director of Nursing/General Manager and the Chief Medical Officer of Hospital. Sent emails to all NUMs, other Managers and Chief Clinicians in the above Divisions and at the other Hospital to introduce ourselves and the project. Project documentation was distributed electronically.</p> <p>Commenced ringing unit/ward staff who had been emailed earlier in the week to make appointments for initial meetings to discuss the Project. Commenced individual meetings with Unit Managers to discuss the project.</p>
<p>Week 2</p>	<p>Continued ringing unit/ward staff who had been emailed in Week One to make appointments for initial meetings to discuss the Project.</p> <p>On-going individual meetings with Unit and Department Managers to discuss the project.</p> <p>Met with the Directors in other areas.</p>
<p>Week 3</p>	<p>On-going initial meetings with Unit Managers and other staff taking part in the project (eg Nurse Consultant, Chief Clinicians, Project staff).</p> <p>Commenced calling staff back to check on progress of self-assessments and to arrange meetings for collection of completed tools and to do evaluations.</p> <p>Tuesday 2003: Reference Committee Meeting.</p> <p>Project Manager attended the Community Advisory Committee meeting at the Hospital to discuss the project with CCC members. Interest was expressed by the CCC members in learning about the findings from the site visit. The Project Manager was invited back to discuss the findings at a CCC meeting later in the year.</p>
<p>Week 4</p>	<p>On-going initial meetings with Unit Managers and other staff taking part in the project.</p> <p>Commenced individual meetings with Unit Managers and other staff to collect tools and conduct evaluations.</p>
<p>Week 5</p>	<p>On-going initial meetings with Unit Managers and other staff taking part in the project.</p> <p>Commenced data entry of the self-assessment data.</p> <p>On-going individual meetings with Unit Managers and other staff to collect tools and conduct evaluations.</p>
<p>Week 6</p>	<p>On-going individual meetings with Unit Managers and other staff to collect tools and conduct evaluations.</p>

