Draft model: A safety and quality model for colonoscopy services in Australia
## Contents

**Introduction** .................................................................................................................................................. 1

- Purpose of this report .................................................................................................................................... 1
- Colonoscopy in Australia ................................................................................................................................. 1
- Rationale for a safety and quality model for colonoscopy ............................................................................. 2
- Current approaches to ensuring the safety and quality of colonoscopy ............................................................ 2

**The Model** .................................................................................................................................................... 3

**A colonoscopy clinical care standard** ............................................................................................................ 4

- Development of a clinical care standard for colonoscopy ............................................................................... 4
- Scope of the standard ...................................................................................................................................... 4
- Certification and re-certification of colonoscopists ......................................................................................... 5
- Information management and continuous quality improvement .................................................................. 6

**Requirement to implement the colonoscopy clinical care standard** .............................................................. 7

**Accreditation against the NSQHS Standards** ............................................................................................... 8

- Approval of accrediting agencies ..................................................................................................................... 8
- Overview of the accreditation process ............................................................................................................. 8
- Consequences if accreditation is not achieved ............................................................................................... 11

**Responsibilities of participants** ................................................................................................................ 12

- Clinicians ......................................................................................................................................................... 12
- Professional colleges and societies .................................................................................................................. 12
- State, territory and Commonwealth governments ............................................................................................. 12
- Health service organisations .......................................................................................................................... 12
- The Commission ............................................................................................................................................ 12
- Accrediting agencies ....................................................................................................................................... 13
- Health Ministers .............................................................................................................................................. 13

**Attachment 1 - Consultation outcomes** ...................................................................................................... 14

- Standards for colonoscopy ............................................................................................................................ 14
- Establishing and stewarding standards ........................................................................................................... 14
- Implementing standards .................................................................................................................................. 15
- Monitoring compliance with standards ........................................................................................................ 15
- Addressing clinician under-performance ...................................................................................................... 15
Collecting data and monitoring quality ................................................................. 15

Attachment 2 - Standards and guidelines that currently apply to colonoscopy services ........................................................................................................................................................................ 17
  Quality Working Group standards ................................................................................................. 17
  NSQHS Standards ...................................................................................................................................... 17
  Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy .......... 17
  Gastroenterological Society of Australia re-certification standards ........................................ 18

Attachment 3 - Alternative text for Figure 1 ............................................................................. 19
Introduction

Purpose of this report

In 2015, the Australian Government Department of Health (‘Department’) appointed the Australian Commission on Safety and Quality in Health Care (‘Commission’) to develop a safety and quality model for colonoscopy. The appointment was made in the context of:

- anticipated growth in colonoscopy numbers arising from the planned expansion of the NBCSP;
- awareness that colonoscopy following a positive screening test through the National Bowel Cancer Screening Program (‘NBCSP’) is performed on asymptomatic individuals, many of whom will be found to have no significant pathology; and
- the Department’s commitment to:
  - optimising bowel cancer detection rates; and
  - ensuring asymptomatic individuals who have a positive screening test through the NBSCP but may have no relevant pathology are not exposed to unnecessary safety and quality risks during colonoscopy.

The Commission engaged Clayton Utz to lead a consultation process to support development of the Model. The consultation process consisted of four workshops, a focus group and a number of one-on-one and small group interviews. A summary of consultation outcomes is included at Attachment 1.

This report describes the safety and quality model (‘Model’) for colonoscopy in Australia developed by the Commission, taking into account the consultation outcomes and research undertaken for this project.

Colonoscopy in Australia

Colonoscopy is performed in adult and, less commonly, paediatric patients and is the gold standard for the investigation and management of large bowel pathology. It is a complex task that requires the colonoscopist to manipulate the colonoscope effectively in order to visualise the bowel.

More than 900,000 colonoscopies are performed in Australia annually. Between 20% and 25% are performed in public hospitals, with the remainder performed in private hospitals and day procedure centres. A relatively small proportion (4.7% in 2015) is performed on people who have received a positive faecal occult blood test through the NBCSP.

---

1 Colonoscopy is the endoscopic examination of the entire large bowel (from the rectum to the caecum) with a flexible endoscope. It may also include examination of the distal small bowel.


4 Statistic from internal Australian Government Department of Health report
Rationale for a safety and quality model for colonoscopy

A high quality colonoscopy is:

- **Safe** – the integrated care delivery system is designed to prevent adverse events, and does so effectively.
- **Effective** – caecal intubation is achieved. Bowel pathology is identified and, where appropriate, treated. Results of the procedure can be relied on.
- **Acceptable** – the consumer experience is optimised.
- **Appropriate** – the procedure is performed for recognised indications.
- **Accessible** – on the basis of time, cost and geography, in the context of the patient’s clinical need.

The risk of serious complications following colonoscopy is estimated to be 2.8 per 1,000 examinations\(^5\). Complications resulting in hospitalisation occur in approximately 2 per 1,000 procedures\(^6\). The mortality rate is estimated to be 0.007 per cent\(^7\).

Complications of the procedure include perforation and bleeding. Complications can also occur:

- as a result of preparation for the procedure; and
- during or following the procedure, as a result of the administration of sedation or anaesthesia.

Current approaches to ensuring the safety and quality of colonoscopy

Various standards and guidelines support the provision of colonoscopy services in Australia. A summary of relevant standards and guidelines is included at Attachment 2.

---


The Model

Taking into account the outcomes of the national consultation process, the Commission proposes to develop a colonoscopy clinical care standard and reference it as a requirement in the next version of the National Safety and Quality Health Service Standards (‘NSQHS Standards’).

The second version of the NSQHS Standards will be finalised in 2018 for incorporation in the 2019 Australian Health Service Safety and Quality Accreditation Scheme (‘AHSSQA Scheme’).

The proposed Model is depicted in Box 1.

Box 1: Proposed safety and quality model for colonoscopy

The colonoscopy clinical care standard will include specifications for:

- delivery of quality colonoscopy services;
- training and performance of colonoscopists:
  - certification of colonoscopists’ initial training and performance; and
  - periodic re-certification of colonoscopists’ performance, in accordance with defined quality indicators and performance targets, incorporated in the colonoscopy clinical care standard;
- collection, analysis and reporting of data, in accordance with a standard national data set.

Quality indicators and performance targets will inform the specifications for certification and re-certification of colonoscopists.

The colonoscopy clinical care standard will be implemented in public and private hospitals and day procedure centres nationally as a component of the AHSSQA Scheme.
A colonoscopy clinical care standard

Implementation of this model would require the development of a clinical care standard for colonoscopy. The Commission would oversee development and maintenance of the standard.

Development of a clinical care standard for colonoscopy

In accordance with the Commission’s established methodology for developing clinical care standards, the Commission will appoint a topic working group of clinicians, researchers and consumers with health service sector and jurisdictional representatives to support the development of the colonoscopy clinical care standard. The topic working group will develop the key elements of colonoscopy care identified in the consultation and not already addressed in the NSQHS Standards and:

• use the most current evidence from guidelines and standards;
• seek information about gaps between evidence and practice;
• apply their expertise and knowledge of the issues affecting the appropriate delivery of care; and
• consider issues of specific importance to consumers.

The topic working group will also be provided with information gained during the consultation for this project, which provided insight and guidance about the provision of safe, high quality colonoscopies in Australia, to support development and testing of the colonoscopy clinical care standard.

The topic working group will be supported by the Clinical Care Standards Advisory Committee, which advises the Commission on the development process for clinical care standards.

A public consultation process will be conducted on the draft standard and associated documents before they are finalised, submitted to Health Ministers for approval and, following approval, published.

Scope of the standard

The colonoscopy clinical care standard will be developed in consultation with the topic working group, however the following elements are likely to be included:

• Informed consent and communication
• Appropriateness of the procedure
• Bowel preparation
• Sedation
• Training, credentialling and performance of colonoscopists:
• Certification of training and re-certification of performance of colonoscopists in accordance with defined clinical indicators and targets (identified by stakeholders as a key element of a safety and quality model for colonoscopy)
• Recovery
• Follow up
• Training and performance of other staff
• Facility requirements
• Reporting and data management requirements.

Certification and re-certification of colonoscopists

The colonoscopy clinical care standard will incorporate:

• training and performance specifications for colonoscopists; and
• a requirement for health care provider organisations to ensure all colonoscopists providing services in their facilities are certified/re-certified by an appropriately recognised body in accordance with those specifications.

This will be a core element of the Model.

The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (‘CCRTGE’)
8 has offered a certification program for some years, although not all Australian colonoscopists participate.

Recently, the Gastrointestinal Society of Australia (‘GESA’) introduced a voluntary triennial re-certification program in colonoscopy, designed to support practitioners to:

• maintain their expertise in colonoscopy;
• continue to develop their skills through subsidised training opportunities and
• increase safety standards and the quality of care being delivered to patients.

CCRTGE certification requirements and GESA re-certification requirements are included in Attachment 2. In May 2016, the Colorectal Surgical Society of Australia and New Zealand (CRSSANZ) endorsed the GESA voluntary recertification program for its members.

The topic working group will build on the CCRTGE and GESA work to advise on:

• specifications for certification of training and re-certification of performance of colonoscopists; and
• processes for recognition of entities that can provide reliable certification and re-certification services for colonoscopists in accordance with those specifications,

to be included in the colonoscopy clinical care standard.

The standards and quality indicators adopted by the CCRTGE and GESA are expected to form the basis of the specifications for certification of training and re-certification of performance of colonoscopists.

It is anticipated that the CCRTGE will continue to offer certification to colonoscopists, and GESA will continue to offer re-certification to its members. Re-certification services will also be required by non-GESA members. The Commission will work with the topic working group and professional organisations to ensure all colonoscopists have access to recognised certification and re-certification services.

8 The CCRTGE is a committee of the Royal Australasian College of Surgeons (‘RACS’), the Gastrointestinal Society of Australia (‘GESA’) and the Royal Australasian College of Physicians (‘RACP’). The Conjoint Committee has set minimum standards for training in colonoscopy and offers applicants formal recognition of their training.
Information management and continuous quality improvement

A national minimum data set will be determined in consultation with the topic working group. Hospitals and day procedure centres in which colonoscopies are performed will be responsible for ensuring accurate and reliable data collection at a facility level.

The standard will require hospitals and day procedure centres to work with colonoscopists to:

• apply performance data to continuously improve quality; and
• where colonoscopists are not meeting performance targets, agree quality improvement plans and protect patient safety while those plans are being implemented.
Requirement to implement the colonoscopy clinical care standard

The requirement for health care organisations to implement the colonoscopy clinical care standard will be specified under Standard 1 of the NSQHS Standards: *Governance for Safety and Quality in Health Service Organisations*.

The Standards are a critical component of the AHSSQA Scheme, which was endorsed by Australian Health Ministers in November 2010. After 1 January 2013, the next scheduled recertification audit or organisation-wide accreditation visit for all Australian hospitals and health services has involved assessment against all ten NSQHS Standards.
Accreditation against the NSQHS Standards

Approval of accrediting agencies

Under the AAHSQA Scheme, the Commission approves accrediting agencies wishing to accredit health service organisations to the NSQHS Standards.

Accrediting agencies wishing to accredit health service organisations to the NSQHS Standards and/or TRP Standards must undergo a formal application and assessment process. Accrediting agencies seeking approval must:

• hold current organisational accreditation with an international recognised body such as International Society for Quality in Healthcare (ISQua) or Joint Accreditation System of Australia and New Zealand (JAS-ANZ);
• offer accreditation programs using the NSQHS Standards;
• maintain an assessor workforce with the skills, knowledge and experience to effectively perform their role and maximise inter-assessor reliability;
• have a formal process for managing complaints and appeals by health service organisations; and
• agree to the conditions of approval to assess to the NSQHS Standards.

The Assessment Panel is convened biannually to assess any future applications received from accrediting agencies.

Overview of the accreditation process

The accreditation process is depicted in Figure 1. An alternative text description is provided at Attachment 3.

For a mid-cycle assessment, periodic review or surveillance audit, health service organisations may not be assessed against all ten NSQHS Standards. Any mid-cycle assessment will, at a minimum, involve:

• Standards 1, 2 and 3;
• the organisational quality improvement plan (or equivalent document such as an operational or strategic plan); and
• recommendations from previous accreditation assessments.

For new health service organisations, interim accreditation to the NSQHS Standards will generally apply for the first 12 months of operation.
Figure 1: The accreditation process
Consequences if accreditation is not achieved

The Commission has been working with states and territories to implement a responsive regulatory approach when health services do not meet the requirements of the NSQHS Standards.

If, at assessment by an approved accrediting agency, actions are assessed as not met, health service organisations have up to three months to address the issue, depending on the associated seriousness and risks. Concurrently, regulators (state and territory health departments) are informed and may take action or provide support to health services as they address the relevant issues.

Each state, territory and Commonwealth health department has specific regulatory and legislative requirements for licensing or managing private hospitals, public hospitals and day procedure services, and to enable health service organisations to access government benefits. Their responses are in line with these requirements.
Responsibilities of participants

The roles of each participant in the AHSSQA Scheme are broadly as follows:

**Clinicians**

Clinicians are responsible for maintaining their skills, keeping records of their activity and outcomes, monitoring their performance, working in partnership with their peers and health service organisations in quality improvement activities and ensuring they achieve benchmarks and targets set by their peers. They are also responsible for participating in reasonably expected teaching and training activities.

**Professional colleges and societies**

Professional colleges and societies are responsible for leadership of safety and quality, support for system-wide quality improvement activities, and provision of appropriate teaching, training and professional development activities. Some professional colleges and societies may choose to offer certification and/or recertification services to their members.

**State, territory and Commonwealth governments**

The state, territory and Commonwealth governments determine the health service organisations required to participate in an accreditation process using the NSQHS Standards. They receive data on the outcomes of accreditation of health service organisations and respond to emerging issues.

**Health service organisations**

Health service organisations implement the actions required to meet the NSQHS Standards and select an approved accrediting agency to assess their compliance in meeting the NSQHS Standards. This involves a contractual relationship with the accrediting agency that recognises that accreditation data will be provided to Regulators and the Commission for reporting and review.

**The Commission**

The Commission:

- develops and maintains the NSQHS Standards;
- develops and maintains clinical care standards;
- approves accrediting agencies to assess against the NSQHS Standards;
- undertakes ongoing liaison with Regulators on opportunities to improve the Standards and the accreditation system; and
- reports to Health Ministers annually on safety and quality.
Accrediting agencies

The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the NSQHS Standards. Approved accrediting agencies are required to:

- assess health service organisations to the NSQHS Standards without modification and in accordance with requirements set out by the Commission;
- regularly report assessment and compliance data, and award accreditation status within agreed timelines;
- provide assessment data and notifications to the Commission and Regulators (health departments) in accordance with agreed protocols;
- maintain an effective working relationship with the Commission through membership of the Accrediting Agencies Working Group.

Health Ministers

Health Ministers endorse the NSQHS Standards and receive information about health service organisations’ performance against the NSQHS Standards.
Standards for colonoscopy

Stakeholders expressed strong ‘in principle’ support for:

- implementation of standards specific to colonoscopy services;
- establishment of quality indicators and performance targets for colonoscopists;
- mechanisms to foster implementation of standards (beyond simple endorsement by an appropriately influential body); and
- an element of regulation, to ensure the system has ‘clout’.

Stakeholders identified the need for the standards to address:

- the appropriateness of the procedure;
- the facilities in which colonoscopy is performed;
- the training and performance of colonoscopists;
- the training and performance of other members of the clinical team (including gastroenterological nurses and anaesthetists); and
- the processes that support the performance of the procedure.

While it was generally agreed that standards, quality indicators and performance targets for clinician training and performance should form the core of a safety and quality model and should be applied consistently across all professions and disciplines, there were differing views about the appropriateness of incorporating a requirement for re-certification of colonoscopists’ performance. Access to sufficient procedure numbers to achieve training and performance targets was highlighted as a significant challenge for trainees in some disciplines, and for proceduralists practising in rural areas.

Participants generally agreed that colonoscopy standards should incorporate standards for appropriateness of the procedure. There was support for incorporation of the Cancer Council Australia Clinical Practice Guidelines for Surveillance Colonoscopy – in adenoma follow-up, following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease (‘Surveillance Guidelines’). It was suggested, however, that a requirement for 100% compliance with the Surveillance Guidelines would be inappropriate, as some patients have legitimate clinical indications for more frequent colonoscopy. A requirement of, for example, 90% compliance with the Surveillance Guidelines may be more appropriate.

There was support for a strong focus in colonoscopy standards on the consumer experience.

Establishing and stewarding standards

Stakeholders agreed that the standards proposed by the NBCSP Quality Working Group would provide a solid foundation for colonoscopy standards, but work would be required to remove duplication and ensure consistency with contemporary clinical practice.

---

There was strong representation regarding the criticality of engaging clinicians of all relevant disciplines, together with consumers and representatives of the public and private hospital/day procedure sectors, in establishing and maintaining standards.

The important leadership role of the CCRTGE in setting voluntary training standards was noted. It was suggested that while the CCRTGE may not fulfill the requirements for a standard-setting body if standards are mandated in the future, it has capacity to make an extremely important contribution to the development and oversight of a comprehensive safety and quality model. Similarly, GESA, the Gastroenterological Nurses College of Australia (‘GENCA’), the Colorectal surgical society of Australian and New Zealand (‘CRSSANZ’), the Royal Australian College of General Practitioners (‘RACGP’) and RACS were identified as organisations with key contributions to make to national standard-setting.

Many participants preferred the Commission as the auspicing body for setting and maintaining colonoscopy standards, on the basis of its statutory role, perceived independence and growing expertise in formulating standards, guidelines and indicators.

Implementing standards

There was stakeholder consensus that agreed standards should apply in all service settings but different mechanisms may be required to support uniform implementation.

There were differing views on the degree of regulation necessary to support implementation of standards. Most stakeholders supported the availability of Medicare rebates being contingent on certification of the training and performance of the clinician, and many also supported linkage of Medicare rebate availability with periodic re-certification of clinician performance.

Monitoring compliance with standards

Views about the appropriate approach to monitoring and ensuring compliance with standards varied, with some stakeholders favouring a requirement for this to occur at the facility level while others proposed a more centralised, national approach. Some stakeholders favoured publication of performance data.

There was concern about the cost and administrative burden of an external accreditation process. There was also, however, support for the introduction of some sort of audit process, at either a facility or central level, to verify compliance with standards. A number of participants suggested accreditation against a small number of standards, quality indicators and performance targets could be incorporated into the NSQHS Standards accreditation process.

‘In principle’ support was expressed for the Commission to assume an overarching stewardship role in relation to monitoring compliance with standards.

Addressing clinician under-performance

Many participants highlighted the importance of appropriate retraining and remedial pathways for clinicians who are unable to meet performance targets, particularly those practising in rural areas.

Collecting data and monitoring quality

The inadequacy of current data collection and management infrastructure, particularly in smaller private sector settings, was noted. There was strong support for a standardised
approach to data collection, including a standardised data set and an electronic collection, storage and reporting capability. A variety of views was expressed about whether data should be:

- collected and analysed locally, with the potential for assessment of compliance with that requirement by an accreditation or licensing entity;
- submitted to a central registry; and/or
- made available to the public.

There was support for establishing a clinical quality registry for colonoscopy to enable monitoring of a range of quality measures including major complication rates, although practical and financial barriers to this were noted.
Attachment 2 - Standards and guidelines that currently apply to colonoscopy services

Quality Working Group standards

In 2009, the Quality Working Group of the National Bowel Cancer Screening Program developed a comprehensive set of standards for the performance of colonoscopy. The standards covered the facilities in which colonoscopies are performed, and the qualifications and performance of colonoscopists. A number of implementation mechanisms were recommended, but not adopted at that time.

NSQHS Standards

The National Safety and Quality Health Service Standards (‘NSQHS Standards’) were developed by the Commission in consultation and collaboration with jurisdictions, technical experts and a wide range of stakeholders, including patients and health professionals. The primary aims of the NSQHS Standards are to protect the public from harm and improve the quality of health service provision. All hospitals and day procedure services across Australia are required to be assessed to ensure they meet the NSQHS Standards, and are expected to have quality systems in place covering the continuum of colonoscopy care from acceptance of referrals to discharge and follow up. This assessment, known as accreditation, is undertaken by independent accreditation agencies.

Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy

The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (‘Conjoint Committee’) is a committee of the Royal Australasian College of Surgeons (‘RACS’), the Gastrointestinal Society of Australia (‘GESA’) and the Royal Australasian College of Physicians (‘RACP’). The CCRTGE has set minimum standards for training in colonoscopy and offers applicants formal recognition of their training. The CCRTGE expects applicants to:

- have received training in radiological and pathological findings as well as the technical aspects of endoscopy;
- have received training in sedation practices pertaining to endoscopic procedures based on the current edition of “Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures - Review PS9 (2014)”;
- demonstrate an understanding of the principles of and practice of cleaning and disinfection of modern endoscopic instruments as outlined in the current edition of “Infection Control in Endoscopy”;
- familiarise themselves with the drugs of sedation and have experience in airway support; and
- keep abreast of current endoscopic literature obtain training in fluoroscopic theory and practice.

The standards adopted by the CCRTGE require trainees to:

- perform a minimum of 100 unassisted, supervised, complete colonoscopies to the caecum and preferably to the ileum in patients with intact colons (i.e. with no prior colonic resection);
- perform successful snare polypectomies on a minimum of 30 patients; and
- achieve at least a 90% caecal intubation rate by the completion of training.

Procedures on patients with obstructing cancer and/or severe colitis must be recorded but are excluded from the calculation of overall intubation rate.

Applicants are expected to demonstrate cognitive and interpretative skills combined with a clear understanding of the role of endoscopy in patient management. These skills are considered by the Committee to be as important as technical skills.

**Gastroenterological Society of Australia re-certification standards**

Recently, the Gastrointestinal Society of Australia (‘GESA’) introduced a voluntary triennial re-certification program in colonoscopy. Practitioners are required to meet the following activity/performance targets to achieve re-certification:

- **Number of procedures**
  - At least 150 procedures over 3 years
  - Procedures must be recorded consecutively (that is EVERY procedure) in blocks of 50 or more
  - To ensure that the recorded procedures are representative of the practitioner’s current practice at least 50 consecutive procedures are to be logged in the 12 months immediately preceding an application for re-certification

- **Target completion**
  - At least 95% to the caecum or terminal ileum in patients with intact colons

- **Adenoma detection rate**
  - At least 25% in eligible patients. ‘Eligible patients’ are 50 years or older, have intact colons, do not have a finding of acute IBD and were intubated to the caecum or terminal ileum

- **Cognitive review**
  - Completion of a short, online ‘cognitive review’ comprising up to 20 multi-choice questions with guidance to the ‘most correct’ answer(s) and with links to further reading
Attachment 3 - Alternative text for Figure 1

Figure 1 depicts the accreditation process.

1. Enrol with Accrediting Agency: Enrolled health service organisations can access information on processes, timing and resources available from their accrediting agency and ACSQHC. An accreditation process involves self assessment and external assessments (organisation-wide assessment and mid-cycle assessment).

2. Self Assessment: An assessment conducted by the health service organisation to review their processes and practices and determine the extent to which they meet the NSQHS Standards. Timing: Specified by accrediting agency.

3. Assessment: Assessment can be organisation-wide or mid-cycle. Organisation-wide assessment is undertaken as an external visit. Mid cycle is generally an external visit but may be a desk top assessment. The collated evidence is reviewed to determine if the actions required in the NSQHS Standards have been met. Timing: Length of onsite assessment agreed between accrediting agency and health service.

3a. Notify Regulators: Health service organisations and regulators are advised by the accrediting agency if a significant risk has been identified. Timing: Once identified.


4. Report on Assessment: Following assessment, the accrediting agency will provide a written report of their assessment. The report will specify all not met actions and provide detail of why the action is not met. Timing: Within 7 days from external assessment visit.

5a. Core actions met: Routine reporting by accrediting agencies to regulators and ACSQHC. Mid cycle, accreditation maintained. Full assessment to all Standards, accreditation awarded. Timing: Subject to assessment type and accrediting agency processes.

5b. Core actions NOT met: Health service organisations have 90 days to implement quality improvement strategies to address not met actions. Timing: approximately 90 days from written notification (120 days during 2013).

5c. Re-assessment: Evidence of improvement provided by health service organisation to accrediting agency and determination made on not met items. Proceed to either 5a (Core actions met) or 5d (Actions NOT met).

5d. Actions NOT met: Accreditation not awarded or accreditation not retained for mid cycle assessment. Quality improvement and self assessment process recommenced. Regulators contact officer are informed in writing by accrediting agency. Timing: Health service and regulator notified.

5e. Remediation: Health service organisation to implement improvements, address any action not met from accreditation process. Action will be consistent with timing and processes specified by jurisdiction. Timing: Specified by the Regulator. Proceed to 2 (Self Assessment).