

# Performance Data Program Information

Performance and Outcomes Services  
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## ACHS 2025 Performance Data Program Information

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# Contents

Contents.....	3
Introduction.....	4
About the ACHS Performance and Outcomes Service.....	5
What are clinical indicators?.....	6
Clinical indicator development and review.....	9
Benefits of performance data.....	9
Utilising performance data.....	10
How do we structure indicators? .....	12
Performance Data Governance Diagram.....	16
Data Reporting .....	17
What clinical areas does the dataset cover?.....	20
Appendix 1: Sample Dashboard .....	24

## Introduction

This document provides information about the Performance and Outcomes Service and the function of the ACHS Performance Data Program.

For further copies of this document or for additional information relating to the Performance Data Program please contact:

ACHS Performance and Outcomes Service

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### Other publications:

- The *ACHS Clinical Indicator User Manuals* are published biannually with updated Clinical Indicators available for collection in the coming year.
- The *ACHS Clinical Indicator Summary Guide* is published annually with updated Clinical Indicators available for collection in the coming year.
- The *Clinical Indicator Report* is published annually and reports aggregate results for all published Clinical Indicators.

## About the ACHS Performance and Outcomes Service

The role of the Performance and Outcomes Service (POS) is to coordinate the development, collection, collation, analysis, and reporting of the performance metrics. ACHS, through POS has considerable information on over 330 Clinical Indicators with more than 600 healthcare organisations (HCOs) participating in the ACHS / ACHSI Performance Data Program. Information from these performance metrics is the largest source of data gathered on the quality of healthcare in Australia and New Zealand.

### What is the Performance Data Program?

The Performance Data Program is a data repository, analysis and reporting service provided to member organisations. It provides a national clinical benchmarking service and is comprised of comparative information on the processes and outcomes of health care (<https://www.achs.org.au/our-services/pos>). Participating organisations can submit data for inclusion in an extensive database. Data are aggregated and analysed six-monthly, and results are provided in the form of comparative reports and a dashboard. The dashboard compares results across all contributing organisations as well as providing a comparison with similar organisations based on several variables.

The POS team also provides individual support to HCOs, via telephone and e-mail. Consultancies can be arranged through the consulting division of ACHS (<https://www.achs.org.au/our-services/consulting>) and education can be provided by the ACHS Improvement Academy (<https://www.achs.org.au/improvement-academy>) on a range of topics related to performance improvement. The Performance Data Program provides all the necessary products, tools and services required for members to participate. These resources are available via a secure website where members can also submit and download their performance data (<https://www.achs.org.au/our-services/pos>).

### Who can subscribe?

Subscription to the Performance Data Program is free for ACHS/ACHS International (ACHSI) accreditation members. All members are encouraged to submit indicator data to demonstrate continuous quality improvement.

Non-ACHS accredited organisations may subscribe to the program, and a membership fee applies. Fees are based on a calendar year subscription.

## What are clinical indicators?

A clinical indicator is a measure of the clinical management and/or outcome of care.<sup>1</sup> A well-designed indicator should 'screen', 'flag' or 'draw attention' to a specific clinical issue. Usually rate-based, indicators identify the rate of occurrence of an event. Indicators do not provide definitive answers; rather they are designed to indicate potential problems that might need addressing, by identifying variations within data results.<sup>2</sup> They are used to assess, compare and determine the potential to improve care.<sup>3</sup> Indicators are therefore, tools to assist in assessing whether or not a standard in patient care is being met.

There is growing recognition that a capacity to evaluate and report on quality is a critical building block for system-wide improvement of healthcare delivery and patient outcomes.<sup>4</sup> Organisations are frequently being requested to provide data on many aspects of their facility to a variety of stakeholders. Indicator results provide valuable information in assessing the performance of health services. This focus on performance management has emerged through increased competition, a more recent focus on quality improvement and safety and an increased demand for evidence of performance.

The use of indicators is an effective tool for measuring and managing the quality of clinical care providing the relevant clinicians are involved and supported with adequate resources to undertake such clinical audit. The reporting of indicator data to the ACHS/ACHSI is not a mandatory component of the accreditation process. However, organisations are required to demonstrate their achievements using data. To do this, the organisation may either use ACHS/ACHSI clinical indicators or other performance indicator metrics. Organisations may also need to demonstrate at the time of survey, evidence of improving performance through evaluation, supported by data.

The ACHS/ACHSI has been involved in the development of clinical indicators in conjunction with Australian and New Zealand medical colleges, associations, and societies since 1989. In this time, the program has seen the development of Hospital-Wide and specific sets of clinical indicators.

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<sup>1</sup> Collopy BT. Clinical indicators in accreditation: an effective stimulus to improve patient care. *Int J Qual Health Care* 2000; 12(3): 211-216.

<sup>2</sup> Campbell S, Braspenning J, Hutchinson A and Marshall M. Research methods used in developing and applying quality indicators in primary care. *Qual Saf Health Care* 2002; 12(3): 358-364.

<sup>3</sup> Howley P and Gibberd R. Using hierarchical models to analyse clinical indicators: a comparison of the gamma-Poisson and beta-binomial models *Int J Qual Health Care* 2003; 15(4): 319-329.

<sup>4</sup> Miller T and Leatherman S. The National Quality Forum: A 'Me-Too' Or A Breakthrough In Quality Measurement And Reporting? *Health Aff (Millwood)* 1999; 18(6): 233-237.

## Types of indicators

Clinical Indicators can be classified according to the aspects of care they address. A comprehensive view of healthcare performance can be built up by investigating information from a variety of sources about different aspects of care.

Indicators will measure either:

- Structure (what is needed)
- Process (what is done)
- Outcome (what is achieved or expected).

### Structure indicators

Structure indicators provide important information about the organisation's environment (infrastructure, physical layout and resources, human resources and organisational framework) required for the provision of quality health care.

An example of a structure indicator is:

- Number of patients who undergo a procedure with an anaesthetist in attendance where there is a trained assistant to the anaesthetist<sup>5</sup> (Numerator ANAE CI 2.1)

### Process Indicators

Process indicators measure what is being done in providing the care. Process indicators provide quantitative data regarding the impact or effectiveness of systems, policies and procedures and can monitor changes over time when measured repeatedly.

An example of a process indicator is:

- Number of patients who have documentation of risks and benefits of the anaesthetic procedure(s) completed by an anaesthetist prior to transfer to the operating suite or procedure room\* (Numerator ANAE CI 1.1)

### Outcome Indicators

Outcome refers to the result of care and outcome indicators provide quantitative data related to the outcomes of health system performance.

An example of an outcome indicator is:

- Number of patients undergoing treatment for postoperative nausea and vomiting in the post-anaesthesia recovery room\* (Numerator ANAE CI 3.2)

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<sup>5</sup> ACHS Performance and Outcomes Service. *Anaesthesia and Perioperative Care version 6: Clinical Indicator User Manual*. Sydney NSW; Australian Council on Healthcare Standards; 2015.

It is often difficult to develop definitive outcome indicators and therefore 'surrogate' outcome indicators may be used.

According to Donabedian<sup>6</sup>, these three areas of care are interlinked, in that sound structures facilitate good processes, which in turn facilitate positive outcomes, the endpoint of care. Donabedian postulated that quality improvement is enabled by receiving feedback about these three aspects of care and responding to that feedback. He called these measures, indicators of quality. Indicators of quality are not direct or definitive measures of quality in themselves. Rather as their name suggests they **indicate** areas of care requiring greater scrutiny.

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<sup>6</sup> Donabedian A. The quality of care. How can it be assessed? *JAMA* 1988; 260(12): 1743-1748.



## Clinical indicator development and review

The Performance and Outcomes Service (POS) has a collaborative framework for developing ACHS/ ACHSI Clinical Indicators which is based on:

- Established working relationships with medical colleges, associations, societies and other relevant clinical organisations
- A multidisciplinary approach to indicator development
- Development of a broad range of CIs for use in acute and non-acute settings
- Provision of clinical coding to align and automate indicators
- Provision of regular analyses/reports to individual organisations
- Publication of an annual report of indicator results and trends

New indicator sets are developed when there is interest from specialty organisations. An indicator set is regularly reviewed to ensure:

- it is relevant for clinicians
- it remains reflective of today's health care environment
- there is consensus of collection and reporting requirements
- the set remains useful for quality improvement.

For more information about the development process please contact the Performance and Outcomes Service on +61 2 9281 9955.

## Benefits of performance data

The benefits of collecting performance data (such as clinical indicators) are outlined below:

- Formal clinical audit processes inherent in the Performance Data Program encourage evaluation of care by the relevant clinicians. Clinician involvement is imperative if quality improvements are to be achieved.
- Strategic benchmarking program which provides comparison of results with national and peer group organisations and is the largest clinical data set of its kind in Australasia.
- The six-monthly dashboard reports enable early recognition of areas of potential improvement.
- The evidence addressing the utilisation of performance data and the associated involvement of relevant clinician groups supports accreditation through demonstration of achievement of appropriate levels of clinical quality.

## Utilising performance data

There are 23 clinical indicator sets and over 330 CIs to choose from in the ACHS Performance Data Program. The Program also supports the Australian Commission on Safety and Quality in Healthcare (ACSQHC) Clinical Care Standard indicators for local monitoring. There is no requirement that an organisation monitor a specific number of indicators, although demonstration in certain areas such as colonoscopy is mandated under the ACSQHC accreditation program. Organisations are required to consider indicators that relate to the health services they provide and are appropriate to their size and type of organisation.

The ability to effect improvements in patient care will depend on the relevance of the indicators being monitored. To identify indicators which are potentially relevant and appropriate, the following points should be considered:

- Will the information be useful and meaningful to clinicians in demonstrating how the service is performing and ways that it may be improved?
- Will the data be accessible to clinicians to allow for monitoring of the indicator?
- Are existing resources sufficient to allow for ongoing monitoring of the indicator?

The ability of the indicator data to influence and improve the standards of clinical care is dependent on the relevance of the indicator to current clinical practice (largely determined by the relevant medical college, society or association), and the resources available to support clinicians in assessing the data and considering alterations to either individual or clinical unit practice. Utilisation of data occurs at local organisational and national levels.

### Local organisational level

Six-monthly dashboard reports, generated in Metrik, provide quantitative data identifying variation from total aggregate and a multitude of peer group rates. The heatmap in the dashboard highlights results which are statistically significantly different to all other organisations submitting data for that particular indicator and where the results are undesirably lower or higher than the expected rate. Trend rates and benchmarking provided along with stratified peers allows an organisation to gain context to their data, enabling them to enact relevant change when they are significantly different to their peers.

Utilisation of indicators is not mandatory within large parts of the accreditation process. However, all organisations are required to show evidence of monitoring, evaluation and improvement using clinical data. Monitoring relevant data within a benchmarking program is one method by which this can be achieved.

### National or International Level: The Clinical Indicator Report

In the Clinical Indicator Report, the data is assessed from a national perspective providing a statistical analysis of aggregated results for each of the published indicators. The results provide health policy planners with relevant information,

particularly results addressing access issues, and professional organisations, such as medical colleges and societies, with information highlighting variation in practice which may assist in improving standards of care.

## How do we structure indicators?

All ACHS / ACHSI clinical indicators (CIs) follow a similar structure with an example given below:

### INFC AREA 4: Vancomycin resistant enterococci (VRE)

#### Rationale

According to the Australian Group on Antimicrobial Resistance (AGAR), the prevalence of VRE infection is rising in Australia. These healthcare-associated infections (HAIs) are commonly seen in high-risk areas such as intensive care units, haematology and oncology units and dialysis centres.

(See Background for more information)

#### Reporting period

1 January – 30 June

1 July – 31 December

#### Inclusions

- Only vancomycin resistant enterococci (VRE) laboratory confirmed bloodstream infections are to be **INCLUDED**.

#### Exclusions

- VRE colonisations are to be **EXCLUDED**.

#### Data cleaning rules

- Nil

#### Definition of terms

A **healthcare-associated infection (HAI)** is an infection that occurs as a result of a healthcare intervention. Infections identified > 48 hours after the admission and not incubating on admission or ≤ 48 hours after discharge should be reported as HAIs. Infections identified ≤ 48 hours after the admission need further evidence to be confirmed as HAIs. Please refer to the Australian Commission on Safety and Quality in Health Care (ACSQHC)<sup>1</sup> and National Health and Medical Research

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1. Implementation Guide for Surveillance of *Staphylococcus aureus* Bacteraemia. Australian Commission on Safety and Quality in Health Care; 2013.  
[https://www.safetyandquality.gov.au/wpcontent/uploads/2012/02/SAQ019\\_Implementation\\_guide\\_SAB\\_v10.pdf](https://www.safetyandquality.gov.au/wpcontent/uploads/2012/02/SAQ019_Implementation_guide_SAB_v10.pdf)

Council (NHMRC) Australian Guidelines for the Prevention and Control of Infection in Healthcare<sup>1</sup> for further clarification.

For the purpose of CI 4.1:

AIHW's definition at <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162> is used for 'bed days' or 'patient days' calculated by counting the total patient days of those patients separated during the specified period, including those admitted before the specified period. Patient days of those patients admitted during the specified period who did not separate until the following reference period are not counted.

For the purpose of CI 4.1:

ICU bed days are defined as the total number of occupied bed days in the intensive care unit (ICU).

### Indicator(s) within this Area

#### CI 4.1: VRE infection within the ICU (L)

<b>Numerator</b>	Number of ICU associated new vancomycin resistant enterococci (VRE) healthcare-associated infections, during the 6-month reporting period.		
<b>Denominator</b>	Number of ICU bed days, during the 6-month reporting period.		
<b>Desirable rate:</b>	High <input type="checkbox"/>	Low <input checked="" type="checkbox"/>	Not specified <input type="checkbox"/>
<b>Indicator type:</b>	Structure <input type="checkbox"/>	Process <input checked="" type="checkbox"/>	Outcome <input type="checkbox"/>

### Background

In 1986, the first noted cases of Vancomycin Resistant Enterococci (VRE) were reported in the United Kingdom and France.<sup>1-3</sup> Since then, the incidence of HAIs as a result of VRE has increased sharply and been prevalent in the United States, Australia and other areas of Europe.<sup>1,2</sup> Considering that vancomycin had been in use for more than 30 years prior to the first reported case of resistance, this came as a shock to the medical and scientific community.<sup>2</sup> Their belief that resistance to glycopeptides was unlikely to occur dissipated with the wide-spread transmission of VRE in the United States and European hospitals over the subsequent decades.<sup>2</sup>

According to the Australian Group on Antimicrobial Resistance (AGAR), the prevalence of VRE infection is rising in Australia, but not at the same rate as seen internationally.<sup>1</sup> It is believed that this could be partly due to the effective management of colonised patients prior to the transmission of this infection.<sup>1</sup> The most common forms of VRE isolates causing HAIs that result in hospital-associated

2. Australian Guidelines for the Prevention and Control of Infection in Healthcare, National Health and Medical Research Council; 2010. <https://www.nhmrc.gov.au/printpdf/book/export/html/51607>

morbidity and mortality are *Enterococcus faecium* and *Enterococcus faecalis*.<sup>3</sup> These HAIs are commonly seen in high-risk areas such as:

- Intensive Care Units
- Haematology and Oncology Units
- Dialysis Centres.<sup>1,4,5</sup>

"The emergence of resistance to various antimicrobial agents, specifically to vancomycin, has become a major clinical and epidemiological threat".<sup>6</sup> This resistance usually occurs with the heavy use of glycopeptides and broad spectrum antibiotics in the aforementioned high-risk areas.<sup>5,6</sup> The treatment options for enterococcal sepsis are limited due to the emergence of vancomycin resistance.<sup>5</sup> The most clinically relevant resistant phenotypes are:

- *vanA* - acquired high-level resistance to vancomycin and teicoplanin
- *vanB* - acquired moderate level resistance to vancomycin and *in vitro* susceptibility to teicoplanin.<sup>1,5,7,8</sup>

In order to reduce the transmission of this infection in hospitals, it is recommended that screening for VRE occur in an outbreak situation, which is in line with the HCO's guideline. Once the laboratory has confirmed the presence of VRE infection, it is imperative that the key personnel be notified to initiate the appropriate contact precautions.<sup>5</sup> The process to prevent the transmission of infection for those admitted and transferred between wards should involve:

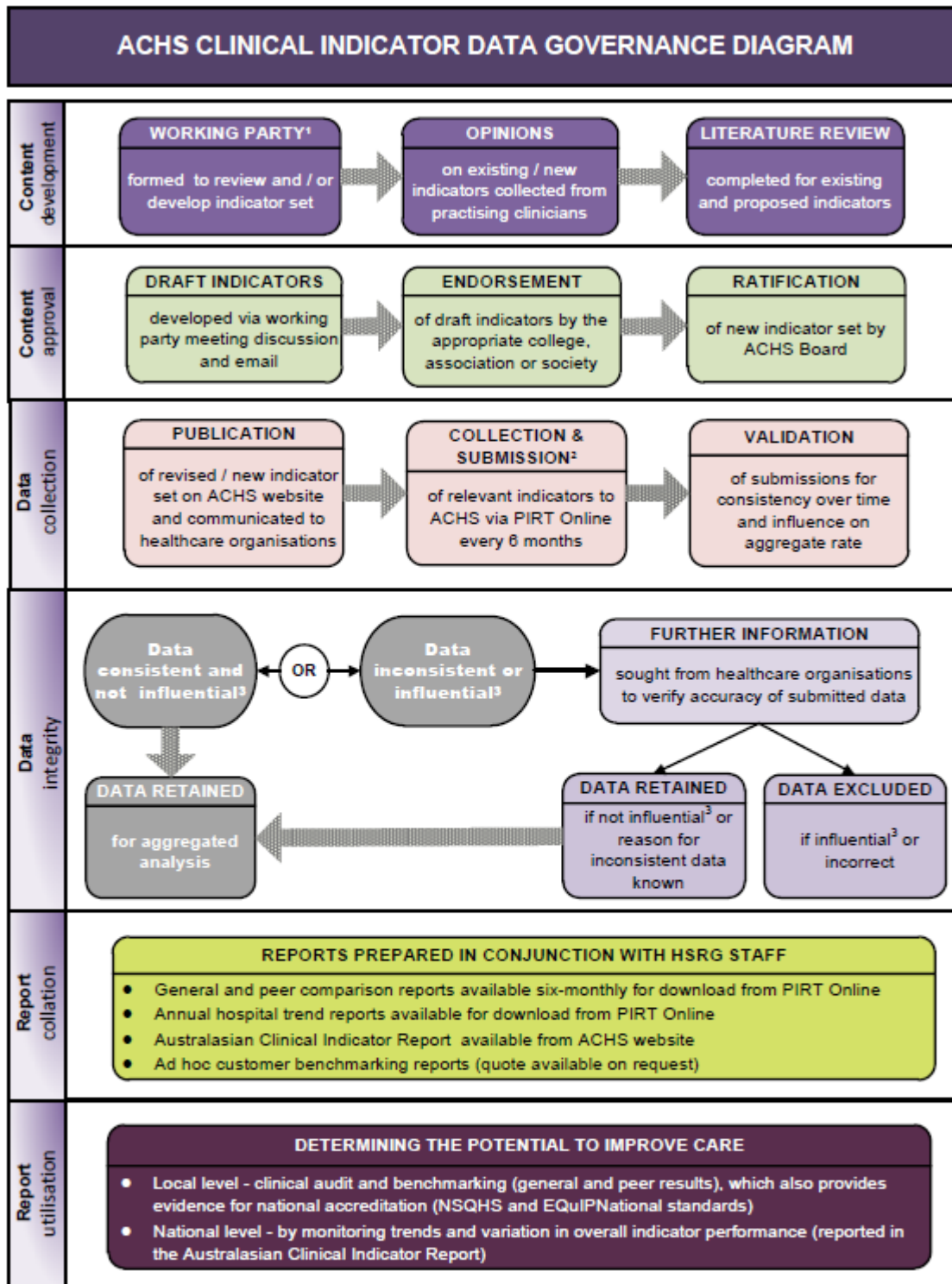
- Medical practitioner(s) responsible for the care of the patient
- Nurse in charge of the ward or unit
- Infection control personnel
- Other personnel specified in the healthcare organizations VRE policy.<sup>5</sup>

## References

1. Australian Commission on Safety and Quality in Health Care (ACSQHC). Reducing harm to patients from health care associated infection: the role of surveillance. Sydney NSW: ACSQHC; 2008.
2. Cattoir V, Leclercq R. Twenty-five years of shared life with vancomycin-resistant enterococci: is it time to divorce? J Antimicrob Chemother. 2013;68(4):731-42.
3. Lu C-L, Chuang Y-C, Chang H-C, Chen Y-C, Wang J-T, Chang S-C. Microbiological and clinical characteristics of vancomycin-resistant *Enterococcus faecium* bacteraemia in Taiwan: implication of sequence type for prognosis. J Antimicrob Chemother. 2012;67(9):2243-9.
4. Queensland Health. Screening and Clearance of Multi-resistant Organisms (MRO) June 2012 10th December, 2013. Available from: [http://www.health.qld.gov.au/chrisp/policy\\_framework/guideline\\_4\\_MRO.pdf](http://www.health.qld.gov.au/chrisp/policy_framework/guideline_4_MRO.pdf).
5. South Australia Health. Guidelines for the Management of Patients with Vancomycin-resistant *Enterococcus* (VRE) Colonisation/Infection. Management of Multi-Resistant Organisms [Internet]. August 2012 12th December, 2013. Available from: <http://www.health.sa.gov.au/INFECTIONCONTROL/Default.aspx?tabid=115>.

6. Hayakawa K, Marchaim D, Martin E, Tiwari N, Yousuf A, Sunkara B, et al. Comparison of the clinical characteristics and outcomes associated with vancomycin-resistant *Enterococcus faecalis* and vancomycin-resistant *E. faecium* bacteremia. *Antimicrob Agents Chemother.* 2012;56(5):2452-8.
7. Centre for Healthcare Related Infection Surveillance and Prevention. Protocol for the management of patients with vancomycin resistant *Enterococcus* (VRE) April 2013 10th December, 2013. Available from: <http://www.health.qld.gov.au/directives/docs/ptl/qh-hsdptl-029-2.pdf>.
8. Healthcare Infection Surveillance Western Australia (2012). HISWA Surveillance Manual. Perth WA: HISWA.

## Performance Data Governance Diagram



1 Nominated representatives from relevant key health bodies (medical and health professional colleges, associations, and societies), consumer organisations, Health Services Research Group, and ACHS staff  
 2 First 12 months of a revised / new indicator set is considered a field study and monitored closely  
 3 Statistically influences aggregated data



## Data Reporting

### Data collection periods

There are two reporting periods each year:

- January to June - Organisations must submit their data by **20 August**
- July to December - Organisations must submit their data by **20 February**

### The collection, analysis and reporting system

Program members are supplied with comprehensive information on how to collect the data which is supplied in the clinical indicator user manuals. Further support is provided by Performance and Outcome Service team members via phone and email. ACHS/ACHSI is not prescriptive about how an organisation collects the data, for example some indicators are collected via manual audit of medical records while others can be generated from internal computer systems, such as adverse event or risk management systems. Organisations should ensure they collect the information in strict accordance with the definitions in the user manual. This ensures that data submitted is consistent.

Organisations are required to submit their data using the Metrik Tool. This tool is an online website where data can be submitted and where the analytics benchmarking can be viewed. It is accessible via your ACHS/ACHSI username and password.

### Reports to individual healthcare organisations

The dashboard is updated on a six-monthly basis after each data submission and are designed with simplicity and ease of use in mind. Compare your facility's performance against all others submitting data for an indicator and against similar (peer group) facilities.

Each report provides information to identify statistically significant differences between the individual organisation, all organisations and peer groups. Outlier data is easily flagged in the heatmap diagram for follow up and to facilitate communication of results to relevant clinicians and management.

The reports also provide for each individual indicator the going trend (including 20<sup>th</sup> and 80<sup>th</sup> centiles) as well as the spread of the data and breakdown by quartiles in a box and whiskers plot. Your data (the green dot) is then able to be compared with your peers.

The dropdown menus on the side for dashboard allow for deeper peer comparison, by set stratification, organisational stratification, rurality, and location. The graphical description and results automatically update based on your peer comparison.

The dashboards are updated approximately four to six weeks after the end of the data submission period. A sample dashboard is provided in Appendix 1.

## Published reports

The ACHS/ACHSI publication, the *Clinical Indicator Report (CIR)*, is published annually and reports aggregated results on all indicators at both a national and international level.

The publication identifies:

- The aggregate rates.
- The 20<sup>th</sup> and 80<sup>th</sup> centiles – the rates at which the top 20% of organisations are already performing and regarded as the goals to achieve depending on whether the desired rate is low or high.
- The trends in incidence since establishment of the national data set.
- Significant variation of rates of performance.
- Rate differences between various strata - public and private, metropolitan, non-metropolitan and states.

## Custom benchmarking reports

The POS team is also able to provide corporate groups with custom benchmarking reports which allow comparison of indicator rates within a specific group of organisations, for example, a Local Health Network or a private hospital group. These reports are typically supplied in excel format allowing members to perform further analysis if required. However, they will be available in dashboard format soon.

## Reports to the relevant college, association, or society

To assist in the development and review of indicators, reports are developed for the medical colleges, associations, societies, and other relevant clinical organisations which participate in the update. The reports describe any statistically significant differences between strata such as, public / private sector HCOs, non-metropolitan / metropolitan and location (e.g., Country / State). Each college, society, association is also invited to comment on the results and remark on any variations in practice. Expert commentary from colleges are published each year in the *Clinical Indicator Report*.

## Interpreting the clinical indicator reports

Organisations need to review the results of the comparative reports to see if there is any statistical difference between their rate and the general or peer comparison rate, based on the relevance to the organisation. When differences are identified organisations need to question why there is a difference. The indicators are not case or risk adjusted (due to the lack of a large anonymising pool of matched peers across social strata) however the peer group stratifications are regularly reviewed to ensure similar organisations are being compared. By reviewing results with risk management in mind, you can prioritise areas for quality improvement.

It is important to remember that variations in the data collected can be found in almost every indicator. There will almost always be a range of performance identified. There are many reasons for these variations. It is not always possible to identify the reasons for the variation. If variation is found however, it is essential that healthcare providers thoroughly examine the cause and implement action for improvement if required.

Indicators flagged as significantly different should be investigated at the organisational level to determine the reason for this difference.

To investigate results and implement change an organisation should follow a quality improvement process such as the Plan, Do, Check, Act cycle or Clinical Practice Improvement Method.

In combination with other quality improvement strategies, indicators can allow for successful probing of potential and actual problems. Other data sources that can be used in combination with the indicators may include:

- adverse events and/or complication data
- incident reports
- consumer complaint data
- staff or patient satisfaction survey data.

## What clinical areas does the dataset cover?

Currently the ACHS has 23 clinical indicator sets. Below is a listing of the current indicator sets and the areas which they cover.

### **Ambulance Health Services version 1**

Patient assessment  
Clinical interventions  
Medication errors  
Behaviours of concern  
Transition of care  
Patient experience

### **Cancer Care version 1.3**

Access  
Assessment  
Treatment  
Outcomes  
Follow-up  
Support services

### **Emergency Medicine version 7.1**

Waiting time  
ST-segment elevated myocardial infarction (STEMI) management  
Emergency department mental health presentations  
Critical care  
Sepsis management  
Discharge communication  
Pain management  
Unplanned re-attendance

### **Anaesthesia & Perioperative Care version 7.1**

Pre-anaesthesia period  
Intraoperative period  
Patient recovery period  
Postoperative period  
Obstetric anaesthesia care

### **Day Patient version 6.2**

Preadmission preparation  
Procedure non-attendance  
Procedure cancellation  
Episode of care adverse events  
Unplanned return to the operating room  
Unplanned transfer / admission  
Discharge  
Departure  
Post-discharge follow-up

### **Gastrointestinal Endoscopy version 3.4**

Failure to reach caecum / neo-terminal ileum  
Colonoscopy adverse outcomes  
Adenoma detection  
Oesophageal perforation after dilatation  
Aspiration following GI endoscopy  
Sedation in GI endoscopy

### **Geriatric Care version 1**

Functional Assessment and planning  
Medications  
Discharge  
Unplanned readmissions

### **Gynaecology version 8.1**

Blood transfusion  
Injury to a major viscus  
Laparoscopic management of an ectopic pregnancy  
Thromboprophylaxis for major gynaecological surgery  
Hysterectomy

### **Hospital in the Home version 6**

Patient safety, selection, communication and care co-ordination  
Service interruption  
Unexpected deaths

### **Hospital-Wide version 13.5**

Hospital readmissions  
Return to operating room  
Pressure injuries  
Inpatient falls  
Patient deaths  
Blood transfusion  
Thromboprophylaxis  
Minimum standards for rapid response system (RRS) calls  
Surgery  
Risk Assessment

### **Infection Control version 5.2**

Infection surveillance  
Surgical antibiotic prophylaxis (SAP)  
Haemodialysis access-associated bloodstream infection surveillance  
Vancomycin resistant enterococci  
Staff immunisation  
Occupational exposures to blood and / or body fluids  
Surgery & Risk Assessment

### **Intensive Care version 6**

Access and exit block  
Intensive care patient management  
Intensive care patient treatment  
Central line-associated bloodstream infection  
Utilisation of patient assessment systems  
Empathetic practice

### **Internal Medicine version 6.2**

Cardiovascular disease  
Endocrine disease  
Acute stroke management  
Care of the elderly  
Respiratory disease  
Gastrointestinal disease  
Oncology

### **Medication Safety version 4.2**

Antithrombotic therapy  
Antibiotic therapy  
Medication ordering  
Pain management  
Continuity of care  
Hospital wide policies

### **Ophthalmology version 7.1**

Cataract Surgery  
Intraocular glaucoma surgery  
Retinal detachment surgery

### **Maternity version 9.1**

Outcome of selected primipara  
Vaginal birth after caesarean section (VBAC)  
Perineal Trauma  
Exclusive Breastfeeding  
Postpartum haemorrhage and blood transfusions  
Foetal growth restriction (FGR)  
Apgar score  
All admission of term neonate to a neonatal intensive care nursery (NICN) or special care nursery (SCN)  
Severe acute maternal morbidity

### **Mental Health version 8.2**

Diagnosis and care planning  
Physical examination of patients  
Prescribing patterns  
Electroconvulsive therapy  
Use of seclusion and restraint  
Major critical incidents  
Mental Health Act status  
Continuity of care  
Community care

### **Oral Health version 5.3**

Returns to the dental centre  
Endodontic treatment  
Children's dental care  
Preventative Services

### **Paediatrics version 5.2**

Appropriateness

Adverse events

Documentation

Paediatric anaesthesia

### **Pathology version 5.1**

Chemical pathology

Haematology

Anatomical pathology

Microbiology

Point of care testing

Whole of service

Immunopathology

### **Radiation Oncology version 6**

Consultation process

Treatment planning

Treatment delivery

### **Radiology version 7**

Adverse patient events

CT dosimetry

Patient identification and consent

Critical test result notification

Report turnaround time

### **Rehabilitation Medicine version 7**

Timely assessment of function on admission

Timely establishment of an initial multidisciplinary rehabilitation plan

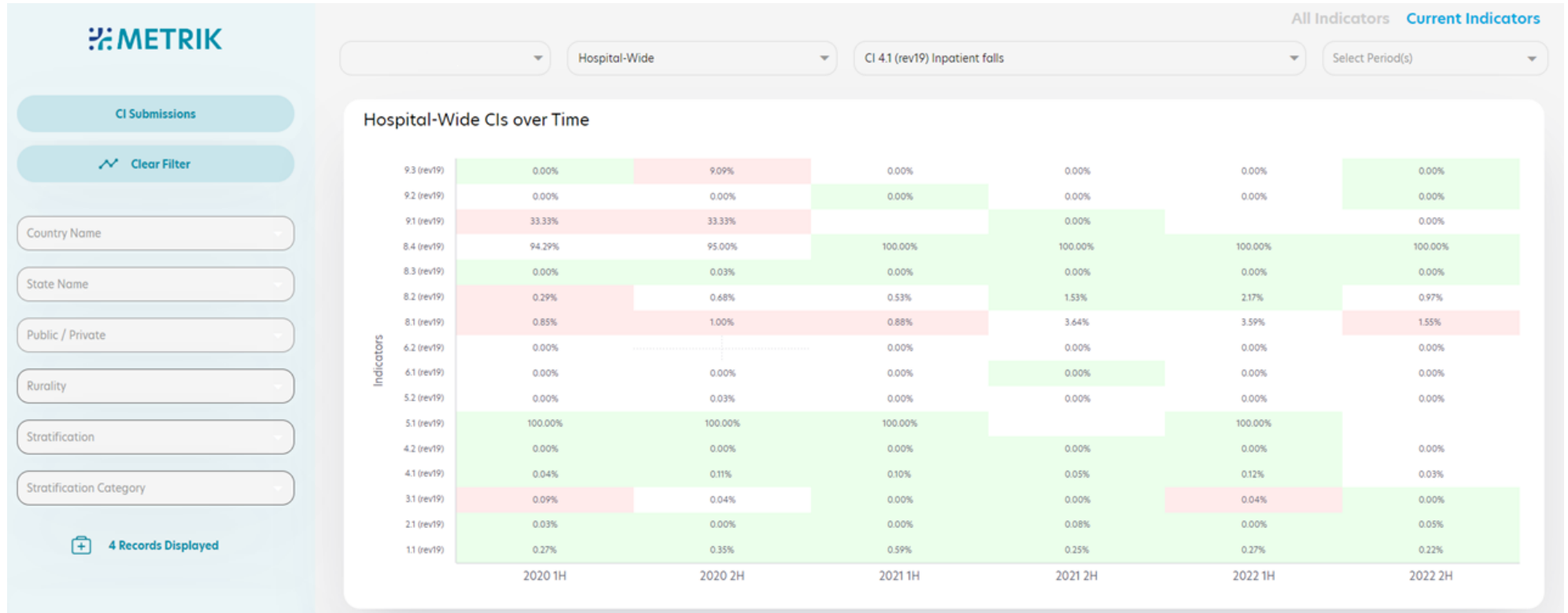
Functional gain achieved by rehabilitation program

Discharge destination

Rate of fallers

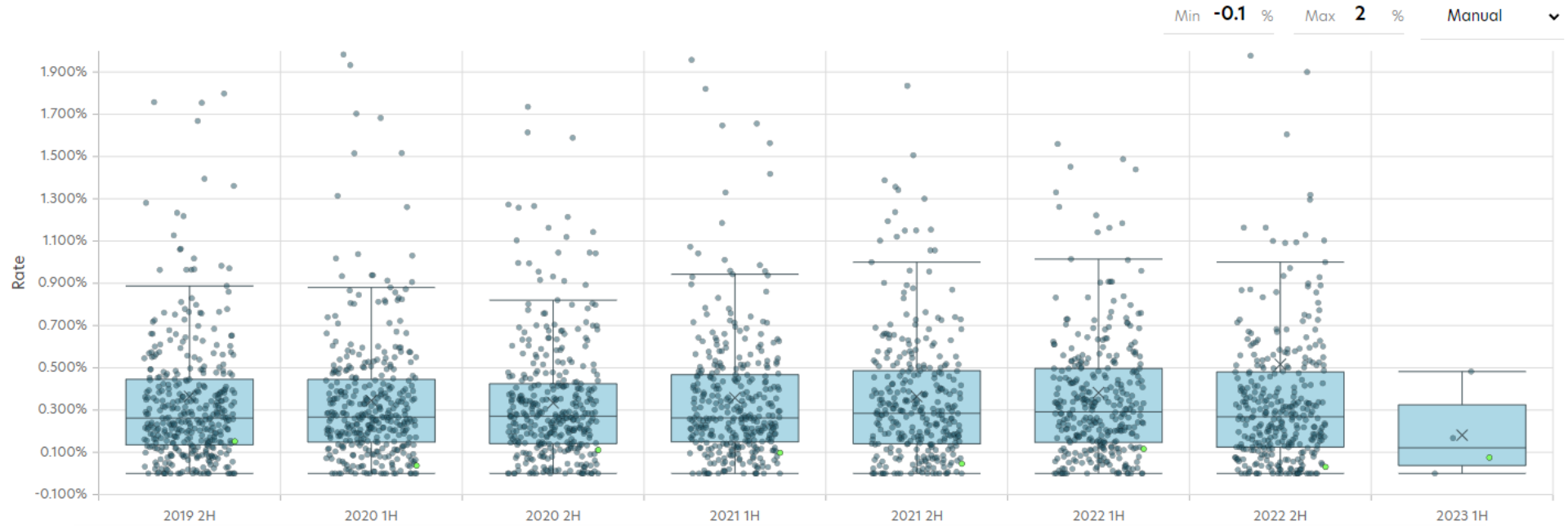
Rehabilitation Intensity

# Appendix 1: Sample Dashboard



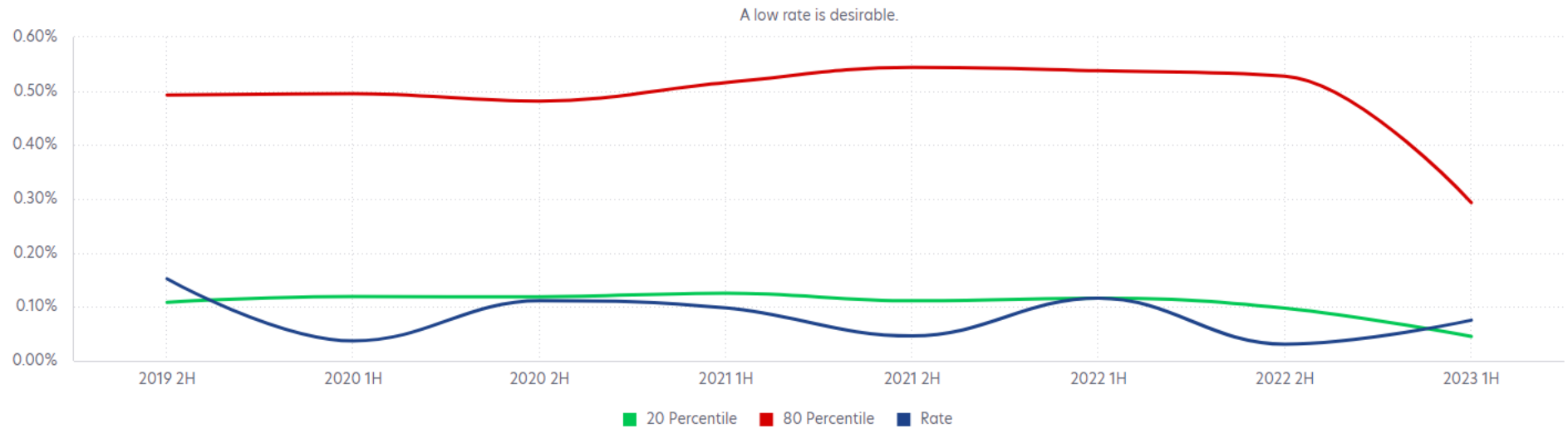


## Clinical Indicator vs. Benchmark



Period	2019 2H	2020 1H	2020 2H	2021 1H	2021 2H	2022 1H	2022 2H	2023 1H
<b>Your Rate</b>	0.152%	0.037%	0.111%	0.098%	0.046%	0.116%	0.031%	0.075%
<b>Aggregate Rate</b>	0.275%	0.293%	0.288%	0.323%	0.305%	0.311%	0.286%	0.329%
<b>Min</b>	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
<b>Q1</b>	0.136%	0.148%	0.141%	0.151%	0.141%	0.147%	0.125%	0.056%
<b>Median</b>	0.262%	0.266%	0.270%	0.263%	0.284%	0.292%	0.268%	0.121%
<b>Q3</b>	0.445%	0.440%	0.425%	0.468%	0.486%	0.491%	0.477%	0.246%
<b>Max</b>	4.169%	3.411%	1.735%	3.846%	3.008%	6.410%	49.057%	0.482%

CI 4.1 (rev19) Inpatient falls over Time



Should you require further assistance in interpreting the reports, or in how to use the data results for quality improvement activities please contact the POS team on 02 9281 9955 or e-mail [pos@achs.org.au](mailto:pos@achs.org.au)