



QUALITY IMPROVEMENT PRODUCT REGISTRATION FORM

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PLEASE RETURN COMPLETED FORM TO QMS, Suite 10, Level 1/104 Bathurst Street SYDNEY NSW 2000 AUSTRALIA Tel: +61 (0) 2 8246 6900 Fax: +61 (0) 2 9283 7545 Email: qms@qms.org.au

CONTACT DETAILS

Organisation Name:			
Former name if changed in the last 3 years:			
Postal Address:			
Suburb:		State:	
			Postcode:
Street Address:			
Suburb:		State:	
			Postcode:
Website:			
ABN Number:			

Please use page at the end of this form to complete address details for any additional sites.

Who is the organisation's Manager?	Name:		Position Title:	
Telephone:		Facsimile:		
Mobile:		Email:		
Who is responsible for Quality?	Name:		Position Title:	
Telephone:		Facsimile:		
Mobile:		Email:		

GENERAL INFORMATION

1. For each column, please tick the box that best describes the organisation:

<u>Location</u>	<u>Jurisdiction</u>	<u>Sector</u>	<u>Sub-Sector</u>
<input type="checkbox"/> Remote	<input type="checkbox"/> Local	<input type="checkbox"/> Public	<input type="checkbox"/> Charitable
<input type="checkbox"/> Rural	<input type="checkbox"/> Area/regional	<input type="checkbox"/> Private	<input type="checkbox"/> Division of General Practice
<input type="checkbox"/> Urban	<input type="checkbox"/> State	<input type="checkbox"/> Non-government	<input type="checkbox"/> Primary Health Service
<input type="checkbox"/> Metropolitan	<input type="checkbox"/> National		<input type="checkbox"/> Other _____

2. In what health area/region is the organisation: _____

3. Please list all the programs, units or departments within the organisation and the number of actual staff and full time equivalent positions (FTEs) that work in each:

1. _____	Actual staff _____	FTEs _____
2. _____	Actual staff _____	FTEs _____
3. _____	Actual staff _____	FTEs _____
4. _____	Actual staff _____	FTEs _____
5. _____	Actual staff _____	FTEs _____
6. _____	Actual staff _____	FTEs _____
7. _____	Actual staff _____	FTEs _____
Total:	Actual staff _____	FTEs _____

4. What word processing software does the organisation use? _____

5. Does your organisation receive any government grants? (please tick one) YES NO

6. If YES, for each grant, please complete the following:

	%	\$		
Grant in relation to total funding:			Source of grant:	
Grant in relation to total funding:			Source of grant:	
Grant in relation to total funding:			Source of grant:	
Grant in relation to total funding:			Source of grant:	

7. Please tick the box which best describes the **overall type of services** the organisation provides **(please choose ONE ONLY)**:

- | | | |
|---------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Aboriginal controlled health service | <input type="checkbox"/> Accommodation and support | <input type="checkbox"/> Aged Care |
| <input type="checkbox"/> Bush nursing | <input type="checkbox"/> Child and family | <input type="checkbox"/> Chronic disease support |
| <input type="checkbox"/> Community legal service | <input type="checkbox"/> Counselling | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Disease Specific | <input type="checkbox"/> Division of GP | <input type="checkbox"/> Drug and alcohol |
| <input type="checkbox"/> Health promotion | <input type="checkbox"/> Health service district | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Home based care | <input type="checkbox"/> Hospital | <input type="checkbox"/> Info, referral and advice |
| <input type="checkbox"/> Local government | <input type="checkbox"/> Maori health (NZ) | <input type="checkbox"/> Maori mental health (NZ) |
| <input type="checkbox"/> Maori multi service (NZ) | <input type="checkbox"/> Maori social services/training (NZ) | <input type="checkbox"/> Men's health |
| <input type="checkbox"/> Mental health | <input type="checkbox"/> Migrant/refugee health | <input type="checkbox"/> Multi purpose service |
| <input type="checkbox"/> Multi service agency | <input type="checkbox"/> Oral health | <input type="checkbox"/> Pacific health (NZ) |
| <input type="checkbox"/> Pacific mental health (NZ) | <input type="checkbox"/> Pacific multi-service (NZ) | <input type="checkbox"/> Pacific social services/
training (NZ) |
| <input type="checkbox"/> Palliative care | <input type="checkbox"/> Peak organisation or
coordinating body | <input type="checkbox"/> Primary and community
health service |
| <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Sexual assault | <input type="checkbox"/> Sexual health |
| <input type="checkbox"/> Specialist health | <input type="checkbox"/> Training and education | <input type="checkbox"/> Women's health |
| <input type="checkbox"/> Youth health | <input type="checkbox"/> Other: (please specify) _____ | |

8. Please tick the box(es) which best describes the activities the organisation undertakes:

- | | | |
|------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Adolescent mental health | <input type="checkbox"/> Adult mental health | <input type="checkbox"/> Advice line |
| <input type="checkbox"/> Aerial medical services | <input type="checkbox"/> Aged health | <input type="checkbox"/> Antenatal care |
| <input type="checkbox"/> Clinical nursing | <input type="checkbox"/> Community midwifery | <input type="checkbox"/> Community nursing |
| <input type="checkbox"/> Community development | <input type="checkbox"/> Communicable disease control | <input type="checkbox"/> Community options |
| <input type="checkbox"/> Counselling | <input type="checkbox"/> Crisis line | <input type="checkbox"/> Day respite care |
| <input type="checkbox"/> Dental services | <input type="checkbox"/> Diabetes services | <input type="checkbox"/> Dietary services |
| <input type="checkbox"/> Disability services | <input type="checkbox"/> Domestic violence advocacy | <input type="checkbox"/> Domiciliary nursing |
| <input type="checkbox"/> Domestic violence crisis | <input type="checkbox"/> Environmental health | <input type="checkbox"/> Ethnic health (inc. PI) |
| <input type="checkbox"/> Family planning | <input type="checkbox"/> Hearing services | <input type="checkbox"/> Home care |
| <input type="checkbox"/> Home visits | <input type="checkbox"/> Immunisation | <input type="checkbox"/> Information service |
| <input type="checkbox"/> Library | <input type="checkbox"/> Medical (GP) | <input type="checkbox"/> Needle exchange |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Palliative care | <input type="checkbox"/> Parenting programs |
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Podiatry | <input type="checkbox"/> Postnatal care |
| <input type="checkbox"/> Pregnancy help | <input type="checkbox"/> Public health | <input type="checkbox"/> Rape crisis |
| <input type="checkbox"/> Referral service | <input type="checkbox"/> Renal health | <input type="checkbox"/> Social work |
| <input type="checkbox"/> Sexual assault survivors' support | <input type="checkbox"/> School dental services | <input type="checkbox"/> Speech therapy |
| <input type="checkbox"/> Stomal therapy | <input type="checkbox"/> Other: (please specify) _____ | |

QUALITY IMPROVEMENT PRODUCT INFORMATION

1. Which Quality Improvement product is the organisation registering to use? (Please tick one or more where a multiple compliance review is required)

- a) QIC Accreditation Review or b) Service Development Review QIC
(go to question 2) (go to question 2)
- c) Service Excellence Framework Validation - d) HACC Appraisal - For South
For South Australia only (go to question 4) Australia only (go to question 4)
- e) Self-Assessment with Desktop audit
(go to question 3)

2. Which QIC review model is the organisation registering to use? (Please tick one)

- Standard Incremental
 Small Organisation (7 or less FTE staff or volunteers)

3. **All organisations use the QIC Health and Community Services Core Standards and at least one Service Delivery Module.**

Please tick the Service Delivery Module(s) that best describes the type of service your organisation provides:

QIC Standards

- Mental Health Services Module
 Community and Primary Health Care Services Module
 Home Based Care Services Module
 Integrated Health Services Module
 Alcohol, Tobacco and Other Drug Services Module
 Maternal and Infant Care Services Module

Other QIC Endorsed Standards

- QMS Community Services Module
 Palliative Care Standards
 Problem Gambling Services Standards
 Psychiatric Disability Support Services Standards
 Supported Accommodation Assistance Program Standards
 Draft QMS and Women's Health NSW Module of Standards for Women's Health Centres
 HACC National Service Standards

4. If you have ticked a) or b) or c) or d) for question 1 then:

What is preferred date for on-site External Review? _____

If you have ticked e) for question 1 then:

What is preferred date for submitting the completed Self-assessment? _____

5. From the list below, identify the organisation's four most important objectives in using this Quality Improvement Product (tick maximum of four).

- | | |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> To assess current level of quality across all areas of organisation | <input type="checkbox"/> To have access to and use the broad quality improvement resources and experience of QMS and the review team |
| <input type="checkbox"/> To improve the quality of services provided | <input type="checkbox"/> To identify areas for improvement |
| <input type="checkbox"/> To improve quality across all areas of the organisation | <input type="checkbox"/> To identify areas of achievement |
| <input type="checkbox"/> To meet funding requirements | <input type="checkbox"/> To align the organisation with national standards |
| <input type="checkbox"/> To improve policies and procedures | <input type="checkbox"/> To facilitate planning for the future |
| <input type="checkbox"/> To further develop CQI systems | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> To achieve QIC accreditation | |

6. Who was involved in deciding the organisation would use this Quality Improvement Product? (Please tick one)

- Senior management in consultation with middle management
- Senior management in consultation with middle management and staff
- Middle management
- Middle management in consultation with staff
- Collaborative decision with representatives from senior management, middle management and staff involved
- Other (please state): _____

7. Has the organisation previously been assessed or accredited by any other agency? (Please tick one) YES NO

8. If YES, which Agency and Standards were used?

What was the date of the assessment? _____

9. Are there external/funder standards that the organisation needs to demonstrate compliance with? (Please tick one) YES NO

10. If YES, please list?

11. Do you have access to the internet to download the relevant resources? (Please tick one) YES NO

12. Do you wish to register for the facility of completing the Quality Journal online on the Quality Improvement Council (QIC) web site? (Please tick one)

YES NO

13. FOR NSW HEALTH NGO QUALITY IMPROVEMENT PROGRAM REGISTRATIONS ONLY

From the list below, identify the organisation's **three** greatest areas of need for capacity building activities (**tick three only**).

- | | |
|--------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Cultural safety and appropriateness | <input type="checkbox"/> Human resources management |
| <input type="checkbox"/> Community capacity building | <input type="checkbox"/> Information technology |
| <input type="checkbox"/> Continuous quality improvement | <input type="checkbox"/> Knowledge management |
| <input type="checkbox"/> Consumer participation | <input type="checkbox"/> Occupational health and safety |
| <input type="checkbox"/> Evaluation | <input type="checkbox"/> Risk management |
| <input type="checkbox"/> Financial management | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Governance and leadership | |

DETAILS OF PERSON COMPLETING FORM

Name:		Position:	
Phone Number:			

How did you **first** hear about Quality Management Services? (please tick one only)

- | | |
|----------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Journal article |
| <input type="checkbox"/> Direct mail promotion from QMS | <input type="checkbox"/> Colleague/friend |
| <input type="checkbox"/> Quality Bound (QMS newsletter) | <input type="checkbox"/> Conference presentation |
| <input type="checkbox"/> Conference exhibition booth | <input type="checkbox"/> Referred by a government department |
| <input type="checkbox"/> Referred by a peak body | <input type="checkbox"/> Referred by Quality Improvement Council |
| <input type="checkbox"/> Website (please specify): _____ | |
| <input type="checkbox"/> Other (please specify): _____ | |

Signature:		Date:	
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PLEASE RETURN COMPLETED FORM TO QMS:

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Email: gms@gms.org.au

ADDITIONAL SITES (PLEASE PHOTOCOPY THIS PAGE IF REQUIRED):

Site name:			
Postal address:			
Suburb/Town:		Postcode:	
Street address:			
Suburb/Town:		Postcode:	
Contact person:		Position	
Telephone:		Facsimile:	
Mobile:		Email:	
Site name:			
Postal address:			
Suburb/Town:		Postcode:	
Street address:			
Suburb/Town:		Postcode:	
Contact person:		Position:	
Telephone:		Facsimile:	
Mobile:		Email:	
Site name:			
Postal address:			
Suburb/Town:		Postcode:	
Street address:			
Suburb/Town:		Postcode:	
Contact person:		Position:	
Telephone:		Facsimile:	
Mobile:		Email:	
Site name:			
Postal address:			
Suburb/Town:		Postcode:	
Street address:			
Suburb/Town:		Postcode:	
Contact person:		Position:	
Telephone:		Facsimile:	
Mobile:		Email:	
Site name:			
Postal address:			
Suburb/Town:		Postcode:	
Street address:			
Suburb/Town:		Postcode:	
Contact person:		Position:	
Telephone:		Facsimile:	
Mobile:		Email:	