Submission in Response to Discussion Paper on

NATIONAL SAFETY AND QUALITY ACCREDITATION STANDARDS

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INTRODUCTION

The process of accreditation is a well accepted in medical settings for the evaluation of the provision of services and as such is constantly discussed as to its efficacy.

A. **The most important dictum in medicine is "FIRST DO NO HARM". The council must bear this in mind when they wish to change the accreditation processes.**

B. Accreditation is simply a management tool not a solution to workforce related issues. It can assist in identification of problems and it can assist in the maintenance of skills. **IT CANNOT WORK MIRACLES.**

C. The perspective of this discussion paper is that a complete change of the Accreditation system has already been decided on and asks only for input as to how this is to be done.

   I. However, discussion is needed as to whether a change is a requirement, necessity, or a complete waste of time and money.
   II. If a change is needed, the current system's advantages and flaws must be assessed and documented to ensure improvement of the system is achieved.
   III. This entire discussion paper starts from the assumption that change is the only option and is flawed by its lack of complete assessment of this situation.
   IV. The question really needs to be raised as to whether this is in fact a discussion document or a document informing us of changes already decided upon

DISCUSSION

There are a few very important points that have been raised on the "Discussion Paper" from the National Safety and Quality Accreditation Standards". They are as follows:

Assumption – That there is a need for change.

1. **That there is a need to change the system**. This is the underlying assumption and is not substantiated. The document is fundamentally flawed for its failures it
   A. Fails to identify where the current systems are flawed
   B. Fails to identify how changing the system will address any flaws in the current system
   C. Fails to weigh up whether any flaws are beyond redemption before assuming the system needs changing.
   D. It fails to offer a PROVEN alternative. The new systems discussed (the English and American models) are flawed as will be discussed later and are not yet validated.

Assumption – That the current accreditation processes cannot evolve

2. **<u>The document assumes that the current accreditation process cannot "evolve and keep pace with those changes" however, I suggest that that is one of its main functions and fortes, which it has done well</u>.**

   A. ISO (which I am familiar with) has many systems to identify the need for change and to allow for this through quality improvements.

   B. Just because the mechanisms of providing health care are changing it does not justify changing our system. An analogy illustrates this point.

   I. At the turn of the century if I wanted a clean house I would mop and sweep the floors

   II. In the current time I would probably vacuum the floors

   III. Either way I have achieved a clean floor.

   IV. **<u>I did not have to re-invent housekeeping principles i.e. the requirement for a clean and tidy house, to accommodate to new technology I simply need to train up in how to use a vacuum cleaner and write an appropriate protocol.</u>**

   C. The commission cites "changes in disease and disorder patterns, technologies, drug regimes and health services delivery" as the motivating requirements for the change of the accreditation process. There are a number of points relevant to this statement.

   I. Except for the development of HIV in the late 70's, there have been no new diseases. Any new diseases will be infectious or chemically related and the process for handling these is well established in "infectious disease" or "toxicology" within the appropriate departments in major teaching hospitals.

   II. There have been no new technologies for 20 years since MRI was introduced, just improvements and additions to current technologies such as ultrasound, CAT scans etc.

   III. Changes in drug regimes are handled by the current system of drug protocols, which are continuously updateable.

   IV. "Changes in health care services delivery", is a motherhood statement. The doctor/patient relationship has not changed since the days of Socrates and Lucanus and the delivery and administration of nurses and their delivery of care has not changed in its principles since Nightingale, so there are no new changes in health services delivery.

Health Funds - Their role and requirements

3. Health Funds are considered stakeholders in the accreditation process. **<u>THEY ARE NOT</u>.** In fact, there are a few very important points to be considered here.

   A. Health funds are insurance companies and simply hold the funds for their members.

   B. There are professional bodies that dictate standards. Health funds are not professionals in the "provision of health care". They have staff from accountancy, business, and insurance backgrounds. Admittedly they have a smattering of medical and nursing professionals but these are not in active clinical practice and are not required to be accredited for

current "best practice" in any case and may well be "Out of Date' in their management concepts. They are not even required to keep their registrations current.

C. In other fields the insurers would have no input i.e. if QBE insures a large bridge would we consider it has a right to sit on the boards setting Australian Standard for the construction of bridges or simply acknowledge its right to view the appropriate certification?

D. Are we to allow all insurance companies that issue life insurance to also have a say in this current model as they also have a financial stake-hold in the provision of health care? Where do we stop?

E. Health funds are not required to be accredited also, however they should be accredited in order to

I. Guarantee to their members that they are providing services in an efficient, professional manner
II. That the concerns of members are treated as they should be
III. That the funds are properly managed
IV. That the funds are honouring their statutory requirements
V. To ensure that they are able to assess the accreditation standards of the facilities that they contract with
VI. Considering the vast amounts of money, they control that they prove they are efficient and well-structured institutions to the government. After all if the fund is a large one the government is in a practical sense required to financially "bale them out" if they are financially unsound. This is taxpayer's money and should be looked after.
VII. The ISO system is internationally recognised and could be utilised here as it has a proven business track record.

F. Health funds have financial issues that may result in a "conflict of interest" from time to time with the institutions or health professionals who are accredited and with whom they contract.

G. Health funds exist to provide their fund members with choice of doctor and choice of facility. As long as the facility and health care profession meet the required standards, there should be a requirement for contracting at a reasonable rate with the health care provider. This would ensure financial compensation for the time and money invested in the provision of quality service

Assumption: That accreditation is the most appropriate tool to assess and control standards

4. **<u>The paper assumes that accreditation is the most appropriate tool to assess and control standards</u>** when in fact

    A. Many of the factors involved in safety and the deliverance of standards are beyond the control of the health care provider (as discussed in point 6b).
    B. Accreditation currently does and should deal with processes and their implementation and in reality should not deal with more.
    C. As will be discussed, standards often reflect an individual's commitment and skill base. These factors belong to another domain other than accreditation i.e. medical boards etc.
    D. The current paper seeks to combine the two and make the responsibility that of the end provider.
    E. **<u>This basic assumption requires a great deal more thought!</u>**

Have the deficiencies in our current accreditation process been clearly defined?

5. The commission acknowledges on page 13 that "A preliminary attempt at mapping health care standards has shown this is a complex task….**<u>It is therefore not possible to identify the extent of duplication in standards, nor the gaps in safety and quality that may exist." They state that in the future they will "identify gaps, duplications and conflicts between sets of health safety and quality standards</u>."** This raises a number of important issues:
    A. How can we accredit to outcomes if the standards governing these outcomes are not defined or even identified?
    B. The commission has not even identified if there are gaps in the standards so what are we changing and why?
    C. Why are we changing our accreditation system **<u>before</u>** we identify the standards and gaps? Surely this means that we run the risk of:
        I. Not identify all issues at the beginning and having to redo the whole process
        II. Have financial and professional repercussions to institutions and individuals when outcomes do not meet one set of standards but do meet another.
    D. If we are to be accredited by standards then there is a need to identify
        I. Who is authorised to write standards?
        II. What credentials must be held in order to authorise standards?
        III. Who controls the regulation of the standards?
        IV. What impact will the changing of regulations have on the health system? I.e. will there be due consultation in the process with the relevant health professionals?

Discussion of the UK model

6. The Commission discusses the UK model on page 8. I am unsure whether it is intending to use this model as a template, however below are the points I believe are relevant to this model.

Principle 1. Pursuit of Improvement

A. *"**The purpose of an external assessment is to pursue improvement**."* This is very nebulous. There is no end to measure against. The goal posts can move forever. Who determines improvement?

Principle 2. Focus on Patient Outcomes

B. *"**The focus of an accreditation visit is patient outcomes.**"* **This is fine if all the people and elements involved in this process of determining these outcomes are:**

I. Equal. I.e. if outcomes are the only measurement, patients who are complicated and represent a high risk will not be accepted for surgery or treatment, for fear that they will "mess up the outcomes". **Patients who may have a 50 % chance of dying under anaesthetic may not even be given the 50% chance of living if the system is punitive which outcomes basis is.**

II. Controllable:

a. Doctors, nurses, and every other profession are made up of groups of people with heterogeneous levels of experience, competence, and commitment.

b. The hospital cannot adjust for this in any way. How can it be accountable when it is dependent on these people and is in a state of skilled worker shortage?

c. How do I "control" a surgeon and make him operate better? Not every surgeon is a Christian Barnard, nor do they need to be. We can all identify the "Doctor Deaths" but how about the surgeon who is 70% as good as your best for example (although how you can assess that, I am not sure. We just know some surgeons are more dextrous than others.) **Are we expected to send him or her back to training?**

d. I am aware that the commission is intending to accredit all area of the health profession, however, an outcomes based system assumes that all human beings are exactly the same and are capable of being trained up to be at the "top of the tree". There is no doubt that we all aspire to excellence, however in the event of it not being achieved; who will the

commission hold as responsible. Will it be the hospital, the surgeon, or the nurses or will it be everyone. Is this practical?

e. Who will decided in a scientific way what is an acceptable outcome for a patient and how will the commission ensure that there are no biases that result in discrimination?
f. How do you allow for a newly trained surgeon when comparing “outcomes” to those achieved by a surgeon who has been in practice for thirty years?
g. How do we implement the new concept of training registrars in private hospitals if the hospital accreditation can be compromised in so doing?
h. How do we allow for the training of registrars in the pubic system?
i. How do you compare” outcomes” in rural Australia where the overall facilities are not as good with those achieved in major teaching hospitals? Not only is there not as much physical backup in equipment, there is often not as many skilled support staff and the doctors are often junior in these areas.
j. **How do you allow for agency staff and casual staff? This is a reality of life.** Many agency staff are not trained fully in the area they work in for their shift, yet there is no alternative except closing the doors. They can certainly affect outcomes however, not having these members of staff may result in even greater problems for the patient
k. **How do you allow for the frailties of human error?**
l. **Patients are living longer, have greater co-morbidities, and take far greater skill to manage.** The “outcome” of a complex patient aged 80 may be poor on this admission; however 20 years ago he or she may well have died from disease processes that are now treated successfully. ***Is it a bad outcome at this admission or a “bloody good outcome" for the fact that they have had twenty years extra life.***
m. **There are so many patient variables here**.
    i. No two patients are in the same physical state necessarily when they enter the operating room or hospital.
    ii. **Some doctors are more competent than others and recognised as such by their peers. They are sent the complicated and difficult work. Their complication rates are often much higher than a less competent surgeon who will look better on paper.**

The patients understanding and compliance also determine patient outcomes. What happens if a hospital is in a lower socio-economic area? How will the system adjust for this? St Vincent’s Hospital in Sydney is a classic case in question. How do you assess the “outcomes” of their patients in the Emergency

Department when a lot of their patients are drug affected? These patients are admitted time and time again with the same problems and no improvement of outcomes yet the hospital is providing a valuable service to the best of their ability.

n. **Outcomes based accreditation requires honest reporting of incidents.** In this system, you rely on accurate records of complications. **IF THERE IS A FINANCIAL PENALTY FOR REPORTING ADVERSE OUTCOMES, THEY MAY NOT BE REPORTED. MASKED PROBLEMS WILL BE A HUGE PROBLEM FOR THE HEALTH SYSTEM.**

   i. **Adverse outcomes can be masked by just not coding them.** Under these circumstances, the auditor will never find them unless they audit every file. Good luck!

   ii. **Who owns the complications can be a difficult question?** Even in something as apparently black and white case as a surgical death, the issue can be clouded.

      1. For example, if a cardiologist performs an angioplasty and ruptures a coronary artery and the patient is taken to theatre and dies is it attributable to the surgeon or the cardiologist?
      2. Conversely, if you have a particularly competent surgeon who" bails out" a cardiologist routinely, he may mask a poorly performing cardiologist.
      3. In addition, the above point re difficulty of cases is extremely important. **IF YOU TAKE ISOLATED OUTCOMES SUCH AS MORBIDITY OR MORTALITY STATISTICS AS YOUR INDICATORS YOU MAY AND DO GET INCORRECT IMPRESSIONS.**
      4. **Statistics can be very misleading if the variables are not taken into account. When we first opened our facility we were a day surgical hospital and since we performed angioplasty we transferred our patients who needed overnight accommodation to other hospitals. Our statistics looked dreadful as day surgeries were not supposed to transfer they we to treat and send home. We were the first day procedure facility in Australia to perform angioplasty. Our statistics didn't fit the mould yet we were completely safe.**

o. **<u>There is no control over what doctors are legally able to do regardless of training</u>**

i. The medical board allows doctors to perform anything as long as they can prove their competence.

ii. I am aware of quite a few cardiologists who perform angioplasty without having undergone "appropriate" training according to the guidelines of the Cardiac Society.

iii. The medical board doesn't stop them and in one case, the doctor concerned threatened legal action if anyone attempted to stop him.

iv. **<u>How can a hospital accredit to outcomes in this situation?</u>**

v. It is fine to state that they must credential the doctor but in both private and public hospitals there are currently many doctors already in position **<u>who claim they have now done the appropriate training "on the job</u>."**

vi. Training on the job however cannot be discounted. New techniques are constantly entering medicine and the appropriate standards are not always in place. By way of example: Echocardiography began in the mid 1970s and has progressively added M Mode, 2D, colour Doppler, Strain etc. A doctor who trained in the early 1970s did not have to have the DDU, indeed it did not even exist, yet he or she may be very competent regardless.

vii. The College of Physicians only has an entrance exam. All members are legally allowed to "swap" to other subspecialties as they wish since there are no guidelines.

viii. Many societies such as The Australian and New Zealand Cardiac Society only have "guidelines". These are not compulsory or are they enforceable.

ix. With all this soft certification, how can a hospital be able to sort out who is or isn't trained and is it really their responsibility? **<u>THIS IS THE RESPONSIBILITY OF THE RELEVANT MEDICAL BOARDS</u>**.

x. Accreditation of doctors is envisaged I believe as I read this document. The commission will need to be very clear as to what its legal powers are in this matter and may require legislation that overrides the State Medical Boards in order to be able to dictate what a doctor can and cannot do. In the absence of this legislation it is not reasonable to put such a "grey" area as the responsibility of hospital CEO's and Hospital Medical Advisory Boards. Consistency cannot be guaranteed and since accreditation has financial and reputation

implications an area as important as this must be concrete.

p. Are institutions undertaking the accreditation process to be freed from the legal shackles of wrongful dismissal and discrimination if they sack someone who doesn't measure up? If they don't have the tools to ensure quality they cannot be penalise for the lack of it.

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p. Is any particular medical institution dealing with exactly the same patient base as any other institution that they are compared to? **All factors must be taken into account so as not to discriminate against any facility.** In an outcomes based accreditation system, the accreditation of a private facility is directly linked to its financial viability. How will the commission ensure that no health care professional or facility is unfairly dealt with because of its patient's demographics?

q. **Are all institutions on a level playing field as far as facilities and staffing levels are concerned?**
   i. This will affect all areas of accreditation.
   ii. We can all have state of the art technology if the health system delivers enough dollars.
   iii. Then all our patients will be happy and the outcomes can be so driven.
   iv. However, if a facility is in an area without a lack of either government or private health insurance backing it is compromised unfairly under this system.

r. **How do we allow for variations in perceived "best practice?"**
   i. If you have an infarct in Port Macquarie the doctors there may follow the internationally accepted viewpoint that thrombolysis is as good or better than acute stenting in a cardiac catheterisation laboratory.
   ii. However, Royal North Shore doctors disagree and favour stenting.
   iii. What is the ideal patient outcome here?
   iv. **Even the experts don't agree.**
   v. **HOW CAN YOU POSSIBLY DEFINE ALL BEST OUTCOMES?**

s. I report over 40 stress echocardiographs per week. This is a large number in anyone's book. I can honestly say that I cannot tell if the echo is the best it could be or not because:

i. The body habitus is different for every patient
ii. Air interferes with the transmission of the sound waves, however when the patient exercises sometimes the image improves and sometimes it worsens.
iii. Sometimes the heart starts to swing (called translational motion) and the technician has to try to guess where the best spot to capture the image has moved to. Considering they only have a minute to get that image there isn't time to try very many options.
iv. Our equipment is very good but other institutions may not have the same equipment. **Does outcomes based accreditation mean we must update all our equipment all the time to the latest and greatest to achieve the best outcome and if so who pays?**
v. Now for the report?
vi. The stated accuracy is 92% on average and in the various studies inter reporter variation is marked.
vii. It is very difficult to compare stress echocardiography with angiography as the first deals with a functional response to exercise and the second deals with fixed obstructions.
viii. Some cath labs call a lesion significant at 60% and others at 50%, so when I compare to cardiac catheterisation as the "gold standard" the goal posts are not fixed
ix. However the fitter you are the higher the stenosis before it manifests as a wall motion abnormality.
x. In addition, the accuracy of angiography varies between 89% and 100%.
xi. What if I have a small sample and a lot of my patients have collateral flow, which stops a wall motion abnormality and I don't achieve my 92% accuracy (whatever that means).
xii. **WITH THE ABOVE IN MIND, HOW DO WE ASSESS THE OUTCOMES OF MY STRESS ECHOS?**
xiii. **THIS IS NOT COMPLEX MEDICINE, OTHER AREAS ARE FAR MORE COMPLEX.**

Principle 3. Patient Perspective

C. **"*The patient' perspective is the lens through which surveyors should assess services*"**

I. **This is ambiguous**.

a. Does it mean we should view the system as the patient sees it? I.e. what the patient feels about the system is what matters or does it mean that the auditor must make a subjective decision as to how he or she would feel if they were a patient in the same situation?
b. Either way the focus is extremely subjective and dependent on the evaluative capacity and emotional overlay of the patient or auditor.

II. Is the patient competent to assess all areas that need to be assessed?

a. A patient's assessment is by nature biased according to
   i. **Their expectation of the service:**
      1. Patients have a limited perspective in the deliverance of health care. It is usually dictated by their own requirements. They expect:
         a. Unlimited resources or in the alternative that someone else is the one to miss out if someone can not be accommodated
         b. Perfection in the outcome. After all that is what they see on TV
         c. To be made to feel happy, however their opinion is coloured by their emotional state at the time. A very emotional patient faced with the possibility of dying will not necessarily be rational and may have expectations, which are unrealistic (as we all may) and not able to be medically achieved.

   ii. **Their previous experiences**;
      1. If we have had a previous good experience with a particular doctor or clinic we are far more likely to be accepting of delays or difficulties than if we have had a previous experience which we deem to be unpleasant or substandard. There is no consistency here.

   iii. **Their capacity to understand what is being a done and any inherent difficulty with the process**.
      1. A person with an IQ of 140 will be able to comprehend a complex medical situation far more easily than a person with an IQ of 80. I am not for one minute suggesting that it is not our responsibility as health care professionals to address this issue and explain as simply as possible what we need to, however success is not always guaranteed.
      2. By way of a simple example in exercise, stress testing sometimes a patient has or develops a

Left Bundle Branch Block. This is a technical problem, but not a life threatening one. In 99% of patients, I can give a satisfactory explanation. In 1% of patients, they still get very worried that they have had a heart attack or something worse. This sample is taken over 30,000 patients and 25 years' experience.

3. The basic nature of the person i.e. their personality type influences their expectations and reactions. As you are aware, there are four basic personality types according to Plato. they are
    a. Sanguine - happy, easy going
    b. Melancholy - must be very ordered
    c. Phlegmatic – harmony at all costs
    d. Choleric – in charge
    e. We are usually a mixture of two
    f. Choleric personalities will usually demand far more than phlegmatics.
    g. **Are we suggesting that the independent measurement of a health service should be subjected to variations of personality types and have its viability depend on the same**?
4. Each combination of personality types will view the same situation differently and will react differently.

iv. **IF YOU WISH TO USE THE PATIENT'S VIEW POINT AS THE BASIS FOR ACCREDITATION, FIRST HAVE A SYSTEM THAT IS ABLE TO ALLOW FOR ALL THE VARIABLES IN PATIENTS SO THAT THE SYSTEM IS MEASURABLE AND NOT DISCRIMINATORY**

v. The patient's cultural background is another area of variation. Clearly, our expectations are different depending on our backgrounds. Two examples are:
1. Chinese herbal medicine is very different from the pharmaceutical regimes we use. Both are accepted in our community. One is evidence based; the other has a very long tradition of acceptability in the Chinese culture. I do not think many hospitals have the ability to brew a herbal concoction nor would their drug licence allow it, however many Australians and Chinese would accept this as valid treatment.
2. If I have a patient who is a devout Jehovah's Witness and refuses a transfusion for themself as a consenting adult, again morbidity and mortality may be compromised. **Are we to refuse treatment because our "Outcomes"**

may be compromised or are we to be penalised if we do continue?

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vi. The patient's diagnosis is very important if their viewpoint is to be a valid indictor of performance.

1. It is quite clear in extreme cases such as a psychiatric patient with a psychosis, that a patient's viewpoint may be "skewed".
2. However, it is far less concrete in a patient with endogenous depression where the whole world looks bleak. This depression of course may also be undiagnosed.
3. **HOW DO WE ALLOW FOR THE UNDIAGNOSED ENDOGENOUS DEPRESSION IN THE COMMUNITY WHEN "LOOKING THROUGH THE LENS OF THE PATIENT'S PERSPECTIVE**"

III. <u>Is an auditor capable of making an unemotional scientific evaluation as to how the patient would feel in this situation</u>?

a. Many of the points above also relate to auditors.

b. If the auditor is not expected to be scientific then the system has introduced and condoned individual variation in assessment.

c. ***<u>NO MATTER HOW WE VIEW IT THIS STATEMENT CAN ONLY INTRODUCE SUBJECTIVITY AND THIS NEGATES THE WHOLE PROCESS OF ACCREDITATION</u>.***

d. ***<u>I NOW MUST PLEASE ALL PATIENTS AND AUDITORS IN ORDER TO KEEP MY ACCREDITATION</u>.***

IV. <u>Can we apply the accreditation process equally in a scientific manner to all situations to achieve a reproducible, auditable outcome?</u>

a. **IF NOT ARE WE TO DISCRIMINATE ON THE GROUNDS OF RACE, SEX, AND MENTAL STATUS AGAINST THE MEDICAL SERVICE PROVIDER.**

V. <u>A motherhood statement of "These things will all be taken into account in the final decision" is not in any ways adequate when the reputation and financial status of the facility or health professional is at stake</u>.

a. **<u>WE REQUIRE CONCRETE GUIDELINES THAT ARE NOT SUBJECT TO THE MOOD OR BIASES OF THE AUDITOR OR THE PATIENT.</u>**

Principle 4. Effort Proportional to Risk

D. ***<u>The assessment effort should be proportional to the risk</u>.***

I. On the surface this seems fair, however all the above points relate most poignantly to the higher risk areas making them far more difficult to assess.

II. By way of example in a coronary care unit the
- a. Patients and relatives expectations are high
- b. There is an enormous amount of emotion
- c. There are emergencies that take priority over paperwork routinely and often
- d. These units will have a lot more spot audits, which will take valuable time away from patient care.
- e. These units may suffer from all the above listed variables so how do you assess outcomes: in any case
- f. **MOST IMPORTANTLY HOW DOES AN AUDITOR ASSESS THESE UNITS WITHOUT BEING A MEDICAL CONSULTANT IN THE FIELD?**
- g. **EVEN THEN HOW DO YOU ALLOW FOR INTER-SPECIALIST VARIATIONS?**

THE MOST IMPORTANT DOWNSIDE IN ALL OF THIS PROCESS IS THAT WE MAY END UP WITH A SYSTEM OF ARBITRARY DECISIONS RE ACCREDITATION WHICH DE-STABILISE THE ENTIRE SYSTEM WITH NO SCIENTIFIC BASIS TO ANY DECISIONS NOR ANY CONSISTENCY

Principle 5. Managers and Self Assessment

E. ***<u>Managers should be encouraged to undertake self-assessment</u>***

I. This occurs under the current system,

II. In ACHS, this is part of the system and in ISO; the managers have to look at every problem that arises and look for solutions.

III. This incorporates “self assessment”

Principle 6. Impartial Evidence

F. ***<u>Impartial evidence should be used where possible</u>***

I. In view of the above discussion, this is not possible in the English system.

Principle 7. Disclosure of Criteria for Assessment

G. ***The criteria used to assess services are disclosed;***

I. This is a motherhood statement in view of the huge number of variables that are in the above points.

II. My concern is that in the process of disclosure there will be more and more nebulous statements such as "auditing to Best Practice" etc which give no format or clear definitions or guidelines, but to the lay public this will look very comforting.

Principle 8. Transparency

H. ***The process is open and transparent;***

I. This is an interesting statement. It implies a certain *scientific standing* in the process when in fact the whole process is variable and full of subjective assessments.

II. **THE OUTCOME OF THE AUDIT WILL INVARIABLY JUST BE THE OPINIONS OF THE AUDITORS AS TO WHETHER OR NOT IT FEELS THAT THE FACILITY MEETS THE ABOVE CRITERIA.**

Principle 9. Value for Money

I. ***The assessment process has regard to value for money, including that of the inspecting body.***

I. By changing the entire process, there will be **A HUGE FINANCIAL IMPOST** on all parties.

Principle 10. Continuous Improvement

J. ***The assessment process supports continuous improvement and continual learning***

I. The current system does this.

Outcomes of the UK System

K. On page 8 of the discussion paper the commission discusses, in generality, a result that has been stated to have been achieved with no documented evidence

I. The fact that the UK has implemented this system does not make it endorsable nor does 20ty signatures make it creditable.

II. What are the "measurable outcomes" of this system and who were the signatories?

Accreditation Issues

Point 1. Identifying Poor Performance

7. **EFFECTIVENESS IN IDENTIFYING POOR PERFORMANCE:** This area is discussed on page 14 of the discussion paper. The main thrust is "In Australia, the process of accreditation has been criticised by health service managers, funders and the public for not reliably detecting poor performance…." There are a number of points to be made here:

A. The accreditation process is dealt with as if one unit performs it. Prior to this, the paper lists all the different accreditation bodies. ***Such a blanket statement is not accurate unless each system is analysed and compared to each other. For all we know ONE SYSTEM may deliver all the goods and we are not all using that system!***

B. I suggest this analysis should be done prior to changing the system. We have an excellent opportunity to compare and identify fortes and weakness in long running systems.

C. We do not want change for change's sake.

D. **We must be assured that any change overcomes clearly identified previous problems in the process of accreditation**.

Point 2. Discussion of assessment of Clinicians and Patient Outcomes as an Accreditation Focus

8. Page 14 also states

"Critics of the survey process suggest that accreditation processes are not effective at identifying patient outcomes, in part because they do not test the transference of policies and procedures by clinicians when and where patients are treated."

<u>This is the key point of the commission</u>. Let us consider it more closely:

A. Is this **<u>a</u>**, or **<u>the</u>** role for accreditation and is it achievable?

B. To assess this we must assess all the concepts involved in assessing patient outcomes and whether or not the facilities can or should be involved in the process of controlling the transference of their policies and procedures by clinicians when and where patients are treated.

C. Let us consider how the current system functions. I will use ISO as my point of reference as I am familiar with it. It functions by requiring the facility to

- **I.** Identify their main functions
- **II.** Write policies and procedures to define what they do or are required to do
- **III.** Monitor and audit these procedures and policies to check that they are conformed to
- **IV.** Provide a mechanism whereby deviations from the system or adverse outcomes can be identified and addressed.
- **V.** Have a system of rectification and follow through regarding any points identified in point d.
- **VI.** Have a mechanism to allow the institution to adapt to change.

B. I have included as <u>Annexure A a fictitious example of how the current system works and is responsible. I have chosen this format as it removes all the emotional connotations that health has.</u>

C. Medicine, I believe, is no different from any other "business" with respect to accreditation.

D. **<u>IT IS MOST IMPORTANT THAT WE DO NOT ALLOW THE PROCESS OF ACCREDITATION TO BE MISTAKEN FOR THE RESPONSIBILITY OF PATIENT MANAGEMENT</u>**.

E. The process of patient management is

- I. Managed by each profession according to their position of responsibility
- II. Monitored by
  - a. The relevant state health departments and licensing bodies
  - b. The State Medical Board
  - c. The Health Care Complaints Commission and
  - d. The relevant colleges and professional bodies including medical, nursing, and paramedical bodies.

9. In an area as complex as health provision it is important to allow for

- **A.** Variation in methods of practice
- **B.** Variation in experience and ability of the various providers
- **C.** Variations in the patient's ability to respond both physically and emotionally to treatment
- **D.** Variations in the demographics related to the provision of health services

E. Variations to the health services that related to difference in religion and racial background.
F. **VARIATIONS DO NOT ALWAYS EQUATE TO INCORRECT MANAGEMENT**

Point 3. Commission's Requirement of an Authority to Enforce Recommendations

10. On page 15 paragraph 3 the Commission discusses "… there must be a clearly identified and accountable entity that has the authority to implement recommendations and make improvements". There are a number of relevant points here.

- **A.** Who is the Commission suggesting should take up this role? The assumption is that they will do so.
- **B.** This topic clearly requires further discussion to be clarified.
- **C.** There currently are a number of government bodies, both State and Federal, that handle problems within the health system. Do we need the cost of another, will it achieve greater benefit, and will it have legislative support to override the current authorities?
- **D.** Implementation of improvements may represent substantial costs. There is no limitation set on what changes can be demanded. Is it envisaged that the Commission could insist that a facility :
  - **I.** Purchase capital items such as a new Cardiac Catheterisation Laboratory
  - **II.** Insist on greater staffing levels
  - **III.** Insist on improvements in the physical structure of an establishment.
- **E.** What time frame are changes expected to be enacted over?
- **F.** **<u>CLEARLY, THE FINANCIAL IMPLICATIONS TO THE VIABILITY OF OUR HEALTH SYSTEMS BOTH PRIVATE AND PUBLIC ARE HUGE</u>.**
- **G.** On page 16 the Commission discusses that "resource replacement may require some trade offs". Will these trade offs be :
  - **I.** Clearly documented
  - **II.** Involve input from the institution
  - **III.** Be covered by a right of appeal and to whom.
  - **IV.** Be applied equally to the Public and Private sector.

Point 4. Surveyors

11. Re Surveyors.

A. Currently we have internationally recognised surveyors in the ISO system. I am aware that there is a request for greater standardisation of surveyors. This is not the same as a request for a complete new system.

B. The availability of competent clinical surveyors is limited. How does the Commission propose manufacturing more?

C. Will it be expecting current surveyors to retrain?

D. Who will bear the cost of this retraining?

E. Who will bear the cost of redoing all the accreditation systems?

F. Obviously, it will be borne by the institution being accredited. These institutions have fixed contracts often and do not have unlimited financial resources.

G. The increased costs may see the closure of some private medical institutions to the detriment of patients.

Point 5. Transparency

12. Transparency is discussed often, but particularly on page 14. This is an interesting concept for a number of reasons;

A. What does the Commission expect to post on its website? This needs clear delineation. It must not

I. Breach any privacy legislation

II. Defame an institution by either omission or inclusion, especially if the criteria and standards are not yet clearly defined

.

III. Place any information in the public domain that may be unfavourable to any individual or institution before any appeals process has been completed.

IV. Not give false impression of excellence due to incorrect information being displayed i.e. the commission must be assured that all statistical information is correct

B. Can the public really understand all the implications of different aspects of their health care in any case?

C. The Commission states "the increased emphasis consumers place on improving the quality of health care has created greater pressure on health services for public disclosure of information." Where is the validation for this statement?

D. The Commission goes on to state "critics of public disclosure argue that disclosure of accreditation outcomes will discourage the full declaration of sensitive information by health services."

    I. How does the Commission intend to handle this?

    II. How does the Commission intend to validate the information that is posted to ensure that full declaration of adverse outcomes does occur?

    III. If the Commission is unable to attend to point II, does the Commission concede that it is potentially compounding a poor situation by

        a. Having the information "go underground"

        b. Giving the public a false impression.

13. Information given to the public must inform accurately:
    A. This information, if it is to be provided, must not give a false impression either positively or negatively about any one individual or facility and must be in a format that is free from misinterpretation by the public.
    B. It must not breach the Privacy Act
    C. It must not be defamatory

Point 6. ISO as an Effective Accreditation Tool

14. On page 22 the Commission quotes that the ISO standards are not perceived as being an effective tool for measuring and maintaining safety and quality in health services
    A. I currently use ISO and find it references many, if not all, the current standards and guidelines.
    B. Its auditors are health professionals.
    C. It is an adaptable system and can adapt to any recommendations that the Commission require.
    D. It has a system for Quality and Safety Improvement built into it.
    E. It has the advantage of being an Internationally recognised system

F. It is registered with JASANZ

Point 7. Accreditation Reform Strategies

15. Accreditation Reform Strategies:

A. Registering of Accreditation Bodies

I. This part of the Draft Proposal assumes the current system is inadequate but gives NO REFERENCES OF PROOF THAT CHANGE IS REQUIRED.

II. The rest of the recommendations are therefore premature.

16. Page 26 deals with collection of data. It is eminently possible to increase utilisation of data without a complete change of the system.

17. However it is important to remember that rubbish in gives rubbish out.

Point 8. Regulation, Funding and Policy Levers

18. System wide accreditation against Quality and Safety Standards:

A. The Commission states "It is proposed that a range of regulation funding and policy levers be used to ensure all health services participate in a registered accreditation and quality process." **What are they, who will enforce them and how?**

B. The Commission deals with reported benefits which, contain many motherhood statements. The one I particularly like is number D. "Accreditation systems and processes exist that can be easily adapted to provide accreditation in all health care settings within a limited time frame".

C. The Commission must provide greater particulars re their plans to introduce generalised accreditation complete with costings, cost related benefits and manpower strategies.

D. The Commission has assumed the power to do this. Does it have it?

Point 9. Tracer Methodology

19. Introduction of Tracer Methodology;

A. "It is proposed that tracer methodology be implemented nationally by all bodies accrediting health services". This statement indicates the decision has been made without discussion. There are a number of serious implications which should be fully discussed before this decision is made. They are:

I. There is a direct involvement in the patient / doctor relationship which is intrusive and invasive to both the patient and the doctor.

II. This may well breach the privacy legislation

III. It constitutes a previously unthought of "right of entry" to a facility which may have far reaching legal implications.

IV. Wishing to "where there are deviations from standard clinical protocols, and review the decision making processes that was used to make changes to an individual's care".

a. First. Are the surveyors accrediting capable of such an audit?

b. Do they have the:

a. Necessary qualifications in all areas they are auditing?

b. Do they intend to take a team of medical and surgical specialists with them when auditing a multi-disciplinary hospital and if so where do they expect to get the manpower and how do they expect to pay them?

c. Medical background in all areas to the level of a medical specialist?

d. Written protocols for all medical and surgical procedures complete with complications and management of co-morbidities. The protocols we are talking about here are usually called medical and surgical textbooks and are huge?

e. Are they able to allow for changes in management of patients that are innovative? I.e. how do you allow for the consultant who has just returned from a conference where a new method of management is recommended? The system must do this to:

    i. Allow for the change and improvement in safety and quality?

    ii. Allow for individual preferences when multiple accepted methods are available to treat a condition.

    iii. Ensure that the accreditation process does not interfere with or hinder the individual patient's management.

f. Is it envisaged that the auditors will intervene in the management?

g. **If so, who will wear the legal responsibility and professional indemnity for management of a patient when the auditors disagree with the management provided?**

h. Is it envisaged that the auditors will refer any specialist with whom they disagree on the management process for disciplinary action and to whom?

i. Is the institution in which the doctor works to have their accreditation revoked because the auditors disagree with the patient management?

j. If so, how does the Commission suggest that the hospitals approach the issue of controlling patient management as they clearly will need to do so to ensure their ongoing viability?

k. How does the Commission plan to deal with all the variables discussed in point 6B. They will need to address all of these individually so as not to discriminate against any doctor or facility or allied health professional.

l. Who will bear the responsibility for any errors made by the auditors? These errors will have marked financial and professional ramifications.

m. Is it envisaged that the auditors will force the attending consultant to stop what he / she is currently doing (i.e. stop their operating or consultations) to justify his or her patient management to the auditors? If so, how do they intend to enforce this?

n. Have the Commission discussed this with the medical profession at large, not just a few select representatives? What is the AMA's view of this approach?

V. It is not guaranteed to achieve an accurate assessment of the patient's treatment especially if the patient has :

a. Recently been under anaesthetic or sedation. This may alter the patient's consciousness and appreciation of their

circumstances clouding any conclusions that may be drawn from such an interview.

b. pain and as such is in a state of distress

c. a difficult emotional situation to address such as finding out that they have had surgery for cancer, which, has not been able to remove all the tumour.

d. **Very importantly it must be born in mind that the very fact that the patient has people in authority "investigating" their doctor may instil doubting the patient's mind. They may perceive this as a formal disciplinary process and doubt their doctor's capacity to treat them. This may colour all answers from the patient. It may also damage the doctor's reputation in the community. This point can not be over looked**

e. **This process may be extremely intrusive such as in a termination of pregnancy clinic. If it can not be applied universally it will discriminate.**

VI. Point h on page 28 of the Discussion Paper states "The tracer methodology can also be used to track the use of equipment and performance management systems; and so is applicable across services such as pathology laboratories and medical imaging services." The Commission needs to elaborate on what this means. Does it mean:

a. That the quality of the equipment is for discussion?

b. That the diagnostic test is to be audited and if so by whom and under which protocol?

c. How does the Commission intend to deal with areas in imaging modality where inter-operator differences are well recognised, even amongst the experts?

VII. The Commission states "Selection of patients could also be based on criteria such as patients with high risk illnesses, patients where there is statistically poor health outcomes, patients that are casemix or length of stay outliers" this selection process :

a. Potentially breaches the Privacy Act because it identifies a patient complete with disease process. Does this mean that the auditors are allowed to view all of the patient's folders and medical histories at will?

b. How does the Commission intend to deal with patients with HIV and the Privacy Act?

c. How does the Commission intend to identify "high risk illnesses"?

d. How does the Commission intend to ensure that it does not discriminate against and victimise those professionals who deal with such high-risk illnesses and potentially not audit other professionals at all?

Point 10. Musts and Must Nots for a New System

20. **MOST IMPORTANTLY, ANY CHANGES TO THE SYSTEM MUST BE DEMONSTRATED BEFORE IMPLEMENTATION THAT THEY WILL NOT IMPACT NEGATIVELY ON THE PROVISION OF SERVICES.**

21. Any changes MUST

A. Have factual evidence as their basis, not "motherhood" statements that are nebulous and allow for auditor interpretation to the possible detriment of the uniformity and fairness of the system.

B. Be demonstrated to be above manipulation for political or financial reasons to the detriment of any provider. This means that no college, health fund, accrediting body etc can remove opposition through the implementation of unachievable, biased, or unfairly implemented accreditation rulings.

C. Have finite endpoints for auditing against which are known in advance, which are based only on factors that are within the control of the health provider being audited.

D. The system must be able to grade recommendations against a standard, i.e. major, minor or just a comment.

E. **<u>Be applied to the public as well as the private sector equally both for standards and punitive outcomes for non-compliance</u>.** In the past public hospitals have failed accreditation and continued to provide services until they have rectified the problems. Accreditation must not discriminate against private services that may have their funding cut and be unable to operate if they have an adverse finding. This is particularly possible under spot audits. **<u>If one group is unable to function under this system in the event of an adverse finding so must the other</u>.** After all, if the problem is that major a patient in the public system must be as protected as a patient in the private sector. This is the basis of the accreditation system - the maintenance of patient safety.

F. Be applied uniformly to all providers and not unfairly disadvantage any one group.

G. Must be clearly defined in such a way that all contingencies are readily identified and treated in a consistent manner

H. Apply to all areas in the system including

- **I.** The auditors must be audited to standards
- **II.** The Health Funds must be accredited and audited

I. Must deliver demonstrable benefits both to those receiving the services and also to those who provide them.

- **I.** End points of achievement must be measurable. Otherwise, how do we know that the system is achieving anything?

- **II.** One measurable benefit here would be the requirement of health funds to provide reasonable (within 15% of the best offered) contracts to all those who achieve accreditation. Accreditation is a costly process and should guarantee a financial return as well as a philosophical return. After all, if we sit for the Higher School Certificate there is not an option at the other end for the government to decide that one student with a TER of 96 could enter engineering, but one couldn't if the cut off was 92.

- **III.** The above point leads on to another very relevant point. For many years, medical student entrance in many faculties has been interview dependent. Many students with high TERs have been denied entrance on the grounds that they did not meet the subjective criteria decided on by the interview process. There is a lot of discussion currently in the medical journals as to the validity of the system. **<u>It did not have measurable endpoints</u>**

nor did it have regulated, controlled criteria that could be measured. Let us not make a similar mistake here.

J. Be the definitive requirement, i.e. we must establish that health funds or other organisations do not just keep moving the goal posts every time certain standards are achieved simply because they do not wish to pay out benefits.

K. Have a process of consultation inbuilt so that unachievable goals do not "slip in", in the future.

L. **Define the penalties for non-conformance to standards (as yet undefined). These must be clear and comprehensive as well as universal.**

M. Identify the powers of the commission and not have a role or rights assigned to them by default.

N. **Must have an appeal process to an independent (overseas if required) body.**

22. Any changes to accreditation MUST NOT

A. discriminate against either patient or provider on the grounds of any of the criteria covered by the discrimination legislation

B. impinge on a patient's or provider's privacy as decreed under the Privacy Act

C. require the provider to work outside any of the legislative requirements of employment legislation in order to achieve accreditation

D. require the provider to have powers greater than the governing professional bodies, such as the State Medical Boards, in order to achieve accreditation

E. make the provider accountable for the inherent medical system problems such as workforce shortages and lack of skilled professionals when such matters are beyond their control

F. destabilise the investment in the private sector either in the present or for the future

G. be able to be manipulated to hide adverse data

Point 11. The Cost of Accreditation

23. There is an assumption in the document that we should be able to somehow provide quality care at a 'competitive rate" if we just buckle down and become efficient.

A. This is not realistic. The health system has been "funds and skilled staff deprived" for many years and has become efficient by necessity.

B. From this point onwards the health system requires investment of funds and personnel to achieve improvements in quality and safety.

C. A quality house with quality inclusions will always cost more than a "prefab" house.

D. I think it is important not to expect it not to cost more but to allow it to cost more with the understanding that reduced complications will give better care.

E. We all appreciate the beautiful engineering in a Rolls Royce car however a Ford will still deliver us from A to B. **When I read "Best Practice", quality outcomes, continual improvement I ask where is the endpoint and in such a complex area who will determine what is adequate from what is inadequate.** What concerns me most is a push for change without clear direction.

Point 12. Are the proposed changes proven?

24. Who is running the change?

A. What qualification do the members of the commission have to assess and change this system?

B. Assuming the current committee has adequate qualifications what will be the qualification requirements for future member?

C. Have these qualifications been endorsed by the health profession as a whole?

D. Is there a member of the AMA on the committee?

E. The American system is as yet unproven and we do not have data available from the English system.

F. What is there to assure us that either represent a quality system or that either is better than what we have?

Point 13. Gains of the Current System

25. There is a tendency for people to disregard gains that have already been made and to always assume more can be achieved.

A. An example is that when in the 1980's we started to reduce bed day stays for inpatients, initially great gains were made - **however there is a finite limit to this process** otherwise we will discharge patients before they are admitted.

B. In addition, it has come at a cost. The patients in hospital are sicker and need more extensive care than they did before. It used to be in a surgical ward you had some first day patients, some second day etc. Now you have predominantly all first day patients and they are sicker.

C. With regards to accreditation, we have made great gains but perfection is not always attainable.

D. My concern here is that the end points must be realistically set so as to be achievable.

E. A perfect system requires huge infrastructure and costs to run.

Point 14. What is the Commission's View of the Role of Accreditation?

26. What is the Australian Commission and Safety and Quality in Healthcare trying to achieve? Is accreditation to

A. Be an instructive tool?

B. Provide a means to control the provision of health care at a Federal level?

C. Be a combined Federal and State initiative to work co-operatively and include all regulations under the one roof?

D. Be an iron fist in a velvet glove approach to demanding compliance or retribution?

E. The end result required will determine the cost and the punitive outcomes for non-compliance.

Point 15. Current Health System in Crisis

27. AGAIN I EMPHASISE THAT THE FACILITIES AND INDIVIDUAL HEALTH CARE PROFESSIONALS CANNOT BE HELD ACCOUNTABLE FOR GOVERNMENT SYSTEM FLAWS SUCH AS WORKFORCE SKILL SHORTAGES AND INADEQUATE REMUNERATION BY HEALTH FUNDS TO ALLOW FOR EQUIPMENT INVESTMENT ETC

WE HAVE A HEALTH SYSTEM IN CRISIS BECAUSE:

A We have a workforce shortage and therefore every one is trying to work faster and things are missed.

B. The financial pressures of wages as well as workforce shortages mean that less skilled people take on more complex tasks and therefore there is a greater risk to patients.

C. Human error is a fact of life and will never be eliminated.

D. We are expecting to be able to continually achieve shorter and shorter day stays with the result that the complexity and the degree of sickness of each patient and hence the workload is progressively higher without the required increase in staff.

E. Nurses miss valuable training during their course because they do not have adequate time in clinical situations.

F. Administration consumes vast dollars at the expense of clinical work.

G. There is not an appropriate increase in funding to allow for the increase in technology and the ageing population. The system, both public and private, is under-funded for the expectation of the public, which is perfect care and perfect results every time. The politicians are not prepared to say this is unachievable.

H. Accreditation will not address nor will it fix any of these problems. A fixation on changing the accreditation system is a "finger in the dyke" approach and will simply cause unnecessary costs and potentially result in the creation of a completely unmanageable system with greater problems where people focus on their viability under the accreditation system and not on patient care.

Point 16. Spot Auditing

28. Spot auditing is an unrealistic concept from a practical point of view for many reasons:

A. It does not represent a statistically valid sample size to make an assessment from. It is easily argued that a small random sample is not indicative of the whole. Indeed this is the very principle upon which medical research and "best practice" is founded. To introduce a system that is so statistically flawed and then to attach to this both financial and reputation consequence it is to open the system to challenge, ridicule and litigation.

B. **<u>All the points in 6B are relevant here</u>.** These points highlight how many variables there are and how it is not possible to expect an institution to be accountable for them all.

C. **<u>Spot audits may well lead to legal issues with respect to the discrimination laws and the Privacy Act</u>.** As discussed above the auditors would have to ensure that they had a system to take into account all variables that relate to age, sex, religion etc with reference to the staff as well as the patients and would not be able to breach patient privacy.

D. Years ago the education departments recognised that examination alone was unfair and introduced a system of assessments.

E. **The spot audit process itself will draw valuable staff away from the patient management and as such will give a false impression to the detriment of the facility.**

F. How can we adjust for agency staff and for staff who are off sick or on holidays on the day? If the intention is that all staff should be at the level of the NUM, DON or quality co-ordinator at all times then how will it be possible to decrease costs?

G. **<u>Being staffed for spot audits must increase costs</u>** not necessarily implying that the units were understaffed and unsafe but simply to have additional staff to allow for the covering of all contingencies to perfection at all times, requires an excess of staff above and beyond the usually required staff. Medicine has its unexpected complications and if the commission wants transparency then a facility cannot afford to have its name muddied by a poor outcome on a spot audit. This raises all the issues of workforce shortages again

H. To quote the example of the Health Department, holding spot audits on restaurants as being similar is to dismiss the many and varied complicating factors in running a medical day. If I am running a fixed menu, I have control. In a hospital, I have both the controlled and the unexpected. These were discussed in 6B.

I. A spot audit with reference to a speed camera check is inappropriate as this is a small selective item. It is not the same as saying I am going to do a full re-licensing of the driver including hazardous driving criteria and skills and take away his/her licence and hence their livelihood if they fail as they may represent a danger to the community.

J. **<u>Allows for the possibility of victimisation</u>** of certain facilities and health care professionals if not overseen by independent bodies. **<u>Ideally, this means not a government body, not a body with any financial involvement in the industry and with an international, auditable capacity</u>.** Otherwise independence cannot be guaranteed.

K. **<u>An appeals process</u>** must be available and independent of the auditing facility.

L. **Holding spot audits may actually damage the delivery of care**. An example is doctors do not always have their professional indemnity and registration documentation available even though it is current.

I. This is because the system within the insurance for professional indemnity has delays in timing for sending these things out.

II. In the strictest sense these doctors should not practice until the documentation has arrived.

III. Are we really going to stop the whole medical system because "The United Medical Protection Society" does not put on enough secretaries?

IV. Alternatively, do we accept that doctors always re-register and allow them to function unless the relevant medical board notifies us that the doctor has been suspended? In reality it is the professional responsibility of the doctors; we are just amassing the documentation.

V. **UNDER SPOT AUDITS, WE MAY BE FORCED TO CANCEL SURGICAL LISTS AND HAVE DOCTORS UNABLE TO ATTEND TO MEDICAL PATIENTS IN HOSPITALS IF THEIR DOCUMENTATION IS DELAYED, AS NOT HAVING THIS DOCUMENTATION IS A MAJOR NON-CONFORMANCE. THIS MAY PUT LIVES AT RISK.**

Point 17. Adverse Event Reporting

29. How do the auditors intend to make sure that all adverse events are reported?

A. Reality says that if there is a punitive response to "Bad Outcomes" then the easiest solution is to not show them at all or to minimise them by

I. decreasing the reported numbers

II. Share the complications around amongst a number of doctors if one has too many complications.

B. If complications are not recorded or coded for then they will never show.

C. I am aware of at least one pubic hospital which is six months behind in its coding. How do we know what is happening in this particular institution. The information is simply not available?

D. The only totally accurate records you will have will be mortality statistics. I don't believe they will hide the bodies.

E. The commission would have to audit all records in all hospitals to check for accuracy. It clearly cannot do this.

30. Who will determine the repercussions of not passing a spot audit? The document is extremely silent on this point.

CONCLUSION

A. The most important dictum in medicine is **"FIRST DO NO HARM".** The council must bear this in mind when they wish to change the accreditation processes.

B. If in changing the accreditation system we destabilise the private and public health sectors by instituting unrealistic goals with punitive measures attached, we will stop investment and may also decrease the viability of currently available health providers.

C. A scientific well-researched approach is required. The "Discussion Paper" demonstrates that the committee is proposing a complete change of the system without assessing the current system and without fully identifying the current system advantages, shortfalls or possible improvements.

D. There has been no substantial investigation into the legal ramifications of proposed changes.

E. There has been no clear delineation of the powers sought by the National Safety and Quality Commission

F. There has been no delineation of punitive options for non-compliance

G. There is no proposed independent appeal process.

H. There has been a motherhood statement that the Commission wishes to decrease the costs associated with Accreditation and achievement of Standards.

- **I.** The simplest way to do this is to modify and adapt all the current systems available.
- **II.** We have currently custom made and internationally accepted Accreditation systems available. These can be modified, however the Commission has dismissed this option completely. **This is a major flaw in this document**.
- **III.** The Commission has failed to demonstrate how it intends to contain costs.
- **IV.** Wishing is not sufficient.

I. Spot Audits

- **I.** Are statistically flawed due to the small sample size
- **II.** Are unmanageable as a concept especially for Full Accreditation
- **III.** Are potentially financially destabilising for both the ongoing running and future investment in the Health Industry.

J. Tracer Methodology

- **I.** Has major obstacles in its setting up and implementation due to appropriately qualified manpower and the difficulties in producing protocols that cope with all contingencies

II. There are major legal implications for both the patient management responsibilities and Privacy Act.

K. Accreditation is simply a management tool not a solution to workforce related issues. It can assist in identification of problems and it can assist in the maintenance of skills. **IT CANNOT WORK MIRACLES.**

L. Finally and extremely importantly, NONE OF THE PROPOSED CHANGES HAVE BEEN PROVEN TO BE EFFICACIOUS. This discussion paper needs to go back to the drawing board and address all the above issues.

ANNEXURE A

1. This annexure relates to the current system and the impact of the proposed changes

2. There is a very apt analogy to be used here, which I will elaborate on. The similarities to our health system will be obvious. An analogy allows us to be removed from the emotive issues associated with health care. It is as follows:

If I have a housekeeper and require my house to be tidy then I will under the ISO system:

A. Give the housekeeper

I. Clear guidelines as to what I expect (Mission statement and my Quality Manual)

II. Write out for the housekeeper what is to be done and how I want it done in consultation with the housekeeper to allow any areas of expertise that she will have to be incorporated (Policy and Procedures). It does not matter in which order the housekeeper does the housework as long as it is all done and done well.

III. Take note of any governing legislation i.e. the Health Department's requirements that I do not have vermin infestation in my pantry.

IV. Train the housekeeper in the procedures and any thing else that is relevant i.e. I may put the housekeeper through a manual-handling course to ensure she uses the vacuum cleaner correctly.

V. Audit the housekeeper to the procedures and policies to ensure she is consistent in what she does.

VI. Provide the housekeeper with paper so she can write down any problems or improvements she would like to make.

VII. Have a system, which will allow the housekeeper to take advantage and incorporate any new technology that is relevant to the housekeeper or to those who visit my house.

B. This will allow me to:

I. Use the house for the purposes for which it was built which may include for example

1. **General living**
2. **Holding dinner parties**
3. **Allowing the children to have friends over for a sleep over**
4. **Allow me to work from home, perhaps to write a book**

C. ***It is important to differentiate the process of accreditation from the required achieved outcome i.e.***

I. A clean and tidy house allows me to hold a dinner party. It does not have any real bearing on what is discussed at the dinner party or the standard of the conversation. That is the domain of the guests.

II. It is up to the guests to have sufficient knowledge to enter into the conversation and if they were inadequate in any way then a

professional body concerning their standards would be the appropriate area to refer the problem to.

III. By way of example, if the purpose of my dinner party was to bring together eminent experts on the Papuan pigmy fowl and to allow them to conduct experiments and treatment of these fowl in my laundry then as the host (CEO) I must

1. Assess each guest with reference to the International Association of Papua Pigmy Fowl Lovers guidelines
2. Make sure that each guest is registered with the association
3. Make sure that each guest participates in any ongoing requirements of the association
4. Monitor any morbidity or mortality of the pigmy fowls
5. Make sure that my laundry has the physical requirement of the experts and complies with any council regulations.
6. Make sure that I will not infringe any government requirements i.e. not attract vermin.
7. Once we start treating the fowls to have a system in place that allows me to enter into any new experiments and procedures that may develop.
8. Make sure that any requirements of the RSPCA are not infringed.
9. Make sure that I can monitor the wellbeing of the fowls and report an trends that are out of the ordinary to the relevant government body i.e. the RSPCA

IV. **<u>It is not my responsibility to</u>**

1. Reassess each candidate to my own self determined standards when they already have their own body
2. Tell each guest how to treat the fowls.
3. Dictate what is to be done to the fowls.
4. Take responsibility if the assessment process of the International Papuan Guinea Fowl Lovers Association is defective. However, my systems will pick up if fowls are dying as my housekeeper will have to remove them and I may report this to the RSPCA when it occurs.
5. The RSPCA can then conduct its own investigations and take any required action if my monitoring detects defects in the carrying out of the experiments and treating of the fowls.

V. **Monitoring my housekeeping policies and procedures harder and longer will not address any fundamental problems in the training and functional capacities of the scientists. Their governing body must address this.**

NOR WILL IT ELIMINATE HUMAN ERROR.

VI. It is important to establish certain standards, which may impact on my guests, i.e. if the floors are wet and not properly cleaned

and a guest slips over and breaks a leg then the process of housekeeping has let us down. It is now up to the system to identify

1. the problem
2. how it could have been prevented
3. how to stop it happening again

D. The next thing to be decided is how often I must have my house spotless. Should it be:

I. Every minute of every day so that if an auditor were to arrive unannounced it would be perfect.

II. Once a week so that I know

1. that it **can** be completely tidy
2. that my systems do work
3. That vermin will not have a chance to establish in the pantry because the unwashed dishes have been sitting around.

III. Once a month

IV. Once a year

E. In the decision process of the auditing I must take into consideration

I. What am I trying to achieve?

II. will my auditing assist or hinder this process

III. am I aiming for perfection or the best functionality

IV. can I achieve perfection and still function

V. What will be the overall benefit of this procedure and to whom?

F. What I am trying to achieve is the best outcome in a way that is reproducible, flexible around change and thought about. It must allow for the changing nature of my day and for the unexpected.

G. If the council (my accreditation body) elected to do spot audits I would have to comply with option d) i.e. and be spotless every minute of every day. This would cause certain problems being

I. The family would not be able to eat unless I employed additional help to pick up every dish as it became dirty and wash it resulting in additional costs

II. If my housekeeper was sick and I had an agency housekeeper and was audited I may not reach the required standards, as he/she may not know all of my policies and procedures. This does not mean that I am operating at an unacceptable standard but simply that **perfection cannot always be achieved if I do not have a guarantee of trained professional staff every minute of every day. This is unachievable**.

III. The family would not be able to cope with unexpected additional guests as their resources would not allow the dishes to be done on the day and doing the dishes in the morning would not be

acceptable even though no bad outcome may have occurred. We would be forced to turn these guests away. This would impact on the very purpose of having a house i.e. to receive guests when they arrive whether announced or unannounced.

IV. The impact of not reaching standards on a spot audit basis would then depend on what was to be lost.

1. **If the council were to revoke my ability to live in the house and/or reduce my rent if it was a rental property or even stop my rents altogether then I would be seriously compromised.**

2. Also potentially the banks would stop housing loans as they would not have financial security

3. People may stop investing in the rental market, as it would be uncertain as to the future of a long-term investment. On any given day, it may have its licence for people to live in the house revoked.

4. This would mean that the public housing sector would have greater pressure put onto it.

5. In addition, housekeepers in private residences would have to work to a different standard if the public housing sector was not required to achieve the same standards or did not suffer the same consequences. (I.e. **if the public system could still allow people to live in their houses even if the audit revealed deficiencies while they kept functioning and not have their rents reduced until the problem was settled.)** It may be harder to get housekeepers for the private sector and we may have to pay them more.

H. It will also, however, not be acceptable to never have a moment where I can stop and assess the system as a whole and say, "Yes we do have a lovely tidy, clean house." There must be a balance achieved.

I. Accreditation must allow the functions of the household to occur.

J. In this instance once a week would probably be the most practical for an internal audit by me (the CEO) to check that everything is functioning well. I would look at things on a day-to-day basis for the important functions i.e. that the dishes for the day had been done in a timely fashion and have an official audit perhaps every six months from an external source. I would also have routine meetings scheduled where I could review all the important functions of the house.

K. If I were to be compared to other houses then **I would want my auditor to be trained and audited him or herself.**

L. **I would need this auditor to be completely neutral**. It could not be related to any competitor if I was renting my property or to any rental board, which helped to set my rents.

M. **I would want the people who set my rent to be accredited as well so that I and my tenants could be assured that these people were reputable and well managed and competent to hold their bond.**

N. **Once I achieved my accreditation and proved my standards if I was the property owner and not living in this house myself, I should be entitled to a minimum rent in my house**. After all I would have invested significantly and require a return in the commercial sense. If this accreditation represents a minimum standard then a minimum return should be attached to it.

O. I must have a level playing field. **This is achievable if the process is kept where it should be i.e. the auditing process must focus on the system and how well it is followed, not on whether or not the desired outcome is achieved as I am not always in control of all the factors affecting the outcome.**

P. The focus of outcomes belongs to the relevant professional bodies.

Q. Certainly, accreditation can be used to collect the relevant data to assess outcomes and indeed should serve this purpose.

R. Failures in outcomes are not going to be resolved by focusing on accreditation as the saviour.

S. It doesn't matter in my analogy what use is made of the house. The accreditation process is always adaptable through changing the processes and procedures. If we were to accredit a household at the turn of the 20th Century we would have had procedures based around washing in coppers and our food storage would not have included cleaning out the fridge. However, housework is housework regardless of what technology brings. To suggest that we need a whole new system to monitor housework simply because we now have vacuum cleaners and refrigerators is ridiculous. All that has changed is the methodology and the expected outcome i.e. a cleaner house in a shorter time frame compared to the early 20th Century. However the cost of cleaning has increased with the use of technology and there is a minimum limit to the time required even with technology, to clean my house. It is not infinitely reducible. The process always allowed for the change in technology

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