

PALLIATIVE CARE AUSTRALIA

Submission to:

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

**Discussion Paper: National Safety and Quality
Accreditation Standards**



**Palliative
Care
Australia**

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EXECUTIVE SUMMARY

Palliative Care Australia is pleased to provide this response to the Australian Commission on Safety and Quality in Healthcare (ACSQH) on the Discussion Paper on National Safety and Quality Accreditation Standards.

Palliative Care Australia is broadly supportive of proposed moves to harmonise and standardise standards and accreditation in healthcare.

However these moves must be appraised in the context of the actual contribution they are likely to make to the realisation of safe, high quality experiences for all health consumers. Palliative Care Australia contends the proposed changes are likely to impact highly on the administrative efficiency and business model aspects and less likely to impact on real patient outcomes and change management. There is little evidence accreditation, in the absence of well linked internal quality assurance activities, achieves quality patient health outcomes.

The proposed accreditation model does not recognise quality health outcomes are achieved through relevant standards operating at different levels of the healthcare system: at the core or generic level, and at the clinically specific or target population level. It also fails to recognise not all standards are developed for the purpose of the accreditation of health services. Many standards, such as PCA's, are developed to provide quality benchmarks to support quality improvement within a specific clinical setting, catering to the needs of a specific target population, in this case those receiving palliative care.

Palliative Care Australia supports the establishment of a core set of patient safety and quality standards that measure the broad systems that support quality and safety and can be adopted by all accreditation agencies. This would have the potential to reduce duplication of accreditation within agencies and facilitate the process of mutual recognition and harmonisation. But, these core safety and quality standards cannot be incorporated into standards at the clinically specific level as this would lead to duplication. In addition to core or generic level standards, services need **clinically specific** standards which potentially have the greatest impact on quality delivered to the needs of the target population. Clinically specific standards such as those developed by PCA do not incorporate core safety and quality elements as these are picked up at the core level and need not be replicated.

Whilst ACSQH notes there are no fundamental failures in the current accreditation system, PCA believes there is little evidence accreditation alone directly influences quality patient health outcomes. Palliative Care Australia agrees much can be done to harmonise and standardise the system, but it cautions against taking this too far, resulting in standards which are neither relevant to the needs of a particular patient population, nor result in improved patient outcomes.

This year, PCA will commence the implementation of a major initiative to see the internal quality assurance and peer review of performance of specialist palliative care services against the Palliative Care Australia Standards. While this work is not accreditation, it does aim to achieve mutual recognition of the clinically specific quality activities with core accreditation processes. Palliative Care Australia's Standards satisfy the *National Health Performance Framework*, developed by ACSQH. When fully implemented and supported with appropriate tools and resources, the Standards will give services the ability to confidently deliver care that meets the nine criteria established by the Framework. Palliative Care Australia's Standards frame care delivery that is: effective, appropriate, efficient, responsive, accessible, safe, continuous, capable and sustainable.

PCA proposes there is an opportunity for the ACSQH to utilise, and perhaps influence, this work as a test model for best practice. As the target consumer population for palliative care is spread across multiple care settings and multidisciplinary health professional teams, it provides an excellent example to explore the processes for realising real quality improvements at the clinically specific level.

RECOMMENDATIONS

Palliative Care Australia makes the following recommendations:

1. The accreditation model must recognise the hierarchy of core level and clinically specific level standards and the importance of both levels to quality patient outcomes.
2. The value of clinically specific level standards in improving patient outcomes must be acknowledged in any process to register and streamline standards.
3. Uniform safety and quality standards cannot be universally applied to all standards, to do so would create duplication.
4. The ACSQH gives consideration to involvement in the PCA National Standards Assessment Program with a view to ensuring emerging best practice principles are incorporated into the assessment and standards framework.

1 - PCA AND PALLIATIVE CARE

1.1 PALLIATIVE CARE AUSTRALIA

Palliative Care Australia is the peak national organisation, representing the interests and aspirations of all who share the ideal of quality palliative care available for all. Palliative care should be: timely, needs-based and evidence-based.

Palliative Care Australia is an incorporated body whose members are the eight state and territory palliative care associations and the Australian and New Zealand Society of Palliative Medicine. The membership of these associations includes palliative care service providers, clinicians, academics, consumers and members of the general community.

Palliative Care Australia was formed over a decade ago to address national palliative care issues, represent the area to the Federal Government and national media, and to act for the sector when dealing with other national peak bodies and professional organisations.

Palliative Care Australia works in collaboration with the Australian Government Department of Health and Ageing to implement the National Palliative Care Strategy and to raise awareness of palliative care, improve the understanding and availability of services across Australia, and encourage discussion to support improved knowledge networks.

1.2 PALLIATIVE CARE

Palliative care is provided to people with an active, progressive and advanced disease or illness, for whom there is little or no prospect of cure. Palliative care is holistic care, focussing on quality of life and helping people live well.

Palliative care addresses the physical needs of the patient, including prevention and relief of suffering by means of early identification and assessment of pain and other problems. As a holistic approach, it also addresses the emotional, social, cultural and spiritual needs of the patient, as well as those of their family and caregivers.

Palliative care is delivered by a multidisciplinary team which may include: doctors (specialists and GPs), nurses, physiotherapists, occupational therapists, dieticians, social workers, counsellors, chaplains and volunteers.

Palliative care affirms life and regards dying as a normal process. Palliative care is intended neither to hasten, nor postpone death. Rather, it is an integration of the physical, emotional and social aspects of care and offers a support system to help patients live as actively as possible until death. Importantly, palliative care offers a vital support system to help the family cope during the patient's illness and in their own bereavement.

2 - PCA STANDARDS

2.1 OVERVIEW OF PCA STANDARDS

The PCA *Standards for Providing Quality Palliative Care for all Australians* are standards that are relevant in the multiple care settings where care is provided for a specific target population – people with a life limiting illness. Care can be provided in the home, a hospital, an aged care home, or in a hospice. The *Standards* are a whole of health care sector approach to ensuring high quality, needs-based care at the end of life.

The PCA *Standards* are relevant not only to consumers, but to all professionals across different care settings who provide care for people who are dying, including: general practitioners, community nurses, staff of aged care homes, staff of acute care facilities, allied health professionals and palliative care specialists.

Palliative Care Australia's *Standards* are clinically specific standards, focussing on the specific health outcomes of the target population – people with a life limiting illness. They are not core standards, for example, standards which focus on generic issues such as safety protocols, incident review, infection control or performance management. The PCA *Standards* are relevant to the delivery of quality palliative care by all health professionals for people with a life limiting illness.

2.2 THE NEED FOR PALLIATIVE CARE STANDARDS

Palliative Care Australia's *Standards* are focussed on a specific target population and are relevant to the needs that population. Core healthcare standards do not and cannot address the specific needs of people who are dying and their families. Palliative Care Australia has recognised quality care is a front line driven issue, and has targeted its *Standards* at this level. Quality cannot be assured by a top down accreditation process which relies upon universal generalisations and does not specifically address the needs of the target population.

The PCA *Standards* are designed to support quality management and improvement activities, and benchmarking – to ensure care provided is at a consistent quality level. Importantly, in articulating standards for care, the *Standards* also set out the essential relationship between care providers, whether primary or specialist, and the level of expectations for all services involved in the provision of care.

Because they apply at the clinically specific level and are intended to ensure quality care for a specific target population, PCA's *Standards* are designed to be used alongside other core standards and accreditation regimes for health services, for example, those produced by the Australian Council of Healthcare Standards, the Quality Improvement Council, the Royal Australian College of General Practitioners, and Aged Care accreditation bodies.

The *Standards* are in their 4th edition. They have evolved, reflecting the development of palliative care from an emergent specialist discipline. As developments in palliative care have occurred in structure, organisation and delivery, and as the role of the discipline in the wider health sector has evolved, the *Standards* have been revised.

Palliative Care Australia recognises there is further work to be done to ensure the *Standards* reflect best practice in standard setting and to ensure they continue to reflect the needs of the target population.

3 – ACSQH ACCREDITATION MODEL AND DISCUSSION PAPER

3.1 PCA COMMENTS ON ACSQH ACCREDITATION MODEL

3.1.1 OVERVIEW

Palliative Care Australia agrees with a number of elements of the ACSQH discussion paper on National Safety and Quality Accreditation Standards. However, any review of the standards regime - whether in relation to harmonising, standardising or implementing stricter controls on development - must result in a demonstrable increase in quality patient care and outcomes. Palliative Care Australia is concerned the proposed accreditation model, if implemented in its entirety, will not result in improved quality in patient care and outcomes, largely because it does not recognise the multiple applications for quality standards and has the potential to act as a disincentive for the development of clinically specific standards.

The proposed accreditation model treats standards as a homogenous entity when in fact, there is a hierarchy of standards from a core or generic level to a clinically specific level. Core standards are important in setting requirements which are universal, for example, safety and infection control. However, to ensure quality care for a given target population, more focussed and clinically specific level standards are required. Consumers can have fundamentally different needs. For example, clinically specific standards governing the care of patients undergoing hip replacement surgery are significantly different to those applying to care of people who are dying.

A top down universal approach cannot ensure quality care and improved patient outcomes. Implicit in the proposed accreditation model is the assumption a core level of standards is sufficient for accreditation and as a consequence, the delivery of quality patient care. Palliative Care Australia argues this is not the case. Services need access to clinically specific standards to guide the service delivery for their target population. It is clinically specific standards that are imperative to the delivery of quality care.

Palliative Care Australia cautions against moves to standardise all standards to include common elements as this does not recognise standards apply to different levels of healthcare. Whilst it is appropriate that core level standards contain common elements, such as those relating to safety, requiring all standards at all levels to contain similar elements would promote duplication as it fails to recognise services use multiple standards at different levels to guide the quality of the care they deliver to their target population.

3.1.2 ACCREDITATION STANDARDS

Palliative Care Australia agrees accreditation should provide an assurance to consumers that health services they access will provide safe and high quality care. However, PCA does not believe quality care can be guaranteed if standards are standardised around key themes and agreed language to such an extent they can cover only core level issues. The needs of consumers who interact with the healthcare system are not homogenous and cannot be fully met by core standards on safety and quality.

Palliative Care Australia argues standards cannot be credible when applied to varying health service environments unless they have the flexibility to incorporate elements which are directly relevant to that clinical service environment or target population.

3.1.2a Standardising language, definitions, structure and framework

Palliative Care Australia agrees harmonising the structure, format and scope of standards has the potential to reduce duplication. However, any such move must recognise and accommodate the necessity for standards to be relevant to the target population. Consistency must be a secondary consideration. Sufficient flexibility must be permitted in language, definitions, structure and framework to ensure the ensuing standards are relevant to those services providing quality care for the target population.

3.1.2b Mapping and analysis of existing standards

Palliative Care Australia supports any move to map the range of standards in existence and of relevance to the healthcare sector in Australia. An understanding of the scope of current standards is important in ensuring standards match best practice principles.

Nevertheless, PCA recognises any subsequent analysis of these standards will be driven by a framework. This framework must recognise the hierarchy of standards - recognise standards are not all equal, neither do they apply to the same levels in the healthcare environment. The framework must recognise the outcome of quality care to specific target populations and not result in the comparison of standards focussed at core and clinically specific levels of the healthcare system.

3.1.2c Registration of standards

Registration of standards is a positive move as it will ensure those registered comply with best practice models, providing best practice models are appropriate. Palliative Care Australia believes the purpose of registration must be improved access, rather than regulation and control which may simply increase bureaucracy.

However, the intention that all standards would be required to include mandatory safety and quality domains fails to recognise standards target different levels of the health system and this directive, in itself, could promote duplication.

Palliative Care Australia's *Standards* do not include elements related to safety as the *Standards* are clinically specific and not intended as a whole of service model as, for example, the ACHS Standards are. The PCA *Standards* apply to a specific element of care. Including a mandatory safety element in the PCA *Standards* would duplicate any safety element a service might already comply with at a core level.

3.1.2d Core safety and quality standards reflected in standards

As noted above, PCA is concerned this criteria does not recognise the hierarchy of standards and the different yet interdependent roles of core and clinically specific level standards. Core standards can be used to assess generic safety and quality domains but will not penetrate sufficiently to measure quality at the clinically specific level.

Safety is an essential aspect in the provision of quality care and is appropriate at the core level of standards. It is inappropriate that this be duplicated at the clinically specific level where the palliative care Standards are targeted. Clinically specific level standards are not intended to comprehensively cover the entire standards continuum but instead to form part of a larger interdependent whole.

3.1.3 MUTUAL RECOGNITION

Mutual recognition of standards is important in achieving efficiencies and reducing the cost and time involved in accreditation surveys. For this to occur, PCA recognises there has to be some consistency in scope and language. This must be done whilst taking account of the hierarchy of standards. Quality of care requires clinically specific level standards suitable for

the target population. Clinically specific level standards for the treatment of mental illness, for example, are not appropriate for palliative care.

PCA's *Standards* are designed to ensure quality palliative care and are designed to be used alongside other standards and accreditation regimes for health services, for example, those produced by the Australian Council of Healthcare Standards, the Quality Improvement Council, the Royal Australian College of General Practitioners, and aged care accreditation bodies.

Further to the issue of mutual recognition, PCA cautions against overly optimistic expectations mutual recognition will achieve efficiencies in the training of surveyors. It is imperative surveyors have knowledge of the specific area in the health system in which they are surveying. The elements of quality care in palliative are fundamentally different from other areas of health. Mutual recognition cannot be automatically universal because of these differences and the skills required to comprehensively assess quality care in clinically specific settings.

3.1.4 ACCREDITATION PROCESS

Palliative Care Australia supports the accreditation of all health care settings, providing the standards by which they are accredited, both at the core and clinically specific level, are relevant to the care setting. Relevance must be of higher importance than uniformity.

3.2 – PCA COMMENTS ON ACSQH DISCUSSION PAPER

3.2.1 ACCREDITATION ISSUES

What core processes or systems need to be in place to ensure poor performance is detected? Is this necessarily part of an accreditation process?

Systems or processes for detecting patient experience and outcomes must be included as part of the accreditation review process to better detect poor outcomes and to increase the relevance of the accreditation process to the wider community and to the sector.

The capacity to detect poor outcomes should be integral to the accreditation process. Actions taken in response to detected poor performance should be framed within a continuous quality improvement framework.

3.2.2 DUPLICATION AND OVERLAP

What needs to be done to integrate and streamline overlapping accreditation processes?

Adoption and integration of the principles developed in the United Kingdom¹ related to the adoption and development of common standards and mutual recognition through the accreditation process will support integration of standards and reduce assessment burden for health services.

3.2.3 RESOURCE REQUIREMENTS

How can accreditation be made more cost efficient and effective?

Accreditation can be made more cost efficient and effective through:

- reduction of duplication through the development of core level national standards for quality and safety

¹ Discussed at page 8 of the *Discussion Paper: National Safety and Quality Accreditation Standards*.

- development of meaningful outcome and patient focussed standards measured through operationally derived data.

3.2.4 SURVEYORS

What must be done to ensure inter-surveyor reliability?

A number of activities have the potential to ensure inter-surveyor reliability, including:

- better engagement with the health care sector to incorporate peer review approaches into the accreditation process
- development of consistent, nationally accredited training and ongoing certification of surveyor competency against national competency standards
- introduction of increased accountability for surveyors through benchmarked performance monitoring
- ensuring clinically specific areas (e.g. palliative care) are surveyed by clinicians/managers with expertise in the clinically specific area.

3.2.5 INFORMATION TO SUPPORT ACCREDITATION

What needs to be in place to allow accreditation data to be collected at a national level?

To allow accreditation data to be collected at a national level, the following is required:

- development and investment in point of care, patient focussed data collection systems to enable capture of meaningful assessment on an ongoing basis
- publication of de-identified survey data
- mechanism for public access to accreditation data, as appropriate.

3.2.6 PROLIFERATION OF STANDARDS

What initiatives are required to coordinate and harmonise standards development?

There are risks inherent in reducing or combining core and clinically specific quality and safety standards. Differentiation of core standards (those having generic applicability regardless of service type) that support national accreditation, and clinically specific standards that enable focussed assessment within specific areas needs to occur.

Palliative Care Australia agrees with the development of a harmonising glossary but does not support regulatory processes that control the content of standards developed by expert groups.

3.2.7 ACCESS TO STANDARDS

What minimum information should be publicly available on accreditation standards?

Accreditation standards, if nationalised, should be publicly available at little or no cost. This is imperative if standards are used to support accreditation and consumer choice. Furthermore, consumer-tailored summarised versions should be freely available at all services.

3.2.8 STANDARDISE ACCREDITATION LANGUAGE AND DEFINITIONS

Who needs to be involved in the standardisation of language and definitions?

A wide consultation process with all relevant stakeholders including health service managers, clinicians, peak bodies, funders, patients and representatives of the wider community, is required to ensure relevance of the outcomes.

3.2.9 INTRODUCTION OF UNANNOUNCED SURVEYS

What needs to be done and by whom, to introduce unannounced surveys in a timely and effective way?

The introduction of unannounced surveys would represent a significant shift in accreditation philosophy from a quality improvement focussed system to a regulatory and compliance monitoring and reporting system. Palliative Care Australia believes there is a potential for unannounced surveys to be counter productive if they are not part of a broad set of supporting strategies leading to accreditation.

Quality assurance can be undertaken through a number of strategies, such as the scheduled peer review process under the PCA National Standards Assessment Program. Alone, there appears to be little evidence to support an assertion unannounced surveys have a universally positive impact on patient safety or clinical quality of care. Any introduction of unannounced surveys must be focussed on quality improvement and be supported, and not punitive.

The development and investment in point of care, patient focussed and outcome based data collection systems that capture ongoing health care quality and safety data can provide meaningful assurance regarding the consistency of standards within health services that supports the survey processes.

3.2.10 INTRODUCTION OF TRACER METHODOLOGY IN EXTERNAL ACCREDITATION REVIEWS

What needs to be done and by whom, to introduce tracer methodology in a timely and effective way?

The introduction of tracer methodology will be critical to reorient health service accreditation from an organisation structure process to a patient journey focus and to change the culture of health service accreditation from a focus on a single “check”, towards ongoing monitoring of core standards and patient outcomes.

The emphasis of the ACSQH should be on the development and introduction of tracer methodology and other point of care data capture systems to support continuous safety and quality monitoring at point of care. Accreditation and other compliance systems can be extracted from the operational quality and safety systems.



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