

Submission to the Australian Commission on Safety and Quality in Health Care

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A relative of mine arrived at the emergency department of a metropolitan hospital with a headache which was so bad that she thought she was going to die. After triage, it was not until 6 hours later that she was seen by a doctor. She was admitted with the diagnosis of meningitis. She was connected to an intravenous drip [?antibiotic]. She complained that it was not her name on the pack and the pack was replaced. Later when ambulatory, she was obliged to use the ward toilet. As she was still connected to the drip a fellow patient had to clean the toilet before it was fit for her to use. Somewhere in that hospital would be proudly displayed an accreditation certificate.

General conclusions

Suffering staff translates to suffering patients

The ACSQHC discussion paper suggests the re-orienting of accreditation systems to increase the focus on patients, rather than processes, protocols and policies. Staff could not agree more. The current bureaucratic-style accreditation process is seen as an intrusion and resented by people who are working themselves to exhaustion.

What is the point in having such administrative luxury when there are not the resources for the average nurse to do her job properly? An accreditation criteria is that there be enough staff to comfortably [i.e. safely] get the job done. The assessors are forced by circumstances to ignore this criteria. There needs to be a moratorium on accreditation until we get our priorities right.

Measuring real outcomes

What needs to be done to increase the probabilities that your child will not be harmed by his or her health care? As a parent, do you settle for the superficial assessment of performance [as external assessments are only capable of] or do you expect that every encouragement be given to the staff-on-the-ground [who know exactly how their service is performing] to make disclosures?

As a parent and grandparent I say that the criteria that count are:

- ▶ How many errors were reported to the patient safety committee in the past 12 months?
- ▶ What were the seriousness of the errors and how did the total number compare to the worst case pictures painted by the Tito and Wilson surveys of 1995?
- ▶ Who did the reporting and what did each informer think of the follow-up both in correcting the error and the culture's treatment of the informing employee following the disclosure?

Failure to confront

This submission is critical of the tradition of feel-good policies substituting for confrontational probing of a public health service's culture. With a claimed 50,000 being permanently damaged by their health care each year in this country, many in the community feel badly let down by those we are being asked to trust to keep us out of harm's way. We are not fully benefiting from the awesome advances in the art and technology of medicine due to organisational failures.

General observations

The session on 28/3/07 at 1 Oxford St. Sydney was, of course, set up in good faith and those involved in the business of accreditation are working conscientiously, but I felt that I was observing yet another component of the bureaucratic process in action. As accreditation becomes more complex it will develop a momentum to exist for its own sake. The paradox will be that as accreditation becomes more of a stand-alone profession, the danger of being in a hospital bed will continue to increase.

Bureaucracy never ceases to try to control human nature through mechanisms. It is a mission which is doomed to fail. The real determinate of success or failure – the understanding by management of human behaviour - is seen to be too complex to get involved with. What scientific observation has revealed about human nature is ignored by public sector management as it moves the same pieces of the jigsaw around on the table hoping the solution will suddenly present itself. The comfort zone of bureaucracy-think are meetings and the seemingly inexhaustible stream of printed paper. This creates the delusion of productivity within an organisation slowly sliding downhill.

From Leadership and the New Science by Margaret Wheatley: *“If organisations are machines, then control makes sense. But, an organisation is about relationships, dynamic systems and process which is full of hidden variables. Seeking to control this through permanent structure is suicide.”* And from Restructuring Society by Russell Ackoff: *“What we experience are complex systems of interacting problems - not individual problems.”* By the piecemeal checking of components and then ticking a box, accreditation is going in the wrong direction. There is no box awaiting a tick which is labeled - “Clear of political intrigue which could render this department dysfunctional.”

The service culture is not ready for any opportunity to improve itself in a real sense. When performance is inadequate to the point where there is a blowtorch to the belly, it can only restructure such that new levels of bureaucracy are created.

Here is one recent and particularly annoying example:

- One of the benefits of the merger of 17 area health services into 8 were to be the area health advisory councils [AHACs] with 50% of their members drawn from the community. As these people would be in direct contact their respective area’s chief executive, here was the best chance in 150 years of public health in NSW to have real community input.
- The minister assured us that the councils would effectively engage the community - but there never was the slightest intention of anybody involved that this would be the objective. After over 12 months of meetings, all but one of the AHACs has bothered to post the minutes of its meetings on the web.
- The minutes of the one AHAC which were posted on the web revealed that the community “representatives” made no contribution at all to raising the quality of health care. Even serious media criticism of their area service could not stir them to make a comment at a meeting.

Choosing community representatives who simply sit on seats can be seen as a manifestation of the area service’s overall human resources philosophy which is more concerned with the selling of an image than getting the best out of the resource.

Extracts from the discussion paper

Extract [1] *“While the initial focus of health services accreditation was on minimum safety requirements, the emphasis has shifted to quality improvement.”*

Comment

The Hospital Reform Group set up by staff specialists and others have made the situation clear. The system is saved from collapse only by the dedication of the staff struggling through in spite of woeful management decisions.

Conclusion

Current accreditation practice is out of place in this reality. It is an image-building exercise and a burden on staff who already have too much to do. Without ruthless confrontation and honesty, extract [1] promises to never move out of Fantasyland.

Extract [2] *“For consumers, accreditation should provide an assurance that health services they access will provide safe and high quality care.”*

Comment

Before anybody is assured, what has to be overcome are the media reminders that being admitted into a hospital is the most dangerous event in the average person's life. Lying in a hospital bed in this country is claimed to be [Tito and Wilson studies 1995] six times more dangerous than driving on a major road.

Conclusion

The chance of ever getting an assurance which can be believed is probably none.

Extract [3] *“Further, they argue if the result of external assessment of a health service was ‘certification’ (as defined by Standards Australia) that the health service complied with a set of standards then consumers could look at those standards and make some judgement as to whether they thought that met their needs.”*

Comment

If following a medical or surgical procedure a patient has 10 hours of pain, how does she know that she should have had only 2 hours of pain and the bonus 8 hours was due to incompetence? The consumer will never know what goes on within a health service unless one or more of its employees blows the whistle.

The consumer is the target of public relations baloney which is relentless. This is coming down from NSW Health and area administrators as a continuous flow. It is patronising, it is dishonest and annoys the staff at the coal-face who know the truth. Further, a false image of competence puts added pressure on the culture to cover-up mistakes. The accountability and transparency rhetoric seems to be increasing as damage control behind the scenes becomes more desperate and ethically more questionable.

One example: NSW Health's latest glossy publication titled *“Fit for the future. Have you say about future directions for health in NSW”* is yet one more expensive promotion of an image that the state government is just about to get on top of things. With 19 separate photos of smiling faces in its 36 pages, marketing plays an increasing role in the thinking of NSW Health.

Conclusion

As was the case in the previous 3 extracts, what is said in extract [3] is divorced from reality.

Extract [4] *“The need for a new model is not because of fundamental failures with the current accreditation system.”*

Comment

From John Menadue [past chairman NSW Health Council] on the Nine Network 29/2/04. *“No-one runs hospitals. You have the minister and the department micromanaging from the top, intervening whenever there's a media problem. As a result of that, executives are gun-shy about making decisions and taking responsibility. They manage upwards to the minister, rather than managing downwards in the delivery of services to the community.”*

Even if the shocking revelations of the Tito and Wilson surveys of 1995 are in dispute [apparently not by NSW Health's Safety Improvement Program Training Manual [1:10] which still quotes the findings] it took 5 years to get the safety committees up and running. There is probably no better example of systemic ineptitude than this. Accreditation in such an unresponsive environment is a bad joke.

Conclusion

Nothing fundamentally wrong in the checking process! An astonishing claim. The staff-on-the-ground may be concerned with human suffering but the collective conscious of the system is oblivious to it. Nothing could be more wrong in the checking process if that fact is missed.

Extract [5] *“However, when a health service is found to be performing poorly after having been assessed and accredited, it undermines the credibility of accreditation and lowers its value to consumer and others.”*

Comment

In August 1997, the Journal of the AMA reported on a spot survey of 8 pathology labs who were accredited and “well recognised”. Over half were under-performing and one made errors in 46% of the specimens it processed. From this it can be deduced by a cynical public the accreditation of pathology labs is a farce.

A more recent example: After 6500 suspect anatomical pathology reports issued by IPATH had to be checked by external experts, SESIAHS promised on 24/3/05 that all at risk examinations will get a second opinion. On 18/3/06 [and a full year later] the Illawarra Mercury reported that the promise was 98% unfulfilled.

Conclusion

The first places to be excused from the accreditation farce should be the pathology services.

Extract [6] *“There is not a vigorous and consistent method of responding to organisations which are found to pose an unacceptable safety and quality risk.”*

Comment

The cynical public wonders why [after 30 years of conducting an inspection of a culture when it is on its best behaviour] that unannounced inspections are only now being considered. An analogy is for the police to stand back and allow an apprehended suspect time to clean up the scene of the crime before the police investigated that scene.

The cynical public wonders why, after being given months of notice in advance that an inspection is coming and a service is still found by the assessors to be failing so fundamentally that proper management practice is clearly beyond the understanding of its current managers, that same management is given a reprieve and allowed even more months to meet the set criteria.

The pouring over graphs and tables of statistics by the inspectors may be no better than reading a novel. The "evidence" could have been invented in the tea room a few days before the inspector arrived. After the inspector has gone, it is back to normal.

Conclusion

What is said in extract [6] is more than just an understatement.

Extract [7] *".....managers face potentially competing pressures associated with implementing quality changes within budget constraints."*

Comment

From the Buchanin/Considine report May 2002: *"There is an increasing preoccupation with cost control and a decline in the quality of the relationship between nurses and their patients with management discussions hardly ever centred around patient care"*.

Conclusion

When management becomes budget-driven, the striving for quality becomes no more than empty talk.

Needed changes

[1] The failure in the management of human resources is almost on the level of importance to the quality of the health service as what inadequate funding is.

Although initially set up to put the consumer case, we at NSW Health Watch Inc. have become more focused on advising public health employees who have problems with their area health management. The justification for this interest is that the job satisfaction of carers has a direct bearing on the quality of care being delivered.

After becoming involved in cases which can only be described as bizarre, the conclusion I have now come to is that the effective management of boss to worker and worker to worker relationships is completely, utterly and absolutely beyond the capacity of the human resources services of NSW Health.

[2] The scientific understanding by management of human behaviour has to replace the perception that people can be managed like cogs in a machine.

When there is a failure, the bureaucrat assumes that some component needs adjusting and when he becomes aware of a general downhill slide, he desperately seeks to impose another mechanism.

[3] The quality of leadership has to be an accreditation criteria.

"Put the right people in charge and the rest will take care of itself." That was the wisdom of the old entrepreneurs. Currently, if we have the right people in middle management they are likely to have the wrong people above them. If we have the right people as area executives they are hamstrung by NSW Health.

People with high standards leave in frustration leaving the mediocre behind clutching their security blankets. Added to this handicap is that the system takes months and even years to get rid of the hopeless.

The rapid promotion of talent and the ruthless demotion of the untalented is essential, and yet, the system won't allow it - and by so doing, mismanages its human resource. There are penalties for creative initiatives that go wrong and there are rewards for covering one's backside. To be unquestioning is to be a "team-player".

[4] The budgets of the most productive people and programs should not be under such close scrutiny.

Middle managers fear not keeping to their budget as if they go beyond it, life becomes harder for the level above. Activities [such as the consumer participation programs, public relations publications, conferences] which cannot show that they have raised the level of health care [or at least maintained it] need to be culled.

[5] Those who make disclosures must not be treated by both superiors and peers as enemies of the organisation which provides the paypackets.

Not only real protection from reprisals of staff making disclosures must be established but so must active support during the months of inquiry which may follow a serious disclosure. The most courageous must not regret making a disclosure. In retrospect most who report an error or the behaviour of a colleague view that disclosure as one of the biggest mistakes of their lives.

[6] Investigation into the processing of employee industrial grievances must be part of an accreditation process.

From The Workplace Bullying Taskforce to the Queensland Government March 2002: *"Proving the existence of workplace harassment and addressing the problem through the system is so arduous that it only serves to compound the feelings of victimisation and discrimination for the victim"*.

Each of the 4 metropolitan area health services have 15,000 employees. In the worst case scenario [from The Workplace Bullying Taskforce to the Queensland Government March 2002] 3000 of this number have been bullied in the previous 12 months. This is a major problem in public health service delivery which is barely recognised.

As stated by one of the people we at NSW Health Watch Inc. attempted [unsuccessfully] to support: *"When doing work which required 100% concentration if the patient was not to be harmed, I was so stressed from the abuse I was receiving that I could hardly think"*.

On behalf of the community and my family I ask that the Australian Commission on Safety and Quality in Health Care spend less time in theory and speculation and talking to people with hidden agendas and more time in the less comfortable role of face-to-face confrontation. If *"I do not want my child harmed by the system"* was the prime motivator of all the decision-makers and their advisors, we would have a very different set of standards.