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Thankyou for inviting responses to this.

Please find enclosed my uncut comments for you, hopefully you will find them constructive;

I find it difficult to comment on a system that is so short on detail. The proposal for the alternative model amounts to a vague idea at this stage with no definitions of what safety assurance actually means and what a quality assurance framework actually is. Is safety assurance implementation of the National Patient Safety Education Framework (including certification)? is it a national, all encompassing clinical and business indicator program? is it something new that applies occupational safety standards to client care systems or is it just a system of projects as the one medication chart, 10 patient safety tips, credentialing, clinical handover, safer systems saving lives etc. have been? Is a quality assurance framework the application of accreditation? and so a yes / no answer is required to pass or fail? Maybe it is the application of principles e.g. risk management, clinical outcome research, consumer feedback and input into planning?

Having worked in Aged Care, community nursing, Acute Health, health administration and private practice I have seen just how dangerous a divided system is to the client and when you not assessing it as an integrated whole it becomes divided, which in my opinion is a serious backward step.

Saying that, I think there are a couple of important concepts that should be embraced: the accreditation of all settings of care as integrated systems, mutual recognition of various review / accreditation processes, registration of all clinicians to ensure competency, application of occupational health standards to patients safety, and the most important of all, something that the accreditation agencies have been perfecting over the years, is the system working as an integrated organism, i.e. seamless care across the continuum. Maybe if the Commission is looking to be innovative then re-engineering the current model of care into a truly seamless one instead of looking at each individual silo would be far better for the client and far more constructive for all services.

1. Separation of safety assurance and quality improvement assessment processes

When a client enters our services for care / support they need an integrated, effective system for continuity of quality care. I can't see how dividing up the accreditation process will do anything but divide up the services. This will only serve to perpetuate the current problems.

1. Separation between safety standards development and assessment of health services.

Logical – agreed to.

1. Accreditation of all settings of care where services are provided by registered health professionals

I have the following concerns about this: some settings of care say they don't need to employ registered health professionals however they have clients within their services that have such profound disabilities (includes co-morbidities of the frail and aged) that they require clinicians to give the care to keep the clients healthy or recognise when they need to escalate their care – there is a need for regulation around who gives the care to these high need clients. So my answer to this is that there should be accreditation for all health services but that it be tailored to the size of the establishment and needs of the clients. I believe that we need to ensure the quality of health services given to all people in care.

1. National minimum safety standards that apply across all settings of care

Agreed – but keep it simple and easy to apply (not like the National Patient Safety Education Framework)

1. Assessment of non-clinical and technical compliance

Again it is vital that a health service be operated as an integrated whole and that they be monitored as such. Clinical, non-clinical and technical systems are so dependent on each other it would be a serious backward step to divide them up any further than they are. Integration in operation and assessment /monitoring is vital for system effectiveness and client safety.

1. Development of a national framework for quality improvement

A National Framework should look like this:

- o Ombudsman remains a statutory office for health complaints.
- o Mandatory standards are developed and set by the government; these will look at the health service in its entirety including clinical, State, Commonwealth, legislative, political reporting requirements. This would encompass mutual recognition and eliminate double reporting.
- o The registration of health services encompasses the minimum standards that must be met for registration of each particular type and size of service. This includes clinical, non-clinical and technical, risk and safety.
- o Health services are all accredited by non-government accreditation agencies in their entirety. The Health Service must comply with the government mandated minimum standards and the assessment of the degree to which the standards are met are evaluated by the non-government accreditation agency.
- o The non-government accreditation agencies are all accredited and registered with the government as legitimate accreditation agencies.
- o The non-government accreditation agencies offer various methods / types of accreditation (mix 'n match) (could include a mixture of the following types of review that are set for each type and size of service) e.g.
- o The service could contract to have the current ACHS / QIC style of program: i.e. onsite, planned surveys with pre-documentation that includes quality journals and evidence of achievements including peer review, best practice guides and benchmarking (clinical),
- o They could have 1 unannounced survey each year, 3 tracer methodologies per year and a series of audits including patient and staff satisfaction, consumer involvement, etc.
- o other types of program.....

1. Establishment of a National Entity to lead and coordinate changes

Yes – to lead and control the quality of health service delivery there needs to be:

- o health service standards mapped, developed and set
- o changes in the registration of health services to include minimum quality standards that are relevant to the type and size of service,
- o accreditation programs set within flexible parameters (mix 'n match) to ensure appropriate standard of service.
- o registration ensuring competency of all health professionals

- o registration of all accreditation agencies

and this needs a national entity to do this initially. I think ultimately a regulation type body could do this work without too much infrastructure.

1. Review of surveyor training

This would form part of the registration process of accrediting agencies and made a focus by their accrediting agencies.

1. Associated Reforms

All of these should be considered during the development of the accreditation process as for 6 above.

regards

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