

Response to The Consultation Paper

“An Alternative Model for Safety and Quality Accreditation of Health Care”

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The consultation paper proposes an alternative model for safety and quality accreditation of health care and asks for comment that relates mainly to implementation of the proposal. However there two fundamental issues, the proposal to separate safety and quality and the separation of safety standards development and assessment of health services, which should be addressed before implementation is considered.

Separation of safety and quality

The separation of safety and quality assumes that patient safety is a discreet entity. However patient safety is one of many management streams that enable the delivery of safe and high quality patient care. The major thrust of patient safety has been to standardise the processes of care, thus reducing the opportunity for discretion, aberrant practice and error. It is clear that many aspects of patient care are amenable to this approach, although it is also clear that in the complex area of health care rule based practice alone is not sufficient. Process control also has the apparent advantage of simplicity, certainty, and potentially provides the ability to measure and control practice and performance.

Although good processes are essential to good systems of care, they are only part of those systems, which are usually complex and involve multiple parties and knowledge sets. The development of care systems, which requires the coordination of the activities of multiple parties requires significant sophistication of management at the organisational level and is not amenable to central directives. Many aspects of patient care are clinically based and depend on professional knowledge and judgement, which have not been shown to be amenable to simple directive management processes. Experience shows that

although good health care that is safe is provided in good health care organisations, poorly managed organisations do not provide safe care.

It is well recognised that incentives will direct management to concentrate effort on particular activities that are recognised by those incentives. In Australia this is manifest in the concentration on the economic or budgetary aspects of health care, particularly in the public system, where adherence to the budget is the primary concern of senior management, sometimes to the detriment of the quantity or quality of patient care. It is likely that separation of “patient safety” will have a similar unintended effect, particularly if it is directed towards compliance with centrally determined safety processes that have been selected in the belief that they represent the most important aspects of safe patient care, but do not take account of the systems of care that demand high levels of integration.

From another perspective, for all the process changes made in the name of patient safety, clinical professional staff still need to have the knowledge and understanding to deliver safe care. In his paper Human Error: models and management, (BMJ 2000, v320 p768), James Reason makes the point that high reliability organisations need to be able to adapt rapidly and substantially to changes, which requires a significant flexibility and ability to exert local control of unexpected situations.

Separation of safety standards development and assessment of health services

The consultation paper proposes the separation of the development of standards and assessment of health services. This is justified on two grounds, ie conflict of interest and removal of barriers to standardisation, possibly on a national basis. It appears that both these arguments are fundamentally flawed.

The Australian Council on Healthcare Standards and other independent surveying bodies use standards that they have either developed or adopted. In the case of the ACHS, the standards have been developed in consultation with multiple stakeholders, including health care organisations and have been refined through several versions. The standards are an analytical framework, which can be used to assess the performance of health care

organisations both in relation to each particular standard, and overall performance. The real conflict of interest is small, and relates particularly to the perception of the survey process by the organisation, which may influence continued participation in the EQUIP process. In contrast state departments of health, which are collectively the largest owners and operators of hospitals, have a very direct interest in the outcome of surveys and there would be a far greater and more serious conflict of interest if they were or had a significant control of the standards and hence the survey process. For example, experience with surveying shows that inadequate resources and poor management may be responsible for deficient patient care. Resources and management are the responsibility of departments of health, which might conceivably move to have consideration of these aspects removed from the survey process.

Standard setting is a complex process that involves much more than setting regulations. State departments of health have had the ability to set standards of safety and quality for their own organisations, but to date have not been actively involved in these processes and have given very limited support to the collection of clinical outcome data. The process of standard setting on a centralised basis is embryonic. Experience with the use of central administrative data to measure clinical performance or the setting of centrally developed clinical performance standards is limited and the capacity of these processes to detect aberrant practice, or have a beneficial effect on patient safety and the quality of care is yet to be established. The study by Sutherland and Leatherman indicated that inspection alone is not successful, particularly if it is not linked to process improvement. Similar conclusions are to be found in the general (i.e. non-healthcare related literature). Similarly, it is clear that there are organisational factors that inhibit the effectiveness of specific centrally directed programs, such as patient safety and safe medication practice. In summary, a completely independent process is the best assurance of quality and safety of care. The actual form of the process may matter less than the fact that it is independent. To date, state departments of health have not been active in ensuring the quality and safety of care and there is little evidence that they have the ability to develop, or to contribute to the development of appropriate standards.

The second argument is that a more centralised process would be more conducive to the development of national standards. However this course may make the development of national standards more difficult than it is at present. Organisations such as the ACHS operate on a national basis and use standards that are applied nationally for surveying health care organisations and are therefore already national standards. In contrast a centrally led process would need to involve state health departments in an exercise of development of a single set of standards that would be acceptable to all states as well as private operators. This would represent a significant exercise of gaining consensus. The standards would then need to be circulated for comment and then tested to provide evidence of their effectiveness. This is likely to be a prolonged and costly process that might not improve matters from the current situation.

Sutherland K. and Leatherman S. Regulation and Quality Improvement: A review of the evidence. 2006 Quest for Quality and Improved Performance

Reason, James Human error: models and management. *BMJ*. 2000 March 18; 320(7237): 768–770.