

## Primary Care and the ACSQHC – what is the link?



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GP Forum  
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## Patient Safety in Primary Healthcare: draft literature review

3 questions

1. What are the main patient safety risks relevant to primary care?
2. What research has been conducted regarding solutions to these risks?
3. What are the gaps in the evidence base about patient safety in primary care?

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## Patient Safety in Primary Healthcare: draft literature review

What are the main patient safety risks relevant to primary care?

- Process errors are common
- Diagnosis related errors greatest severity of harm
- Most frequent process errors

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## Patient Safety in Primary Healthcare: draft literature review

What are the main patient safety risks relevant to primary care?

- Process errors
  - administration (7 - 40%) includes message handling, recall systems
  - investigation (8 - 70%) includes each step in process
  - treatment (2 – 45%) includes medication errors
  - communication (4 – 15%) impact of health literacy
  - payment (1 – 4%) cost of health care; fear of litigation

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## Patient Safety in Primary Healthcare: draft literature review

What are the main patient safety risks relevant to primary care?

- Process errors (80%)
  - medication errors – prescribing and dosage – most frequent
  - communication errors prevalent
- Diagnosis errors (20%)
  - greatest severity of harm
- Vast majority of literature derived from general practice

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## Patient Safety in Primary Healthcare: draft literature review

What research has been conducted regarding solutions to these risks?

- No simple solutions
- Need solutions for
  - organisational change
  - prescribing
  - communication
  - diagnosis

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## Patient Safety in Primary Healthcare: draft literature review

What research has been conducted regarding solutions to these risks?

- Any approach requires consideration of:
  - systems for reporting errors organisation nationally
  - 'ground up' implementation methods
  - safety education in core curricula
  - managers, leaders, doctors and nurses embracing safety
  - careful design of systems to aid safety (eg IT)
  - avoid blame and litigation
  - development of informed patients
  - cooperation between service providers

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## Patient Safety in Primary Healthcare: draft literature review

What are the gaps in the evidence base about patient safety in primary care?

- Problems with evidence
  - lack of evidence, especially regarding solution
  - evidence descriptive, expert opinion, commentary
  - lack trials regarding medication
  - lack evaluation technology including IT systems, decision support.

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## Patient Safety in Primary Healthcare: our national challenge

- Error rates 5 – 80 per 100,000 consultations
- Clinical negligence data base
  - failure or delay in diagnosis 50%
  - medication prescription error 5%
  - failure or delay in referral 5%
  - failure to warn of side effects 5%
  - commonest recorded outcome: death 21%

Woodward, S Clinical Risk (2005) 11, 142-144

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## Patient Safety in Primary Healthcare: our national challenge

Seven steps to patient safety

1. Build a safety culture
2. Lead and support staff
3. Integrate risk management activity
4. Promote reporting
5. Involve and communicate with patients and the public
6. Learn and share safety lessons
7. Implement solutions to prevent harm

Woodward, S Clinical Risk (2005) 11, 142-144

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## The Australian Commission on Safety and Quality in Health Care

- Established by Health Ministers in 2005, commenced in 2006
- Reports to all Health Ministers
- Commissioners diversity and strength
- Committee structure:
  - IJC, PHSC, PCC, ISC
- Stakeholders / Colleagues include:
  - Consumers
  - Professional organisations
  - Health Service Executives
  - Safety and Quality organisations

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## Health Ministers Established ACSQHC to:

1. Lead and coordinate safety and quality in health care
2. Advocate for safety and quality and report publicly
3. Recommend national data sets
4. Provide strategic advice to Health Ministers
5. Recommend nationally agreed standards

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## Our Programs

- Australian Charter of Healthcare Rights
- Open Disclosure
- Basic Care Issues
  - Healthcare Associated Infection
  - Patient Identification
  - Medication Safety
  - Clinical Handover
  - Patient at Risk
  - Falls Guidelines
- Tools
  - Accreditation and Credentialling
  - Information Strategy

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## AHMC and ACSQHC: 2008

- Review of national safety and quality accreditation standards
- National Open Disclosure Standard
- Australian Charter of Healthcare Rights
- Specifications for a standard patient identification band
- HAI surveillance in all Australian Hospitals (and reporting of *Staphylococcus aureus* bacteraemia and *Clostridium difficile* infections)
- National Hand Hygiene Initiative
- Use of paediatric NIMC for all hospitalised children
- Standardised terminology, symbols and abbreviations to be used in hospital medicines prescribing and administering

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# Australian Charter of Healthcare Rights

## AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

### Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

- 1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.
- 2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.
- 3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.



For further information please visit [www.safetyandqualityinhealthcare.au](http://www.safetyandqualityinhealthcare.au)  
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### What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
<b>Access</b> I have a right to health care.	I can access services to address my healthcare needs.
<b>Safety</b> I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
<b>Respect</b> I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
<b>Communication</b> I have a right to be informed about services, treatment options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
<b>Participation</b> I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
<b>Privacy</b> I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
<b>Comment</b> I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.



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# The Role of a National Safety and Quality Framework

- Basis of strategic and operational safety and quality plans
- Mechanism for refocussing activities, reviewing investments and designing goals
- Promote discussion with consumers, clinicians, managers, researchers and policy makers.

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## Patient Focused

Safe, high quality health care is always patient focused:	What it means for me as a patient or consumer:	Strategies for action by health systems and providers:
This means providing care that is respectful of and responsive to individual preferences, needs and values. It means a partnership between consumers, family, carers and their healthcare providers. Processes of care are designed to optimise the patient experience.	I can access high quality care when I need it.	<ul style="list-style-type: none"> <li>• Develop service models which improve access to health care for patients.</li> </ul>
	I can obtain and understand health information, so that I can make decisions about my own care and participate in ensuring my safety.	<ul style="list-style-type: none"> <li>• Increase health literacy.</li> <li>• Involve patients so that they can make decisions about their care and plan their lives.</li> <li>• Provide care that is culturally safe.</li> </ul>
	My health care is co-ordinated because people and systems work in partnership with me.	<ul style="list-style-type: none"> <li>• Enhance continuity of care.</li> <li>• Minimise risks at handover.</li> <li>• Provide case management for complex care.</li> <li>• Enable multidisciplinary care.</li> <li>• Facilitate patient-centred service models</li> </ul>
	I know my healthcare rights	<ul style="list-style-type: none"> <li>• Promote healthcare rights.</li> </ul>
	If I am harmed during health care, it is dealt with fairly. I will get an apology and a full explanation of what happened.	<ul style="list-style-type: none"> <li>• Inform and support patients who are harmed during health care.</li> </ul>

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## Driven by Information

Safe, high quality health care is always driven by information:	What it means for me as a patient or consumer:	Strategies for action by health systems and providers:
This means enhancing knowledge and evidence about safety and quality. Safety and quality data are collected, analysed and fed back for improvement. Action is taken to reduce unjustified variation in standards of care, and to improve patients' experiences and clinical outcomes.	<b>My care is based on the best knowledge and evidence.</b>	<ul style="list-style-type: none"> <li>Reduce unjustified variation in standards of care.</li> <li>Collect and use data to improve safety and quality.</li> </ul>
	<b>My clinical outcomes and experiences are used to build the evidence base for care and for strategies designed to improve care.</b>	<ul style="list-style-type: none"> <li>Learn from patients' and carers' experiences.</li> <li>Encourage and apply research that will improve safety and quality.</li> <li>Continually monitor the effects of healthcare interventions.</li> </ul>

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## Organised for Safety

Safe, high quality health care is always organised for safety:	What it means for me as a patient or consumer:	Strategies for action by health systems and providers:
This means that safety is a high priority in the design of health care. Organisational structures, work processes and funding models recognise and reward taking responsibility for safety.	<b>I know that governments, healthcare managers and healthcare staff take responsibility for my safety.</b>	<ul style="list-style-type: none"> <li>Clinicians recognise their responsibilities for safety.</li> <li>Managers recognise their responsibilities for safety.</li> <li>Governments recognise their responsibilities for safety.</li> </ul>
	<b>Our money funds a safe and efficient health system.</b>	<ul style="list-style-type: none"> <li>Restructure funding models to support safe, appropriate care.</li> <li>Support and implement e-health.</li> <li>Design facilities, equipment and work processes for safety.</li> </ul>
	<b>I know that when something goes wrong, actions are taken to prevent it happening to someone else.</b>	<ul style="list-style-type: none"> <li>Take action to prevent or minimise harm from healthcare errors.</li> </ul>

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Quality Health Care Conversation brought to you by the AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

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Welcome to the Quality Health Care Conversation

**Draft National Safety and Quality Framework**

Organised for safety	Driven by Information	Patient Focused
<p><b>What it means for me as a patient or consumer:</b></p> <ul style="list-style-type: none"><li>I know that governments, health care managers and healthcare staff take responsibility for my safety.</li><li>Our money funds a safe and efficient health system.</li><li>I know that when something goes wrong, actions are taken to prevent it happening to someone else.</li></ul>	<p><b>What it means for me as a patient or consumer:</b></p> <ul style="list-style-type: none"><li>My care is based on the best knowledge and evidence.</li><li>My clinical outcomes and experience are used to build the evidence base for care and for strategies designed to improve care.</li></ul>	<p><b>What it means for me as a patient or consumer:</b></p> <ul style="list-style-type: none"><li>I can access high quality care when I need it.</li><li>I can obtain and understand health information, so that I can make decisions about my own care and participate in ensuring my safety.</li><li>My health care is co-ordinated because people and systems work in partnership with me.</li><li>I know my healthcare rights.</li><li>If I am harmed during health care, it is dealt with fairly, I will get an apology and a full explanation of what happened.</li></ul>
Strategies for action by health systems and providers.	Strategies for action by health systems and providers.	Strategies for action by health systems and providers.

have your say share your views what do you think contribute say share your views

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Safe and high quality health care for Australia