10 September 2009

National Safety and Quality Framework
GPO Box 5480
SYDNEY NSW 2001

Dear Sir / Madam,

I attach a submission to the ACSQHC, following the release of its proposed National Safety and Quality Framework, and request for input regarding this. I do not purport to represent the opinions or policy of the administration of the health service for which I work. However, I have been a full-time staff consultant physician at this health service in Melbourne for the past nine years, and prior to this I worked as a visiting medical consultant for twelve years to the same health service, while simultaneously working in private practice. I am passionate about patient safety, and to this end, have completed a Masters in Quality Improvement in Health Care, and a Masters in Medical Science (Clinical Epidemiology). I have been a member of my health service's Adverse Outcome Committee for a number of years, in addition to several other committee's within the health service. Consequently, I have had close and frequent exposure to most issues relating to patient safety within a public hospital setting.

The basic framework proposed by the ACSQHC, focussing on patients, driven by information and organised for patient safety is excellent. It remains to be seen however, to what extent governments will be prepared to implement the details contained within the framework. In the interest of patient safety, I hope that this submission may help to support the case for decisive action.

Yours sincerely,

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Submission to the Australian Council for Safety and Quaility in Health Care regarding proposed National Safety and Quality Framework **G. Lane 10 Sept 2009**

A. "What do you consider most important for safe, high quality care?" (in order)

1. Rapid implementation of a national electronic health record as part of an integrated electronic clinical systems, with appropriate access only by authorised clinicians and health officials. There also needs to be an appropriate and equitable increase in investment in ICT as an essential component to the provision of safe medical care. These measures would greatly lessen the risks of medical error, markedly improve the availability of clinical information that is necessary in decision making, avoid duplication of investigations, enhance continuity of care, and allow the appropriate systematic collection of data that is required to properly manage patient safety issues at a local as well as national level (1).

2. Widespread implementation of appropriate clinical decision support systems within healthcare systems This has been previously shown to result in marked improvements in patient safety and quality of care (2,3).

3. Active government support for the more careful selection of medical students, with criteria to place more emphasis on factors that are likely to be associated with improved patient safety, such as personality attributes, rather than academic performance (4).

B. <u>What do you consider to be the current barriers to safe, high quality care?</u>

One could list many reasons for the lack of speed with which the problems regarding the safety and quality of healthcare are being fixed . However, most, if not all of them, arguably relate to the low level of knowledge regarding factors affecting patient safety among politicians and lay society. There is a consequent lack of a sense of urgency for improvement. The reasons are not soley related to clinicians and health services.

1. Political expediency. Full implementation of appropriate healthcare innovation requires a long term vision, and willingness to implement major change over the medium to long term. Major changes in infrastructure to improve patient safety require initial major expenditure. It could reasonably be predicted that the full benefits of this expenditure would only be realised after several (five to ten) years. However, the total financial savings caused by improvements in patient safety and other aspects of quality of care would far outweigh the initial expenditure (5). Such changes are not possible when politicians look with expediency to the next election which may be either “early”, or at the most, three years away, at a national level. A major factor perpetuating this political expediency is the lack of universal fixed national and state parliamentary terms of office that have been successfully implemented in other entities such as the European Union, the United States, Canada, and many individual states, without most of the consequences threatened by previous naysayers.
2. Concerns by civil libertarian groups and individuals regarding privacy and trust with regard to electronic medical and health records. These may be either perceived or real; genuine or vexatious. However, regardless of whether threats to privacy can be

validly substantiated, they will likely deter governments from proactively implementing electronic medical and health records (6). Despite this, practical and pragmatic discussion and proposals have already been had in this regard (7,8).

3. The inefficiencies caused by the administration of different levels of healthcare by different levels of government. The administration of healthcare would be more efficient, with less duplication of both bureaucracy and provision of health services, if coordination of all or most services was transferred to a national level, *provided that* there was representative, meaningful and competent input to national decisions from local area health services and/or regions.
4. The marked variability in whistleblower legislation between different states and territories. Despite situations where there has been no meaningful attempt to rectify gross inadequacies in processes or policies within health organisations, government bureaucracies or system processes that detrimentally affect patient safety and other aspects of quality of care, fear of the consequences of making problems public knowledge is endemic, While this includes clinicians, it is particularly problematic for managers within healthcare organisations and governmental health departments, who are often in a prime position to recognise the above mentioned inadequacies Current legal protection for whistleblowers only revolves around administrative law, rather than any intent to report processes which have a negative impact on patient safety or quality of patient care (9).
5. The inadequate understanding by local politicians, both state and federal, of what infrastructure issues are determining the level of patient safety that can, or cannot, be achieved in health services in their own electorates.
6. The lack of general awareness by the public as to how potentially dangerous, as well as inefficient, the health care system currently is, given its current infrastructure (10).

In particular, how often major critical decisions are made without the availability of neccessary information. Unavailable, because it is paper based, and unobtainable at the time of the decision making process. There are multiple possible reasons why such documents are unobtainable when required. Without this awareness by the public, there is minimal pressure from them on hospital administrators, and more importantly, local state and federal politicians, to address the problems that are occurring in their own electorates.

7. There is inadequate input into key strategic decision making, at a local hospital level, by patients and currently active clinicians from within the hospital or hospital service area (11,12). The long term consequences of a hospital board or executive decision still resound long after the board members or executive have moved on to other employment. Senior clinicians and patients however, are still likely to remain, to experience the consequences. Appropriate and meaningful input from the local community and clinicians with the coal-face experience and clinical knowledge would better enable a hospital board or executive to make decisions with long term consequences that are more likely to be appropriate.

C. ***What do you think about any or all of the strategies described in the discussion paper?***

"Principle 1: Patient Focussed"

Strategies:

"1.2 Increase health literacy"

This should include measures to prevent unrealistic community expectations in situations of irreversible conditions, or in situations where aggressive medical intervention would be futile. There should be more open and widespread discussion and promotion of advanced medical directives at a federal and state health departmental level.

"***1.3 Involve patients so that they can make decisions about their care and plan their lives"***

Although the discussion paper points out that involving patients in decision making has not been shown to change outcomes, intuitively this can only be a good thing. One mundane but critical practicality that should be promoted as totally acceptable is for a patient to ask of, or remind a health care provider who is attending to them as to whether they have cleaned their hands before examining them.

"1.5 Enhance continuity of care"

In a hospital setting, it is impossible to have continuity of care by one doctor, but further steps can be undertaken to minimise the number of changes in continuity of care by more careful attention to the details of ***rostering*** of medical, nursing and allied health staff. In a medical team, there are often frequent changes in senior and junior medical staff managing a patient. A significant proportion of these changes are often potentially avoidable.

"1.6 Minimise risks at handover"

In a hospital setting, clinical handover occurs frequently and is a high risk time. Although one size does not fit all, making handover "electronic", in addition to face-to-face, is the one intervention that would most reduce risks of poor communication at times of handover, while at the same time ensuring that handover actually takes place. This would help ensure that critical information, as well changes in responsibility for patient care were not overlooked. Electronic handover would also minimise

duplication of work, and help facilitate transmission of information between hospital and community health care workers. Electronic handover would also allow easier auditing of the handover process than is currently possible.

"1.10 Inform and support patients who are harmed during health care"

There needs to be uniformity between Australian states and territories in relation to the legal aspects of "open disclosure".

"2. Driven by information"

Strategies:

"2.1 Reduce unjustified variation in standards of care"

Without a more unified and usable form of information technology, including electronic health records, it will be impossible to make significant, sustainable improvements in this area.

"2.1 Collect and use data to improve safety and quality "

It is true that "few facilities routinely combine and analyse data from medical records, pathology, incident reports, prevalence audits, patient experience surveys and outcome studies", as the discussion paper states. This is unlikely to occur without the implementation of a fully integrated IT system which enables the merging of data from the patient health record, pathology, radiology, pharmacy, medication prescription and dispensing, and electronic patient management system.

"*Collecting and using data to support safety and quality...*" would involve an extensive use of information technology to ensure points "a-g" (p 20 in document), including linking of datasets.

"2.5 Continually monitor the effects of healthcare interventions"

This is only systematically possible and sustainable if there is a fully integrated clinical IT system

"3. Organised for safety"

Strategies:

"3.1 Clinicians recognise their responsibilities for safety"

The discussion papers comment that "doctors are increasingly alienated from the healthcare system" is currently and commonly evidenced in clinical practice. Clinicians are increasingly less willing to

contribute to planning process improvements when their previous efforts at input, based on practical experience, has often been ignored, unvalued, or not sought, by hospital, state and federal bureaucrats. The resultant cynicism, though difficult to overcome, could be lessened if both clinicians and bureaucrats/politicians adopted a less partisan approach than that which has characterised some of the past experiences. Until such a change in approach occurs, it is quite possible that only a minority of clinicians will willingly participate "in safety systems and improvement initiatives, to ensure that the best possible care is given." The framework correctly states that: "If clinicians are to be held to account for the quality outcomes of the care they deliver, they also need the power to affect those outcomes" (13).

The comment that clinicians should "encourage each other to speak up for safety, and knowing that they will be protected when they do so" could be considered wishful thinking and non-credible, given the existing whistleblower legislation in most states and territories

"3.2 Managers recognise their responsibilities for safety"

This responsibility/ accounatability should be explicitly extended to include hospital Boards (where existing) and CEOs/ other hospital executives. Performance indicators for boards and executives should be constructed so that outcomes for patient safety have at least the same emphasis as other performance and financial targets.

"3.3 Governments recognise their responsibilities for safety"

For Governments (as well as individual health services) to be held accountable for their role in fostering patient safety, the parameters by which they measure patient safety need to be broadened. The data required for this can only be sustainably collected if there is an efficient, and fully integrated clinical IT system.

"3.4 Restructure funding models to support safe, appropriate care"

Agree with comments.

"3.5 Support and implement e-health"

Agree with comments. To date, the perception has been that outcomes from NEHTA have been slow and seemingly small.

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