Australian Dental Association Inc.

Australian Safety and Quality Goals for Healthcare

Submission to Australian Commission on Safety and Quality in Healthcare

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Authorised by
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About the Australian Dental Association

The Australian Dental Association Inc. (ADA) is the peak national professional body representing over 13,000 registered dentists and dental students engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are to:

• Encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry; and

• To support members of the Association in enhancing their ability to provide safe, high quality professional oral healthcare.

There are ADA Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au.

Introduction

The ADA welcomes the opportunity to provide comment on the Australian Commission on Safety and Quality in Health Care (ACSQHC)'s Consultation Paper *Australian Safety and Quality Goals for Health Care* (ASQGHC). The Consultation Paper aims to identify those goals that will identify priority areas that could form the basis of coordinated national action and provide the opportunity for integrated effort to maximise the benefits that can be achieved from existing and new safety and quality work.

The ADA urges government to consider the recommendations in this submission to ensure that areas of healthcare provision where greater safety and quality is needed are supported by appropriate frameworks, coupled with the appropriate feedback on how this may best be delivered by those providing the healthcare.

The ADA's comments are made in relation to the three identified goals and the consultation questions and are based on consultations it has had with its members and from its Branches. We trust that our comments provide a constructive contribution to the further refinement and implementation of the ASQGHC.

Executive Summary

Goal 1: Safety of care

Recommendation 1: That Goal 1 recognises that in dentistry there is no need for reform in this area because:

- There are minimal adverse medicines events/quality use of medicines issues within the dental practice environment, the dentist profession has adequate arrangements to ensure the quality prescription and use of medicines in the dental context; and
- The dental profession has adequate existing guidelines to address infection control requirements.

Goal 2: Appropriateness of care

Recommendation 2: To ensure the initial priorities for Goal 2 are addressed, the ACSQHC outline the need for primary health contacts to refer their patients that have diabetes/advanced cardiovascular diseases onto dentists for a comprehensive oral health assessment.

Goal 3: Partnering with patients and consumers

Recommendation 3: Any objectives relating to patients and consumers must be realistic, and cognisant of the different practice environments of the office based dental practice.

Consultation Paper Questions

Recommendation 4: That when the ACSQHC proposes and develops frameworks and initiatives that have a direct impact on the dental profession and the practice of dental care, it recognises that the bulk of dentistry is office based, private practice service delivery. The ADA urges the ACSQHC improve its existing consultation processes to facilitate this end.

Recommendation 5: That the development of goals for safety and quality better recognise that certain issues in the medical/hospital context give rise to oral health risks and so appropriate processes to identify and address these risks needs to be developed.

Recommendation 6: That goals/priority areas and safety/quality frameworks and assessment processes must be developed only where there is a validated evidence base that such programmes need to be instigated. Furthermore, relevant health practitioners should be key stakeholders in consulting on the need for such goals and developing the appropriate response when required.

Recommendation 7: That the targeting and framing of the Goals, and associated frameworks and assessment processes be done in a manner that does not duplicate existing regulations.

Overview

Safety and quality issues outlined do not apply to Australian dentistry

The Consultation Paper states that:

"The safety and quality 'problem' has not yet been fixed, and more needs to be done to achieve the vision of the safe and high quality health care described in the Australian Safety and Quality Framework for Health Care."

While agreeing with this statement the ADA emphasises that the literature on adverse events shows that these occur primarily in hospitals and major institutions and not in small office based practice and most particularly, not in private dental practice, which constitutes in excess of 80% of dental service delivery in Australia. **The ADA has frequently sought data from ACSQHC to substantiate the need for improved safety in practices but this has never been provided.**

The ADA agrees that the quality process should consider factors such as:

- The impact on the health system in terms of issues such as the burden of disease, cost to the system and number of adverse events; and
- The existence of significant safety and quality problems, such as high levels of preventable harm and significant gaps between evidence and practice.

The ADA notes that the number of adverse events as well as their health outcomes is exceedingly low for dentistry compared to medicine or other areas of health care.

The ADA cautions the ACSQHC to be wary of proposing frameworks and regulations that are imposed on private dental practices when such protocols may be relevant to other areas of health delivery but not required in dentistry. To do this will impact adversely on efficiencies and costs of office based dental service delivery. Increased regulatory burden on private dental practise will mean that there will be increased costs in terms of resources and time; which will ultimately mean that patients will have less access to care and a higher cost for the service provided. This will also transcribe into hospital and large clinic based care and due to deferred treatment times leading to complications requiring hospital admission and thus longer hospital waiting lists. The risk of adverse health outcomes arising would increase.

Goal 1 – Safety of care: That people receive their health care without experiencing harm

The ACSQHC's initial priorities under this goal are to:

- Reduce harm from adverse medicines events and improve quality use of medicines; and
- Reduce harm from healthcare associated infections through effective infection control and antimicrobial stewardship.

a. Adverse medicines events/quality use of medicines

The ADA supports this first goal but emphasises that dental practitioners generally use a limited range of medicines and that prescriptions of medicines such as antibiotics to support treatment of infections comprise only a small fraction of current antibiotic usage in Australia. Moreover the dental profession has produced its own comprehensive guidelines on the use of antibiotics and other prescription drugs in dentistry, which stress the application of the principles of safe prescribing and the quality use of medicines.

The ADA cautions government from restricting the dental profession's prescribing rights in any fashion as this will greatly increase the risk of more serious sequelae from dental infections which may result in unnecessary hospital admission. Furthermore, if all dental patients were required to visit a medical practitioner for antibiotics then that would increase the burden on medical practice, increase the cost of service and require a significant educational programme for medical practitioners to identify and prescribe the appropriate antimicrobial agent for the specific dental disease. We advocate that dentists are in the best position to understand the pathogens involved in oral infections and are best able to prescribe the appropriate antibiotic.

b. Healthcare associated infections

The ADA notes that the majority of healthcare associated infections (HAIs) occur in hospitals, large institutions and public sector facilities, and not within office based dental practices.

It is appropriate to place emphasis on the former rather than the latter. Catheter associated urinary tract infection (CAUTI) and central line associated blood stream infections (CLABSI), are the most common and costly HAIs. These are not associated with dental practice.

Moreover, the ADA has developed and promulgated its own comprehensive guidelines on infection control which draw on the *Australian Guidelines for the Prevention and Control of Infection in Healthcare (*developed by the National Health and Medical Research Council and ACSQHC). These guidelines provide detailed advice for dental practice in Australia on a wide range of topics including hand hygiene, personal protective equipment, handling and disposal of sharps, routine and environmental cleaning, as well as contact, droplet and airborne precautions. They are also part of the requirements for Dental Board of Australia dental registration.

Recommendation 1:

That Goal 1 recognises that in dentistry there is no need for reform in this area because:

- **There are minimal adverse medicines events/quality use of medicines issues within the dental practice environment, the dentist profession has adequate arrangements to ensure the quality prescription and use of medicines in the dental context; and**
- **The dental profession has adequate existing guidelines to address infection control requirements.**

Goal 2 – Appropriateness of care: That people receive appropriate, evidence-based care

The ACSQHC's initial priorities under this goal are for:

- People living with type 2 diabetes; and
- People with acute coronary syndrome or stroke.

The ADA has supported educational campaigns outlining the interactions between oral health and systemic disease, particularly for diabetes and cardiovascular disease. The current evidence suggests two-way interactions in the case of diabetes and a number of associations (but not direct cause-effect relationships) with cardiovascular disease. There is also an increased risk of aspirational pneumonia associated with severe periodontitis.

Periodontal status is known to affect diabetic control, and periodontal disease is recognised worldwide as the sixth major complication of diabetes, the other five complications are retinopathy, neuropathy, nephropathy, cardiovascular disease and peripheral vascular disease. Multiple epidemiological studies have demonstrated that both type 1 and type 2 diabetes are predictors of periodontal disease when the systemic condition is poorly controlled. Many clinical studies have provided evidence that control of periodontal infection has an impact on improvement of glycemic control agents evidenced by a decrease in demand for insulin and decreased haemoglobin A1c levels.

In addition to periodontal infection and gingival inflammation, a number of other oral complications have often been reported in patients with diabetes. These include xerostomia, dental caries, Candidiasis, burning mouth syndrome, lichen planus and poor wound healing.

The ADA stresses the need for patients with diabetes and advanced cardiovascular disease to be referred for dental assessment, particularly in relation to the health of the periodontal tissues. Inflammatory conditions affecting the periodontium are recognised as important contributors to the total body burden of infection and inflammation. Treating periodontal infections can be influential in contributing to glycemic agent control management and possibly to the reduction of the burden of complications of diabetes.

Recommendation 2:

To ensure the initial priorities for Goal 2 are addressed, the ACSQHC outline the need for primary health contacts to refer their patients that have diabetes/advanced cardiovascular diseases onto dentists for a comprehensive oral health assessment.

Goal 3 – Partnering with patients and consumers: That there are effective partnerships between patients, consumers and healthcare providers and organisations at all levels of healthcare provision, planning and evaluation

This third goal as discussed by the Consultation Paper is focused around hospital and institutional based care and therefore has only very limited application to office based dental practice, particularly in the private sector. The evidence base referred to by the Consultation Paper relates to length of hospital stay and other metrics which are not relevant to dental care.

Recommendation 3:

Any objectives relating to patients and consumers must be realistic, and cognisant of the different practice environments of the office based dental practice.

Consultation Paper Questions

1. How do you think national safety and quality Goals could add value to your existing efforts to improve the safety and quality of care?

The Goals, as currently framed and presented, unfortunately provide little benefit to the practice of dentistry or to dental practice as the profession already has guidelines that ensure that safety and quality dental care is provided. This is evidenced by the considerably low incident rate of adverse patient outcomes.

ACSQHC education material has had little or any penetration into dentistry. The dentist profession had not received any engagement by the ACSQHC to educate or initiate its education into the profession until practice accreditation was proposed.

The ADA is very disappointed with the manner in which the ACSQHC developed and implemented the practice accreditation framework. The ADA has repeatedly attempted to provide the key message that office based service delivery of dental health and its intricacies be recognised. Unfortunately the ADA has seen a "one size fits all" approach to safety and quality being created – this approach has not been applied anywhere else in the world and should not be applied to the Australian healthcare landscape.

Recommendation 4:

That when the ACSQHC proposes and develops frameworks and initiatives that have a direct impact on the dental profession and the practice of dental care, it recognises that the bulk of dentistry is office based, private practice service delivery. The ADA urges the ACSQHC improve its existing consultation processes to facilitate this end.

2. Do you agree with the topics that have been included as Goals and priority areas? Are there other areas that should be considered?

The ADA has already noted that the Goals and priority areas identified are primarily based on a hospital/medical practice model. The dental practice environment is very different from the hospital/medical practice model and as such, framing such safety and quality goals in this manner risks patients' health not to mention the additional costs this will create.

What should also be noted is that safety and quality requirements are part of the National Registration Law and that these ACSQHC goals are largely just duplication of other statutory bodies' domain.

It also needs to be pointed out that many medical conditions that are addressed need to be looked at not only purely from a medical perspective but from the point of view of dental health diagnosis. Safety and quality issues from a medical practice perspective can neglect critical oral health implications and risks, for example:

- Patients being prescribed bisphosphonate therapy without a dental review increasing the potential risk of osteonecrosis of the jaws;
- Patients undergoing chemotherapy and radiation therapy without suitable dental oversighting prior to and during treatment; and

- Patients having cardiovascular and prosthetic joint replacements without a dental review or the risks post operatively of poor oral care.

Recommendation 5:

That the development of goals for safety and quality better recognise that certain issues in the medical/hospital context give rise to oral health risks and so appropriate processes to identify and address these risks needs to be developed.

3. What do you think about the specificity of the Goals and priority areas? Are they too broad or too specific?

4. Do you think that there should be specific targets attached to the Goal or priority area? If so, what form should such a target take?

The ADA urges that goals and priority areas must be created to address actual health safety and quality needs and concerns, and targeting of assessments and data collection activities must be done in a scientific manner. While the Consultation Paper in some sections does attempt to do this, the ADA urges the ASQHC to ensure that it is targeting areas for which there is substantiated evidence of a problem or risk.

Inappropriately targeted health areas will be costly and time consuming, not to mention failing to deliver on the safety/quality aims of both the ACSQHC and Australian health practitioners.

Recommendation 6: That goals/priority areas and safety/quality frameworks and assessment processes must be developed only where there is a validated evidence base that such programmes need to be instigated. Furthermore, relevant health practitioners should be key stakeholders in consulting on the need for such goals and developing the appropriate response when required.

5. How do you see the Goals applying in different healthcare settings or for different population groups?

Office based dental service delivery has an exceptionally high safety record and a quality that is in many respects enviable. There is no comparison to hospital based delivery; nor should mishaps that occur in hospital based delivery be transcribed to office based dental service. Dental practice in Australia already has existing safety and quality frameworks which to date have proven to operate exceptionally well.

6. What systems, policies, strategies, programmes, processes and initiatives already exist that could contribute to achievement of the Goals?

As raised repeatedly in earlier submissions, the ADA is concerned that the ASQHC in this Consultation Paper could duplicate existing regulatory frameworks such as:

- Registration requirements and guidelines of the Dental Board of Australia;
- OH&S legislation and requirements including Workcover Acts;
- Privacy Act; and

- Environment Protection Acts including radiation.

There are in fact an excess of 37 varying Acts and statutory requirements that influence professional care.

Recommendation 7: That the targeting and framing of the Goals, and associated frameworks and assessment processes be done in a manner that does not duplicate existing regulations.

7. What do you think should be the initial priorities for action under the Goals?

8. How could the different stakeholders within the healthcare system be engaged in working towards achievement of the Goals?

No comment.

9. What barriers exist in achieving the Goals? How could these be overcome?

The ADA calls for a total review of the effectiveness of practice accreditation and the achievements that have occurred (if they have). Medicine has had in excess of 30 years of Practice Accreditation experience and there is anecdotal evidence that complaint incidence has not changed or is in fact deteriorating.

The investment dollar in safety and quality should be redirected into achieving goals that can be met, and an approach of making incremental changes is best. It provides the appropriate middle balance where any change that is needed is adopted, and, should further evidence suggest the actual safety/quality benefit to the patient is not delivered, that a response can be developed with less cost than if a uniform approach was taken.

Conclusion

The ADA agrees that more needs to be done to achieve the vision of the safe and high quality health care described in the Australian Safety and Quality Framework for Health Care and the facts identified by ASQGHC.

However, the ADA is at pains to note that the ACSQHC needs to recognise that with respect to dentistry the actual evidence of adverse events as well as their health outcomes is very low for dentistry, unlike medicine or other areas of health care.

Under the existing regulatory framework and current dental professional guidelines, dentistry has largely been able to provide dental care to patients with a very high level of safety/quality.

The ADA urges the ACSQHC to refrain from applying a blanket approach which presumes that those safety and quality issues that have been identified within the hospital/medical practise model context would correspondingly be required to require a regulatory/review type response in the dental practice context. The ADA urges that a consideration of all the evidence, particularly those that are relevant to the dental practice, and substantive and rigorous consultation with the dentist profession, needs to be considered, before any such frameworks are considered to be developed. Were this not to occur, patients' safety and quality of dental care would be at risk due to the added unnecessary additional time and resource costs that would be imposed on health practitioners via inappropriately developed frameworks and requirements.

In adopting the recommendations set out in the Executive Summary, the Goals will be better able to operate in accordance with its objectives, and assist in the safe and quality practise of healthcare to all Australians.

Should further explanation or detail be required please contact the ADA office at 02 9906 4412 or email to ceo@ada.org.au.

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Friday 10 February 2012.