Dear Adjunct Professor Picone

Audiology Australia (AudA) welcomes the opportunity to provide input into the Australian Commission on Safety and Quality in Health Care's (ACSQHC) *Patient safety and quality improvement in primary care: Consultation Paper* (the Consultation Paper). AudA has over 2600 members and represents over 95% of Australian audiologists.

Audiologists conduct audiological assessments and devise individualised intervention plans including counselling, communication training, and/or the selection and fitting of appropriate hearing devices (wearable or implantable). Audiologists help Deaf and hard of hearing people of all ages including those with complex needs to improve their ability to communicate and interact in all situations. Audiologists must have completed at least the equivalent of an Australian university Masters-level degree in clinical audiology.

AudA has provided some general comments on primary health care services and audiology and then – based on member feedback – addressed some of the specific questions raised in the Consultation Paper.

**Primary health care and audiology**

Primary health care is a fundamental element of audiological clinical practice across both the public and private sectors. Primary health care services provided by audiologists are broad ranging and may include: health promotion, prevention and screening, early intervention, treatment and management. Audiologists may provide primary health care services in their own clinical practice, together with other audiologists or as part of a multidisciplinary health team.

The primary care services provided by audiologists are set out in more detail in AudA’s Professional Practice Standards – Part B Clinical Practice.

The Professional Practice Standards focus on primary health care services in the context of patient centred care. As each person’s experiences of auditory and vestibular disorders are different, the Professional Practice Standards take into account the needs and circumstances of particular patient groups by highlighting aspects of practice that are unique or particularly pertinent to their care.

For example, neonates require different testing protocols from most other patients because of their age; Aboriginal and Torres Strait Islander patients obtain the best audiological outcomes when their cultural requirements are also taken into account; people with vestibular disorders experience a different impairment at the body function level and
manifest different activity limitations and participation restrictions from the majority of patients with hearing loss only.

AudA anticipates that the demand for primary hearing health care is only going to increase in coming years. As highlighted in the recent Deloitte Economics report on 'Social and Economic Costs of Hearing Loss', the prevalence of hearing loss in Australia is currently estimated to be 3.6 million people or 14.5% of the Australian population. In 2060, it is estimated that the prevalence of hearing loss will reach up to 7.8 million people – 18.9% of the population. Based on this projection, approximately one in every five people in 2060 will have some form of hearing loss.

**Primary health care standards**

AudA strongly supports high quality standards in primary health care and ongoing improvement to those standards. A strong primary health care system is essential to keep patients, their families and carers at the centre of health care service delivery.

The Consultation Paper states that the National Safety and Quality Health Service Standards for primary care settings (the NSQHS Standards) will not replace or duplicate existing sets of standards or accreditation programs. However, for those primary care services or practitioners where safety and quality standards currently do not exist or where access is limited, the NSQHS Standards could provide a framework to assist with the implementation of quality improvement activities.

We note that there is no current primary health care standard for hearing services in Australia. While the Australian Government’s Hearing Services Program (HSP) places quality obligations on accredited service providers, these obligations do not extend beyond services delivered to people receiving services under the HSP.

Accordingly, AudA strongly supports the development of the NSQHS Standards for primary care settings, including hearing health care services. We believe that the development of these standards will:

- help reassure community members that they will be receiving the right standard of health care in high quality clinics by appropriately qualified professionals
- provide benefits for the providers of hearing services because it demonstrates to members of the public and their health colleagues that these services have made the quality and safety of their practices a priority
- establish a clear and consistent outline for the delivery of hearing services in accordance with best practice as well as encourage continuous quality improvement.

Based on the feedback of AudA members, we have addressed the following specific questions in the Consultation Paper.

**Q1 - The scope of primary care services as the focus for the Commission’s program of work.**

The Consultation Paper defines primary care services as: ‘services provided by general practitioners, practice and community nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists and Aboriginal and Torres Strait Islander health practitioners either, in the home, general or other private practice, community health services and local or non-government services’.

AudA notes that it is important not to confuse ‘primary care services’ with ‘services that use primary care centres/facilities’. With the increase in portable equipment and recognition of
need in regional areas, there has been an increase in the number of secondary and tertiary services providing visiting and outreach services and using primary care settings such as a GP surgery as their home base.

An example of this is audiologists who work in rural and remote community health areas. An audiologist may work as a diagnostic audiologist (secondary service provider) or as a rehabilitative audiologist (tertiary service provider) but in both roles, they support primary care providers by training/mentoring in ear health surveillance and otitis media identification, verifying screening results and clarifying referral requirements.

In addition, telehealth services are rarely primary care consultations but are likely to be accessed via the telecommunications equipment in a primary care setting in regional and remote areas.

Therefore, not all medical and allied health professionals working from primary care centres will be providing primary care services. However, as their patients will be accessing the facilities of the primary care services, these visiting/outreach groups have a vested interest in the safety and quality of the patient experience in this environment.

Q2 - Safety and quality issues in Australian primary care services.

What are the safety and quality issues experienced by primary care service or the primary care services you support?

In all practice locations, one of the primary causes of safety and quality issues can be communication. This can be a particular problem in rural/remote areas.

Part of this involves communication between services in rural areas. There are many short-term contract staff and visiting/fly-in services trying to maximise effectiveness in limited time. This means that important information can be lost in transition between short contract/temporary staff groups.

In practice, communication takes time as there is a need to advise other health professionals about the existence of a particular health service, the kind of health care it provides and when to refer to that service. This is something that needs to be done each time a health professional visits due to high staff turnover and/or different visiting services on each trip.

Another complication is that different geographical areas and health jurisdictions recognise different scopes of practice. For instance, Aboriginal Health Workers in the Northern Territory are able to diagnose and treat ear health conditions while east coast Aboriginal Health Workers are limited to ‘identify and refer’ services; some jurisdictions allow nurses to clear a foreign body from the ear with a betadine wash; in others, the guideline is to have the GP suction the foreign body out of the ear.

Communication with patients is another important aspect. In rural/remote areas, patients frequently have significant hearing loss from middle ear disease and noise exposure/noise trauma from farm equipment, guns or mining. They may have more advanced health conditions before they present to the relevant service, meaning that treatment and discussion is more complex. They may also have difficulties with health literacy and/or not use English as their first language.

To address these issues, it is important for primary care service providers to spend time with these patients to ensure they understand and are satisfied/able to comply with their management plan and to develop their health literacy relevant to their health condition. Other useful options include:
• use of interpreters where available can be invaluable
• language pitched at the understanding level of the patient
• use of visual aids, demonstrations, analogies and decision aids.

Q3 - Developing a set of NSQHS Standards for primary care services other than general practices

What are the barriers and enablers for implementation of these standards in primary care?

The following are potential enablers for the implementation of the NSQHS Standards:
• Having a pre-determined set of quality improvement criteria for audits and benchmarking can significantly reduce time required for such activities and promote a holistic concept of quality and safety that all health care staff can utilise.
• Improvements in quality of care and safety of primary care patients often also improves the safety of health staff in terms of risk exposure.
• Many primary care teams have dedicated clinical development time and access to skype/video teleconferencing for telehealth and so could access training for the NSQHS Standards in this way.

The following are potential barriers for the implementation of the NSQHS Standards:
• The way in which the NSQHS Standards interact with, and are prioritised against jurisdictional interpretations of health legislation needs to be clear.
• Staff require time to implement changes. Many primary care settings in smaller practices or rural areas may be understaffed as well as having patients with more complex and advanced healthcare needs, which necessitate use of that time clinically.
• Health professionals coming into the primary care space may be from levels of care other than primary care, or they may have advanced or altered scopes of practice to meet the requirements of their role and organisational need. This would need to be recognised and clearly articulated by the NSQHS Standards.
• Awareness raising and training of the NSQHS Standards may be a barrier given that many staff in primary health care services are short-term. Therefore, ensuring that these staff have access to training in the NSQHS Standards and time to build them into their practice if required could be difficult. With large numbers of secondary and tertiary services providing outreach/visiting services through primary care facilities, there would be a need for these services to be made aware of the new NSQHS Standards as well in order to support their primary care requirements.
• Therefore, we recommend that the ACSQHC place a strong focus on developing appropriate governance, systems and structures to support smaller primary care practices – in all parts of Australia – to obtain the benefits of accreditation. It is also essential that the ACSQHC actively promote the value of the NSQHS Standards, including through primary care workers’ professional associations such as AudA. Gaining the support of individual primary health care workers is also vital. While the benefits of accreditation under the NSQHS Standards are clear, member feedback suggests that - in the context of a heavily credentialed primary health care workforce that is already laden with professional standards, scope-of-practice restrictions, codes of conduct, state-based guidelines and service expectations - demonstrating the particular value of the NSQHS Standards may be challenging.
Q4 - Reviewing the Commission's practice-level safety and quality indicators for primary care

What are the barriers and enablers for the review process, development and implementation of indicators in primary care?

Some suggested enablers are new technologies that are gradually being incorporated into primary care settings, which could be used to:

- streamline auditing processes and document safety/quality issues
- develop assessment tools to support patients with low literacy to provide experience feedback to services.

Some suggested barriers are:

- The term 'near miss' is prone to wide variation in its interpretation; whether an incident was near enough to warrant filling out an incident report is often a point of discussion after the fact.
- Time required to implement indicator usage in a busy, understaffed primary care setting - especially as so many of the indicators are dependent on patient participation in experience surveys, which low literacy and second language learners may not manage alone so presumably a staff member will need to find time to assist them with it.

Q5 - Safety and quality improvement in primary care more generally

Often, staff in primary care settings – who are faced with significant resource limitations – already mitigate risk through basic techniques such as anchoring chairs on castors for patients, roping off soft spots in the floor, mopping up and putting buckets under roof leaks and so on.

These environmental safety issues are often not to be found recorded in risk registers or incident reports, but are likely to be identified through asset audits and maintenance registers.

In rural/remote zones, the time between reporting a need and getting the funding and/or personnel to alleviate it can be great, and so these hazards become part of the terrain which are adapted to, but may never be reported as a hazard. These types of hazards require organisational support and diligence to be remedied in a reasonable timeframe.

Audiology Australia looks forward to continuing to work with the ACSQHC to assist with the development and implementation of the NSQHS Standards for primary care settings.

If you would like to discuss any aspect of this submission, please contact Elissa Campbell, Research and Policy Manager, Audiology Australia at: elissa.campbell@audiology.asn.au or (03) 9940 3904.

Yours sincerely

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