

**AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE**

AUSTRALIAN SAFETY AND QUALITY GOALS FOR HEALTH CARE

Development and Consultation Report

September 2012

Contents

Executive summary	iv
Introduction	1
Part A: Development of the Australian Safety and Quality Goals for Health Care	4
1. Scope and selection of the Australian Safety and Quality Goals for Health Care	5
2. The Australian Safety and Quality Goals for Health Care	7
3. Changes from consultation paper to final proposed Goals	24
4. Further development of the Goals	25
Part B: Policy context and implications	26
5. How can the Goals be used to improve care?	27
6. Monitoring improvements	34
Part C: Consultation feedback	36
7. Consultation process	37
8. Overall consultation findings	40
9. Question 1: How do you think national safety and quality goals could add value to your existing efforts to improve safety and quality?	43
10. Question 2: Do you agree with the topics that have been included as Goals and priority areas? Are there other areas that should be considered?	46
11. Question 3: What do you think about the specificity of the Goals and priority areas? Are they too broad or specific?	49
12. Question 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?	52
13. Question 5: How do you see the Goals applying in different healthcare settings or for different population groups?	55
14. Question 6: What systems, policies, strategies programs, processes and initiatives already exist that could contribute to achievement of the Goals?	58
15. Question 7: What do you think should be the initial priorities for action	61

under the Goals?	
16. Question 8: How could the different stakeholders within the healthcare system be engaged in working towards achievement of the Goals?	64
17. Question 9: What barriers exist in achieving the Goals? How could these be overcome?	67
18. Summary	73
Acknowledgements	74
Appendices	79
Appendix 1: Australian Safety and Quality Framework for Health Care	80
Appendix 2: Written submissions received during the consultation process	82
Appendix 3: Tools, resources and strategies suggested in submissions	84
References	90

Executive summary

In August 2011 the Australian Health Ministers Advisory Council asked the Australian Commission on Safety and Quality in Health Care (the Commission) to identify a small set of national safety and quality goals and to recommend them to Health Ministers for endorsement. In response to this request, the Commission undertook a development and consultation process in 2011-12 and have proposed the Australian Safety and Quality Goals for Health Care (the Goals). The Goals set out important safety and quality challenges for Australia that would benefit from a coordinated national approach to improvement over the next five years.

The proposed Goals for 2012-17 are as follows:

1. Safety of care: That people receive health care without experiencing preventable harm

Initial priorities are in the areas of:

- 1.1 Medication safety
- 1.2 Healthcare associated infection
- 1.3 Recognising and responding to clinical deterioration

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

Initial priorities are for:

- 2.1 Acute coronary syndrome
- 2.2 Transient ischaemic attack and stroke

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

It is intended that the priority areas within the Goals are the initial areas of focus only. There is potential to add or remove specific priority areas in the five year timeframe identified for the first set of Goals.

When selecting the issues to be included in the Goals and priority areas, consideration was given to:

- 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
- the existence of significant safety and quality problems, such as high levels of preventable harm and significant gaps between evidence and practice
- the existence of a body of work that could be built on to make improvements, with broad agreement about clinical guidelines or other evidence-based strategies

- the potential for the goal to be amenable to national action at multiple levels of the health system
- the likelihood that improvements would be achieved in a three to five year timeframe
- the existence of links to other national priorities, particularly the National Safety and Quality Health Service Standards
- the potential for the goal to be relevant across disease groups, sectors and settings of care
- the existence of measures, or potential to develop measures, that could be used to monitor progress.

The Goals have been proposed in an environment where many initiatives and organisations already exist that aim to improve the safety and quality of care. The broad policy framework for the Goals and mechanisms for improvement can be summarised as follows:

- The overarching vision for safety and quality in Australia is described in the Australian Safety and Quality Framework for Health Care, which states that safe and high quality care is always consumer centred, driven by information and organised for safety.
- The Australian Safety and Quality Goals for Health Care set out a small number of specific high priority areas that could benefit from a coordinated approach to improvement over the next five years. Improvements in these areas will move the Australian health system closer to achieving the vision described in the Framework.
- One of the ways in which the improvements in safety and quality described in the Goals can be made is through taking action to meet the National Safety and Quality Health Service Standards.
- There are many other programs, activities and initiatives from the Commission and other organisations that will support improvements in the safety and quality of care in the areas identified in the Goals.
- The Goals can provide direction regarding health policy and planning in the new environment that is currently developing from the health reform processes. Of particular importance will be the National Health Performance Authority and the Independent Hospital Pricing Authority.
- The Goals can also contribute to planning processes within and between jurisdictions, Local Hospital Networks and Medicare Locals.
- It is not intended that any new processes be established specifically as part of the development of the Goals, or for reporting achievements against the Goals. Where possible, existing reporting processes will be used to monitor progress towards the Goals.

As part of the development of the Goals, a consultation process was conducted between November 2011 and March 2012. Ninety written submissions were received about the Goals, and six workshops were held to discuss them. The key themes arising from this consultation were:

- uncertainty about connections, particularly regarding the links between the Goals, the Australian Safety and Quality Framework for Health Care and the National Safety and Quality Health Service Standards
- the need for collaboration between national bodies such as the Commission, Independent Hospital Pricing Authority, National Health Performance Authority and the National Lead Clinicians Group
- the potential for the Goals to guide planning and cooperative action between local governance bodies such as Local Hospital Networks and Medicare Locals
- the reporting and accountability burdens that are already placed on jurisdictions and health services, and the need to not add to this with the Goals
- that the Goals and priority areas had been recognised as important safety and quality problems for some time
- the need for more detailed work to guide implementation and measurement of progress against the Goals.

These issues have been addressed in the proposed set of Goals, considerations of the policy context in which the Goals sit, and resources that have been developed by the Commission to support achievement of the Goals.

Introduction

The landscape of the health system in Australia is changing with current health reforms. The National Health Reform Agreement aims to improve health outcomes and ensure the sustainability of the Australian health system.¹ It is intended that the reforms included in this agreement will improve access to care, improve efficiency, increase public information about health service performance and ensure more transparent funding of public hospitals.

Safety and quality is central to the delivery of health care, and considerations about safety and quality are embedded in the health reforms. One of the elements of the National Health Reform Agreement is the establishment of the Australian Commission on Safety and Quality in Health Care (the Commission) as a permanent independent body from July 2011. The Commission will operate with the other structures being established as part of the health reforms, particularly the National Health Performance Authority, Independent Hospital Pricing Authority, National Lead Clinicians Group, Local Hospital Networks and Medicare Locals.

In this context there is currently an opportunity to build on the wide range of work that has been carried out over the last five to ten years to improve safety and quality in Australia. There is an opportunity to agree on the key safety and quality challenges that could form the basis for concerted and collaborative national action to improve health outcomes and the efficiency and effectiveness of the health system.

In August 2011 the Australian Health Ministers Advisory Council asked the Commission to identify a small set of national safety and quality goals and to recommend them to Health Ministers for endorsement. In response to this request the Commission undertook a development and consultation process in 2011-12 and have proposed the Australian Safety and Quality Goals for Health Care (the Goals). The Goals set out important safety and quality challenges for Australian that would benefit from a coordinated national approach to improvement over the next five years.

The proposed Goals for 2012-17 are as follows:

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

Initial priorities are for:

- 2.1 Acute coronary syndrome

2.2 Transient ischaemic attack and stroke

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

It is intended that the Goals should be built into, and linked with new and existing systems, structures and processes to highlight specific priority areas where a coordinated approach would bring improvements over the short to medium term. Of particular importance in this regard are the National Safety and Quality Health Service Standards (the Standards). Goals 1 and 3 reflect four of the Standards, and implementation of all of the Standards will support achievement of the Goals. As part of its legislated role, the Commission will develop clinical standards, and there is the potential to link Goal 2 and the priority areas within it to this work.

It is not intended that any new processes will be established specifically as part of the development of the Goals, or for reporting achievement against the Goals. Where possible, existing reporting processes will be used to monitor progress towards the Goals.

To encourage and promote use of the Goals six action guides have been developed that make specific recommendations about actions that can be taken to support and inform change and improvement in each of the Goals and priority areas. These actions describe some of the activities that can be undertaken, but are not exhaustive and are generally not mandatory (except where actions are linked to the National Safety and Quality Health Service Standards). The way in which these actions are developed and put into practice will vary considerably depending on the nature of the setting, organisation and issue to be addressed. Actions have been proposed for:

- consumers, patients, families and carers
- healthcare providers
- organisations that provide and support local healthcare services, including public and private hospitals, private practices, community health centres, Local Hospital Networks and Medicare Locals
- governments, regulators and organisations that set, or advise on healthcare policy
- education and training organisations
- other groups such as consumer groups, non-government organisations and researchers
- the Australian Commission on Safety and Quality in Health Care.

The Goals, and priority areas within them, have been proposed as the focus for coordinated and collaborative action over the next five years. It is anticipated that while the three broad Goals would be likely to remain, the priority areas within them may change during this five year period. The identification of the Goals is the beginning of a long-term process that will contribute to, and support efforts to improve safety and quality in Australia.

The purpose of this report is to describe the processes that were undertaken in developing the Goals, the way in which the Goals can be integrated in the Australian health system, and the feedback received as part of a consultation process conducted about the Goals. The report has three parts:

Part A: Development of the Australian Safety and Quality Goals for Health Care

Part B: Policy context and implications for the Australian Safety and Quality Goals for Health Care

Part C: Consultation feedback regarding the Australian Safety and Quality Goals for Health Care.

Part A: Development of the Australian Safety and Quality Goals for Health Care

The purpose of this section is to describe the process undertaken to develop the Australian Safety and Quality Goals for Health Care. Included is an overview of the scope of the Goals, how the specific goals were selected, changes from the initial draft Goals that were the subject of consultation and a proposal for future development of the Goals.

1. Scope and selection of the Australian Safety and Quality Goals for Health Care

This section contains information about the scope and overall selection process for the Goals.

1.1 *Scope of the Goals*

The scope of the Goals is on the safety and quality of care delivered within the health system. This means that the focus is on reducing the risk of unnecessary harm associated with health care, and on increasing the likelihood that individuals and populations will achieve desired health outcomes that are consistent with current professional knowledge.² The focus of the Goals is generally not on prevention, although it is recognised that this is essential for the health and well-being of the population.

Although the emphasis varies for different Goals and priority areas, the focus is on the entire health system in Australia, including care delivered in the public and private, primary and acute care sectors.

The Goals are focused on areas where action can be taken to improve outcomes and experiences for all people, not just for specific groups or sub-populations. However, it is recognised that within the general population there are specific groups such as Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, older people and people who have both physical and mental health conditions who have significantly worse health outcomes or receive significantly poorer care. Achieving the Goals is particularly important for these groups, and an explicit focus on the Goals will be particularly important in the planning and delivery of health services for them.

1.2 *Selection of the Goals*

The purpose of the Goals is to identify a small number of key safety and quality challenges that could be the basis of concerted and collaborative action. Incidents reported by hospitals,³⁻⁷ information about patient safety risks in primary care settings,⁸⁻⁹ and research about gaps between evidence and practice¹⁰⁻¹¹ indicate that there are many areas in which outcomes are not optimal and where improvements are needed. Therefore a process of prioritisation was required to identify those issues that would be put forward as national goals.

The process for identifying the proposed Goals and priority areas was based on research that included a review of international health and safety and quality goals, literature reviews, review of state and territory incident information, feedback from the Commission's standing committees, consultation with a technical advisory panel made up of consumers, clinicians, managers, policy makers and researchers, and consultation with clinical experts.

During this process, the broad criteria that were considered when deciding to include a specific topic within a Goal were:

- 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
- the existence of significant safety and quality problems, such as high levels of preventable harm and significant gaps between evidence and practice
- the existence of a body of work that could be built on to make improvements, with broad agreement about clinical guidelines or other evidence-based strategies
- that the potential goal was amenable to national action at multiple levels of the health system
- the likelihood that improvements would be achieved in a three to five year timeframe
- the existence of links to other national priorities, particularly the National Safety and Quality Health Service Standards
- the potential for the goal to be relevant across disease groups, sectors and settings of care
- the existence of measures, or potential to develop measures, that could be used to monitor progress.

In addition to the topics included within the draft and final proposed Goals, a number of other issues have been considered and proposed as potential priority areas for the Goals. A list of the proposed additional goals and priority areas identified in the consultation process is provided in Section 10.2. It is acknowledged that some of these additional topics have a significant impact on the health system and have evidence-based strategies that could be built on to make improvements. The initial priority areas included within the Goals were selected because the Commission considered that they represented significant safety and quality problems, they showed the greatest potential for nationally coordinated safety and quality improvement at multiple levels of the health system, and for measurable improvements to be made in the desired timeframe. As described in Section 4, there is potential to add or remove priority areas within the five year timeframe identified for the first set of Goals.



2. The Australian Safety and Quality Goals for Health Care

This section contains detailed information about each Goal, including information on the impact of the issue on the health system and consumers, and evidence describing the impact of, and potential strategies for, the selected outcomes.

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

Priority area 1.1: Medication safety

The aim of this priority area is to reduce harm to people from medications through safe and effective medication management.

The case for medication safety

Medication safety is associated with the prescription, dispensing, administration¹² and monitoring of medication. Medication error often results in adverse medicines events, which can affect a person's health in a range of ways, from mild allergic reactions to death.¹³

Adverse medicines events are more likely to be experienced by those who are most vulnerable including young children,²⁹ those aged 65 years and older,^{29,34-35} and people with multiple conditions and medications.³⁶

A 2004 study found that around one in ten general practice patients experienced an adverse event after using a medication in the previous six months, with almost 50% of these events reported as resulting in a moderate to severe reaction.¹⁴

A 2011 systematic review of the incidence and nature of hospital-based adverse events found that drugs were the second most common cause of adverse events.¹⁵ It is estimated that around 2–3% of all hospital admissions are medication-related.^{12,16} However, this proportion is not consistent across the population, and a recently published five year study of the Australian veteran population found that the overall proportion of potentially preventable medication-related hospitalisations within elderly Australian veterans was as high as 20%.¹⁷

Researchers have suggested that around 50% of medication-related admissions are preventable or avoidable.^{12,16}

In addition to the base cost of medication-related admissions, patients who have adverse medicines events tend to have longer, more expensive hospitalisations. For example, a US study based on data from the early 1990s found that, on average, additional costs of US\$2013 and an increased average length of stay of 1.74 days per patient per episode were attributable to an adverse medicines event.¹⁸

Outcome 1.1.1: Older people living in the community experience fewer adverse medicines events

Older people are a particularly vulnerable group. They are more likely to experience multiple morbidities, attend multiple health care professionals, be prescribed multiple medications¹⁹ and generally have greater variability in their level of health (from those who are fit to those who are frail).²⁰ These, and other factors, put older people at a higher risk of adverse drug events, particularly within the community where there is a greater reliance on self-management and monitoring.

A study by Roughead et al estimated that around 30% of unplanned geriatric admissions to Australian hospitals are medication-related.¹² Many studies have shown a correlation between increasing age and adverse medication events, and that a large proportion of these adverse medicines events have been found to be potentially avoidable.²¹

Medication reviews have been proposed as a strategy for reducing adverse medicines events. Although a 2009 literature review on medication safety in the community found that the research available at that time did not demonstrate a significant impact of medication reviews on patient outcomes,²² the use of multifaceted interventions which included medication review was found to show some benefit.²² Research which has focused specifically on the implementation of home medicines review programs, including an Australian government funded program, has found that these types of structured reviews can be effective in reducing the risk of adverse medicines events.²³⁻²⁴ Studies have shown that home medicines reviews can delay time to next hospitalisation for patients on warfarin in the six months following review²⁴ and delay time to hospitalisation for those with heart failure.²⁵ In addition, it has been demonstrated that home medicines reviews can improve the appropriateness of prescribing and consequently can contribute to improved patient outcomes.²⁶⁻²⁸

Outcome 1.1.2: Older people experience fewer adverse medicines events at admission to and discharge from hospital

The transition from one healthcare sector to another presents an increased risk of medication error. Stowasser suggests that there is a two-fold increase in the relative risk of readmission associated with the omission of a medication from a discharge summary.²⁹ A 2010 study found that over one third of patients had a medication error at admission, 85% of which originated in their medication histories.³⁰ Studies have also shown that there are unintentional discrepancies of 30-70% between medicines taken before admission and prescriptions on admission.³¹

Implementation of a systematic medication reconciliation process can decrease the incidence of medication errors that occur at points of transition of care.³²⁻³⁴ For example, in 2003 Pronovost studied the effectiveness of a medication reconciliation process, including a discharge survey, in intensive care units and found that by week 24 nearly all medication errors in discharge orders were eliminated.³²

In addition, strategies such as the use of clinical pharmacists to review medications at admission have been shown to reduce the error rate within emergency departments.³⁵⁻³⁷ A 2006 systematic review found that the use of clinical pharmacists in medication reconciliation in the acute setting generally improved the quality and safety of care. Of the trials that looked at adverse medicines events,

adverse drug reactions and medication errors, almost 60% found the use of clinical pharmacists reduced these adverse outcomes.³⁸ A 2012 comparative economic analyses of patient safety improvement strategies also found that pharmacist-led medication reconciliation cost less and was safer than no medication reconciliation.³⁹

Outcome 1.1.3: Adults experience fewer venous thromboembolisms associated with hospitalisation

Venous thromboembolism (VTE) is a significant cause of harm to people, particularly those who have been hospitalised. Hospitalised patients are over 100 times more likely to develop VTE compared with the rest of the community⁴⁰ and approximately half of VTE cases occur soon after admission for surgery or medical illness.⁴¹

VTE is estimated to result in approximately 2,000 deaths per year in Australia.⁴² MacDougall has estimated that around 10% of hospital deaths can be attributed to VTE.⁴³ The consequences of developing VTE can range from mild discomfort to death; however, many cases are preventable.^{10,44}

In 2003, the National Institute of Clinical Excellence identified VTE as an area where there was a significant evidence-practice gap and commenced a program of work to reduce VTE in hospitalised patients.⁴⁵ This program included the implementation of national programs in public and private hospitals, and the development of evidence-based clinical practice guidelines.

There is strong evidence that appropriate risk assessment and prophylaxis can reduce the risk and incidence of VTE,^{44,46} and the *Clinical Practice Guideline for the Prevention of Venous Thromboembolism (Deep Vein Thrombosis and Pulmonary Embolism) in Patients Admitted to Australian Hospitals* describes the evidence and recommendations for practice.

Despite this guidance, the Commission's *National Inpatient Medication Chart VTE Prophylaxis Pilot Project: Interim Report* found that of the 19 hospitals surveyed only 15 of those had formal VTE prevention policies in place and only three of those were based on the guidelines.⁴⁷

In 2008 Cohen et al. undertook a multinational cross-sectional survey which identified the proportion of at risk medical and surgical patients receiving any prophylaxis for VTE. In Australia rates were around 51% and 82% for medical and surgical patients respectively,⁴⁸ indicating that there is still considerable room for improving the rates in which risk assessment and prophylaxis is implemented.

Outcome 1.1.4: Children experience fewer dose-related adverse medicines events

Children are another vulnerable group who are likely to experience frequent, significant and serious adverse medicines events.⁴⁹ Children have unique physiology and developmental needs which often make designing medication regimens, including calculating dosage, challenging. Research indicates that incorrect dosing and omission errors are some of the most common errors for paediatric patients.⁵⁰⁻⁵³

A 2007 systematic review of paediatric medication errors identified the lack of clear information on dosage calculation as a barrier to understanding the impact and extent of adverse medicines events in children.⁵⁴ Researchers suggested that a key step in improving medication safety for children is identifying and communicating standard paediatric doses for medications, and building the requirement that dosage rules are incorporated into computerised prescribing tools.⁵⁴

Outcome 1.1.5: People taking warfarin in the community experience fewer adverse medicines events

Warfarin is a commonly used oral anticoagulant which can prevent thrombosis. It is the only Vitamin K antagonist antithrombotic agent listed on the Pharmaceutical Benefit Scheme⁵⁵ and is dispensed in Australia almost 2.5 million times per year.⁵⁶

Warfarin is also a high risk drug which requires continual monitoring and adjustment to ensure that an appropriate international normalised ratio value is maintained. Failure to test and adjust dosage can result in life threatening haemorrhages.

Internationally, warfarin is frequently cited as the most common medication involved in serious adverse drug events, contributing factors include its widespread use and difficult management.⁵⁷⁻⁵⁸ A recent US study found that warfarin was implicated in one third of adverse medicine events associated with hospitalisation in older adults.⁵⁹

In addition, the costs associated with a warfarin-related bleeding event are significant; a recent US study found that the mean cost of a hospitalisation for a warfarin-related bleeding was US\$10,819.⁶⁰

However, anticoagulation strategies, such as the use of trigger systems⁶¹ and the provision of information including detailed medication instructions from a pharmacist or physician,⁶² can reduce the risk and associated costs of hospitalisation due to a warfarin-related bleed.

Priority area 1.2: Healthcare associated infections

The aim of this priority area is to reduce harm to people from healthcare associated infections through effective infection control and antimicrobial stewardship.

The case for healthcare associated infections

Healthcare associated infections (HAIs) are one of the most common, significant and preventable patient safety issues today. HAIs generate considerable health and economic burden for both the individual and the health system and are a clear risk to patient safety.

The impact of HAIs includes increased patient morbidity and mortality risks, prolonged hospital stay, reduced quality of life, and additional costs to both the patient and the system for consumable items used to treat the infection.⁶³⁻⁶⁶

Infections such as catheter associated urinary tract infection (CAUTI), central line associated blood stream infections (CLABSI) and *Staphylococcus aureus* bacteraemias (SAB) are some of the most common, costly and potentially lethal HAIs.⁶⁷⁻⁶⁸

Added to this, prolonged use of antibiotics as a first line of defence to an increased number of infections has led to the rise of antibiotic-resistant bacteria. These bacteria are considered to have a greater impact on morbidity and mortality, hospital stays and costs compared to those that result from infections with antibiotic susceptible bacteria.⁶⁹⁻⁷⁰

Outcome 1.2.1: Healthcare providers, consumers and patients use effective, evidence-based hand hygiene practices

Hand hygiene has long been regarded as an effective preventive strategy for HAIs.⁷¹⁻⁷³ Bacteria causing infections are most commonly transferred between patients via the hands of health care providers.

The World Health Organization's framework identifying the 'Five moments for hand hygiene'⁷⁴ has been trialled and internationally adopted as the critical times that hand hygiene should be performed.⁷⁵

These 'Five moments for hand hygiene' are reflected in Australian and international health policy. The *Australian Guidelines for the Prevention and Control of Infection in Healthcare* describes appropriate practice and recommendations for implementing hand hygiene practices.⁶⁶

Hand hygiene is a key modifiable risk factor for the prevention of HAIs, yet there is still inconsistent practice. The quarterly audit of the National Hand Hygiene Initiative from June 2011 indicates a national average compliance rate for medical practitioners of 58% and for nurses and midwives 77%.⁷⁶

There are a range of strategies which have shown to be effective in improving hand hygiene compliance but experts suggest that implementing a multidisciplinary, multimodal program to address hand hygiene practice is the most effective approach.⁷⁷ Standard 3 of the National Safety and Quality Health Service Standards⁷⁸ outline minimum requirements for safe and high quality care in regard to infection control and prevention.

Outcome 1.2.2: Antimicrobials are prescribed appropriately and people experience fewer infections from resistant pathogens

Inappropriate use of antibiotics has contributed to the emergence of antibiotic-resistant bacteria, which increases the risk of patient harm.⁷⁹ Research shows that up to half of antimicrobial regimens prescribed in Australian hospitals may be inappropriate.⁸⁰⁻⁸³

Patients with infections due to antibiotic-resistant bacteria experience delayed recovery, treatment failure and in some cases death.⁸⁴ A study by Roberts et al. in 2009 reported that twice as many patients with antimicrobial-resistant infections died than patients infected with non-resistant organisms.⁸⁵ When multi-resistant pathogens are common, clinicians are forced to use broader spectrum and usually more expensive agents to treat seriously ill patients. All of these effects contribute to increasing healthcare and societal costs.⁸⁵

An effective approach to improving antimicrobial use in hospitals is implementing a systematic antimicrobial stewardship (AMS) program.⁸⁶⁻⁸⁷ Effective hospital AMS programs have been shown to decrease antimicrobial use and improve patient

care.^{86,88} AMS is considered a key strategy in local and national programs to prevent the emergence of antimicrobial resistance and decrease preventable healthcare associated infection.

Systematic AMS programs have been shown to result in a reduction in antimicrobial use, increase in appropriate antimicrobial use, reduction in institutional resistance rates, reduction in morbidity and mortality, as well as reductions in healthcare costs to both the hospital and the consumer.^{86,88-93}

Outcome 1.2.3: Fewer people experience central line associated bloodstream infections, surgical site infections and catheter associated urinary tract infections

CAUTI, CLABSI and SAB are the most common and costly HAIs and are considered to be largely preventable. In Australia, it is estimated there are at least 3,500 cases of intravenous catheter associated bloodstream infections annually and the mortality rate directly attributable to intravenous catheter sepsis is 12%. This equates to around 1.5 infections per 1000 admissions.⁹⁴ This estimate is based on studies in the 1990s and is likely to be an underestimate.

In addition, surgical site infections (SSI) have the greatest impact on length of hospital stay.⁹⁵ A 2006 Victorian study examining the costs attributed to SSIs associated with hip and knee prostheses found that when the excess length of stay and all additional costs were added together, 126 SSIs had cost the Victorian healthcare system around \$5 million.⁹⁶

In Australia, state level data indicates that in some states the rates for these types of infection have remained stable or increased over time.⁹⁷⁻⁹⁸

There is now growing evidence that interventions such as the use of checklists and bundles of care supported by education and training programs, audits, cross monitoring, surveillance and feedback can significantly reduce the rates of CAUTI and CLABSI infections.⁹⁹⁻¹⁰³ A 2007 Australian study in intensive care units in NSW hospitals found that compliance with all aspects of central venous line insertion using a checklist resulted in a 60% reduction in CLABSI rates.¹⁰⁴ The study also demonstrated an increasing interest in the value of these types of strategies, as participation increased from 65% of eligible intensive care units in the first 6 months to 92% in the final 6 months.¹⁰⁴

This builds on the work of Pronovost, et al. who found that an intervention that combined these activities resulted in up to 66% reduction in the rate of catheter-related bloodstream infections at 16–18 months after implementation.¹⁰⁵ Significant reductions in morbidity and healthcare costs are possible if these types of intervention can be introduced successfully nationwide.

Priority area 1.3: Recognising and responding to clinical deterioration

The aim of this priority area is to reduce harm to people from failures to recognise and respond to clinical deterioration through implementation of effective recognition and response systems.

The case for recognising and responding to clinical deterioration

The characteristics of patients are changing, both in Australia and internationally. Acute care hospitals now have an increasing proportion of patients who have complex problems and who are more likely to be or become seriously ill during their hospital stay.¹⁰⁶ Warning signs often precede serious adverse outcomes such as unexpected death, cardiac arrest and unplanned admission to intensive care.¹⁰⁷⁻¹⁰⁸

The number of patients in hospital with signs of physiological instability and at risk of deterioration is significant. A recent Australian point prevalence study across 10 hospitals found that 3% of patients had physiological abnormalities that were sufficient to warrant a call to the medical emergency team (MET) at the time observations were taken, and 5% had fulfilled the criteria for a MET call in the 24 hours prior to this point.¹⁰⁹

Patients who receive a MET call have a greater risk of dying in hospital than those who do not require a MET call. An Australian study found that 17% of patients without a not-for-resuscitation order who receive one MET call die in hospital, and 34% of patients who receive more than one MET call die in hospital.¹¹⁰ This compares with an overall in-hospital mortality rate of approximately 4% and an in-hospital mortality rate for patients admitted to intensive care of approximately 12%.¹¹⁰ In addition, there is evidence now emerging that people who have received a MET call also have a longer length of stay, which can be associated with increased costs.¹¹¹

Outcome 1.3.1 Recognition and response systems are in place in acute healthcare facilities and fewer people experience harm because deterioration in their physical condition is not identified or acted on appropriately

Although there are warning signs of physiological instability prior to adverse outcomes such as a cardiac arrest, unexpected death or unplanned admission to intensive care, these warning signs are not always identified, and if they are, they may not be acted on appropriately.¹¹²

Patients in acute care settings can often go for prolonged periods without having physiological observations measured,¹¹²⁻¹¹³ which can lead to failure to identify and respond to a patient's deterioration.

Hospitals are complex systems, and a proactive approach that focuses on the needs of patients across all parts of this system is needed to ensure that patients whose condition deteriorates in hospital receive appropriate and timely care.¹¹⁴

Analysis of incidents about failures to recognise and respond to clinical deterioration within some states and territories have identified a wide range of contributing factors, including:¹¹⁵⁻¹¹⁶

- not monitoring vital signs consistently or not understanding observed changes in vital signs
- lack of knowledge of signs and symptoms that could signal deterioration
- failing to recognise the significance of apparent deterioration

- uncertainty about whether assistance should be called for, or a reluctance to call for assistance
- delays in notifying medical staff of the signs of deterioration
- delays by medical staff in responding to such notification
- lack of skills and knowledge about managing deteriorating patients among ward medical and nursing staff
- failure of ward staff to promptly seek supervision or advice
- failure to communicate with other staff about concerns, including in handover situations
- failure of essential equipment such as resuscitation trolleys
- lack of clarity about roles and responsibilities for care of deteriorating patients.

A systematic approach to recognising and responding to clinical deterioration is needed to address these factors and ensure that patients who deteriorate in hospital receive safe and high quality care.

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

Priority 2.1 Acute coronary syndrome

The aim of this priority area is to provide appropriate, evidence-based care for people with acute coronary syndrome.

The case for acute coronary syndrome

Cardiovascular disease (CVD) is the leading cause of death and disability in Australia.¹¹⁷ Acute coronary syndrome (ACS), which encompasses acute myocardial infarction and angina, is responsible for the majority of the burden of cardiovascular disease.¹¹⁷

ACS leads to over 120,000 hospitalisations a year and costs the health system over \$1.8 billion a year.¹¹⁷ The outcomes for patients experiencing these life threatening and debilitating events are influenced by the health care they receive both acutely and in the long term.¹¹⁸

The *Guidelines for the Management of Acute Coronary Syndromes (2006)* indicate there is significant research to demonstrate that patients having an acute coronary event have better outcomes when they receive:

- organised and comprehensive pre-hospital care which may include en route electrocardiograph (ECG) assessment and treatment with a fibrinolytic if appropriate
- immediate ECG assessment upon presentation to hospital
- timely reperfusion
- early risk stratification if the patient is experiencing a non-ST-segment-elevation myocardial infarction (non-STEMI) or unstable angina



- initiation of medical therapy prior to hospital discharge
- referral to a cardiac rehabilitation program.¹¹⁸

In addition, a 2004 study by Scott et al found that quality improvement programs for coronary patients are effective when they feature multifaceted interventions across the continuum of care. These interventions may include implementing systems of decision support, targeted provider education and performance feedback, patient self-management, and hospital–community integration.¹¹⁹

To achieve evidence-based care it is essential that an appropriately trained workforce is available and the necessary systems and processes are in place to guide, monitor and evaluate the care given and the outcomes achieved.^{118,120}

Outcome 2.1.1: All people with acute coronary syndrome receive care in line with nationally agreed clinical standards at all stages of the patient journey

Pre-hospital

The *Guidelines for the Management of Acute Coronary Syndromes* state that people experiencing ACS symptoms should seek emergency help promptly, including accessing emergency medical transport services.¹¹⁸

Paramedics and ambulance services play an increasingly important role in the early detection and management of ACS as the most important initial requirement is access to a defibrillator,¹¹⁸ which are now carried in all Australian ambulances. There is good evidence suggesting that travelling to hospital by ambulance shortens pre-hospital delay times for suspected heart attack, consequently reducing time to treatment.¹¹⁸

Yet, in December 2011 the Heart Foundation released a report showing that around 7% of people who responded to their ‘Warning Signs’ survey would delay calling 000 for a suspected heart attack purely based on the cost of an ambulance.¹²¹ This reluctance can result in delayed diagnosis and treatment, and resultant poorer health outcomes.

The *Guidelines for the Management of Acute Coronary Syndromes* also describe key pre-hospital management recommendations which are known to improve outcomes including:

- pre-hospital ECG assessment and transmission to the destination medical facility
- hospital bypass to the most appropriate facility
- pre-hospital fibrinolysis treatment, as required.¹¹⁸

Hospital care

Despite the fact that there are clear Australian guidelines for the management of acute coronary syndrome, there is evidence that patients experiencing a heart attack or angina do not always receive appropriate, evidence-based acute care.

Preliminary data from the Cooperative National Registry of Coronary Care, Guideline Adherence and Clinical Events (CONCORDANCE) registry indicates that 18.8% of ST-segment-elevation myocardial infarction (STEMI) patients who arrived

within 12 hours of symptom onset did not receive reperfusion therapy and over 70% did not receive thrombolysis within the recommended 30 minutes.¹²²

In addition, the *Guidelines for the Management of Acute Coronary Syndromes* recommend that all patients should be started on appropriate medications before hospital discharge.¹¹⁸ Data from both the CONCORDANCE registry and the Discharge Management of Acute Coronary Syndromes (DMACS) national quality improvement initiative found that approximately 40% of eligible patients were not prescribed all the guideline-recommended medications prior to discharge.¹²²⁻¹²³

Secondary prevention

As the treatment of ACS patients has improved through new technologies and therapies, the survival rate improves, and there is now an increasing pool of patients who require ongoing management and secondary prevention.

In addition to evidence-based acute care, it is imperative that individuals with cardiovascular disease receive ongoing, evidence-based secondary prevention through outpatient and primary health care services. Secondary prevention is known to reduce their risk of future cardiovascular complications by focussing on achieving effective management of cardiovascular risk factors through lifestyle counselling and appropriate medical management.^{120,124}

A variety of secondary prevention programs, including cardiac rehabilitation, have been developed and trialled for ACS patients. Generally, programs which are flexible, multifaceted, culturally appropriate and integrated with existing care show benefits beyond the benefits achieved from revascularisation and pharmacotherapy alone.¹²⁵⁻¹²⁶ However, the DMACS initiative and CONCORDANCE registry found that approximately 40% of patients were not referred to a cardiac rehabilitation program prior to discharge and the CONCORDANCE data suggests that referral rates vary quite significantly between hospitals (16.3–91.6%).¹²²⁻¹²³

Priority area 2.2: Transient ischaemic attack and stroke

The aim of this priority area is to provide appropriate, evidence-based care for people with transient ischaemic attack (TIA) and stroke.

The case for transient ischaemic attack and stroke

Transient ischaemic attack (TIA) is considered a 'warning event' where symptoms similar to a stroke are exhibited. It is estimated that around 15% of strokes are preceded by a TIA.¹²⁷

Stroke is the second leading cause of death in Australia and a major cause of disability.¹²⁸⁻¹²⁹ It is estimated that over 60,000 new or recurrent strokes occur each year.¹³⁰ The impact of stroke on individuals, families and the healthcare system is substantial. Approximately 89% of people who have a stroke are admitted to hospital and 88% of stroke survivors are left with some level of disability.¹²⁹ In 2004-05 \$546 million was spent on stroke care.¹³⁰

The *Clinical Guidelines for Stroke Management 2010* identify a robust body of evidence which indicates that people who have had TIA or a stroke are more likely to survive and have a better quality of life when they receive:¹²⁰

- organised acute care delivered in a specialised unit by a multidisciplinary healthcare team trained in stroke care
- thrombolysis within 4.5 hours of stroke onset
- antiplatelet therapy within 48 hours of stroke onset
- antihypertensive medications as soon as possible after their stroke
- early and ongoing rehabilitation therapy.

As with ACS, it is critical that there is an appropriately trained workforce in place, and that the necessary systems and processes are established and implemented to support evidence-based stroke care.^{118,120} It is important that high quality stroke services follow the patient across the care pathway; that care is coordinated through discharge, referral and admission processes, through engagement of patients and families, and through the education and training of healthcare professionals in stroke care.¹²⁰

Outcome 2.2.1: All people with a transient ischaemic attack or stroke receive care in line with national clinical standards, and have improved quality of life at all stages of the patient journey

Pre-hospital

The early identification of symptoms of TIA or stroke is a key factor in effective management and minimisation of the impact of stroke.¹³¹⁻¹³² This requires broader public awareness of the signs and symptoms of TIA and stroke and an understanding of the need to seek early medical assistance.¹³³ The *Clinical Guidelines for Stroke Management 2010* recommend that there should be ongoing public education in this area.¹²⁰

In addition, the Guidelines recommend that ambulance services play a central role in the initial stage of identification and management of TIA and stroke. The Guidelines recommend that ambulance services should ensure patients with high risk TIA or stroke symptoms be triaged with a high priority, commence initial assessment and preventive treatment measures and notify the destination medical facility of the patient's status.¹²⁰

In order to do this, systems and processes need to be in place to ensure that paramedics and ambulance services have the tools and resources required to undertake pre-hospital rapid stroke screening, implement pre-notification systems and transfer patients to appropriate stroke services, where available.

However, according to the 2011 National Stroke Audit around 60% of hospitals did not have arrangements in place with ambulance services to facilitate rapid assessment and around 40% did not have protocols in place to guide transfer of patients with stroke. In addition, over a third of hospitals do not have emergency department protocols for rapid triage.¹³⁰

Hospital care

There are clear Australian and international clinical guidelines for the management of TIA and stroke in hospital settings. Yet, the Stroke Foundation's biennial National Stroke Audit has consistently found that hospitals who deliver care to stroke patients do not always deliver evidence-based stroke care.

For example, the Guidelines recommend that all stroke patients are treated within a stroke unit or by stroke services, however, the 2011 National Stroke Audit found that 40% of acute stroke patients did not receive their clinical care in a stroke unit.¹³⁴

There is also evidence of significant benefit for patients who receive thrombolysis within 4.5 hours of symptom onset, yet only around 40% of patients arrived at hospital within this timeframe and approximately one third of hospitals offered stroke patients thrombolysis.¹³⁴

The audit also identified that 20% of patients were discharged from hospital without the appropriate blood pressure and cholesterol medications to prevent a recurrent stroke and half of patients did not receive a discharge care plan to support their transition home.^{130,135}

The series of audits which have been conducted by the Stroke Foundation since 2007 show improvement in the in-hospital care that is delivered to stroke patients, however, there are still opportunities to deliver more effective stroke care in Australia.¹³⁴

Community care

Community care of stroke survivors commences from discharge. The organisation and planning at the point of stroke patient's discharge is of critical importance to the patient's recovery prospects.

A recent Australian literature review on clinical handover identified hospital to community handover (e.g. discharge from acute care) as one of the key high risk scenarios in clinical communication.¹³⁶ A study by Foster et al following discharged patients found that nearly one in five patients experienced an adverse event during the transition from the acute care to the community.¹³⁷ The extent of these injuries ranged considerably however, around one third of the events were considered preventable.¹³⁷

For stroke patients it is important that assessment of discharge needs occurs early in the hospitalisation.¹²⁰ Regular needs assessment, support and communication is required to identify and manage social, emotional and physical issues and clear, regularly maintained care plans are required to support the capacity for ongoing self-management.¹²⁰

The 2011 National Stroke Audit found that nearly 40% of hospitals did not provide routine assessment of the ongoing need for rehabilitation, only around half of the hospitals reported providing a discharge plan routinely and approximately 30% reported using protocols for post-discharge review.¹³⁴

In addition, there is evidence that early supported discharge can reduce length of hospital stay, long-term dependency and admission to institutional care for patients with less complex stroke outcomes.¹³⁸⁻¹³⁹ The audit found that only around 20% of

patients had access to early supported discharge teams and 75% of hospitals had access to community based rehabilitation teams.¹³⁴

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

The case for partnerships with consumers

Delivering care that is patient-centred and focused on partnerships provides many benefits for the consumer, provider, organisation and system. Evidence is building about the link between a patient-centred approach, good patient experience and high quality health care.¹⁴⁰⁻¹⁴⁴ For example there is evidence patient-centred care is associated with:

- improved clinical outcomes¹⁴⁵⁻¹⁴⁸ including associations with decreased re-admission rates¹⁴⁹
- decreased healthcare acquired infections¹⁵⁰⁻¹⁵²
- improved delivery of preventive care services¹⁵³
- reduced length of stay^{151,154}
- improved adherence to treatment regimens¹⁵⁵
- improved functional status.¹⁵⁰⁻¹⁵¹

These benefits have implications across the primary, acute and aged care sectors.

In addition, one US study found that using patient-centred approaches to care resulted in reduced hospital costs, including gross savings in utilisation costs of more than three times the cost of providing patient-centred care.¹⁵⁶

A recent study found that when implementing patient-centred care an organisation-wide approach is critical to success. Key organisational facilitators of success included:

- strong, committed senior leadership
- clear communication of strategic vision
- active engagement of patients and families throughout the institution
- sustained focus on staff satisfaction
- active measurement and feedback reporting of patient experiences
- adequate resourcing of healthcare delivery redesign
- staff capacity building
- accountability and incentives
- a culture strongly supportive of change and learning.¹⁵⁷

Outcome 3.0.1 Consumers are empowered to manage their own condition, as clinically appropriate and desired

The prevalence of chronic illness is increasing, driven largely by population ageing and an increase in preventable lifestyle risk factors.¹⁵⁸⁻¹⁵⁹ It is estimated that 77% of Australians have at least one long-term medical condition and around 55% of people aged 65-84 years have five or more long term conditions.¹⁶⁰

This increase in chronic illness, coupled with the desire to make care more patient-centred, is fostering a growing need to encourage and empower consumers to manage their condition, as clinically appropriate and desired.

There is considerable research on a range of different self-management interventions for specific conditions.¹⁶¹⁻¹⁶² Research suggests that self-management interventions have the potential to reduce the demand on the health system and increase patient satisfaction, while at the same time providing effective care at a low cost.¹⁶¹

Research indicates that for people with long-term conditions, self-management interventions based around information, communication, education and planning can reduce hospitalisation rates,¹⁶³⁻¹⁶⁴ unscheduled visits to the doctor and days off work or school¹⁶⁴ as well as overall healthcare costs.¹⁶⁵

In addition, the 2010 Picker Institute Europe review of research on self-management found that self-monitoring and self-management can improve quality of life for people with cardiovascular disease and diabetes,^{161,166-168} and that health education and stress management programs in particular can improve health outcomes of patients with coronary heart disease.^{161,169}

It can be difficult to achieve engagement of consumers, healthcare providers and organisations with self-management programs.¹⁷⁰ However, given the potential benefits involved it is in the interests of consumers, healthcare providers and organisations to support the development of consumers' skills and capacity to understand and manage their risk factors, condition, treatment and healthcare needs.

A recent Australian study showed that around one third of consumers who participated in a chronic disease self-management education program reported substantial development of skills, techniques and self-monitoring.¹⁷¹ The Picker review also found that most studies on self-management interventions reported improvements in patients' satisfaction, coping skills, confidence to manage their condition and perceptions of social support.¹⁶¹

Outcome 3.0.2 Consumers and healthcare providers understand each other when communicating about care and treatment

Patient-provider communication is one aspect of partnerships with consumers that has been researched in detail for quite some time. Almost twenty years ago Stewart conducted a systematic review of the literature and found that most of the 21 studies she reviewed on patient-physician communication demonstrated a correlation between effective communication and improved patient health outcomes.¹⁷²

Effective communication is now accepted as an essential component of high quality care and patient safety.^{161,173-174} Research has shown that patients who experience communication problems are likely to be at highest risk of preventable adverse events¹⁷⁴ and that embedding concepts such as cultural competence and patient- and family-centeredness into the care process can increase patient satisfaction and adherence with treatment.¹⁷⁵⁻¹⁷⁶



Studies that have specifically focused on improving patient-provider partnerships through communication and collaboration found these strategies resulted in a reduction in the number of diagnostic test orders and other referrals,¹⁷⁷⁻¹⁷⁹ better adherence to treatment regimens,¹⁸⁰ greater patient satisfaction^{161,178,180} and greater capacity to cope with their medical condition.¹⁷⁸

A number of studies have found that patient participation in decision making can be associated with favourable health outcomes¹⁸¹⁻¹⁸² and patient mediated interventions such as decision aids have been shown to improve patient knowledge and involvement in decisions, both in acute and primary healthcare environments.¹⁸³

In addition, a critical aspect of effective communication is the capacity to communicate information about risks of treatment options in a way both patients and providers can understand.¹⁸⁴ Statistical information is often presented in a way that can lead to misunderstandings, poor decisions and inappropriate care.¹⁸⁵ Gigerenzer recently argued that until statistical literacy and ways of presenting statistical information to patients is taught, shared decision making will be hampered.¹⁸⁶

Healthcare professional training and support is considered an important factor in improving communication, and increasing participation and partnerships.¹⁸⁷⁻¹⁸⁸ The 2010 Picker review of best buys in patient engagement found that communication skills training for clinicians can lead to improved communication, reduced anxiety and greater patient satisfaction.¹⁶¹

However, a 2010 Commonwealth Fund survey of primary care patients' and physicians' views on care experiences found that, though Australia fared well in terms of overall patient-centred care, when it came to engagement and partnerships only 66% of surveyed patients reported that their doctor told them about treatment options and involved them in decisions about their care.¹⁸⁹ This suggests that though there is considerable research on the benefits of effective communication, shared decision making and partnerships, these strategies are not always used.

Outcome 3.0.3 Healthcare organisations are health literate organisations

Health literacy is an issue that influences a consumer's capacity to understand, integrate and act on information about their health and care needs. Health literacy is closely linked to social determinants of health¹⁹⁰ and it is often (although not always) associated with vulnerable populations such as culturally and linguistically diverse populations, those with a low socioeconomic status, the young and the elderly.

However, the issue is much broader than that. In Australia, according to a 2006 national survey, almost 60% of those between 15 and 74 years old do not have a level of health literacy required to meet the complex demands of everyday life.¹⁹¹

Patients' health literacy is critical to their participation and engagement in their health care, and influences aspects of health care such as knowing when to seek medical help, being able to effectively communicate with health professionals, and maintaining treatment and following up with other health services and supports as required.¹⁹²

There is now strong evidence of the link between health literacy skills and health outcomes.¹⁹³⁻¹⁹⁵ One US systematic review on health literacy found that lower

literacy was associated with increased emergency department and hospital use, lower use of screening for cervical cancer (through a Pap test) and breast cancer (mammography), lower influenza immunization, and less access to insurance.¹⁹⁵

Over the past decade, there has been significant work undertaken in the US and Canada to develop policies and strategies which address health literacy.¹⁹⁶⁻¹⁹⁷ Most recently, in 2012 the Institute of Medicine's Roundtable on Health Literacy identified a series of key attributes of a health literate organisation.¹⁹⁸ These attributes have been developed to help healthcare organisations understand the kinds of actions they can take in order to reduce the environmental and organisational barriers to health literacy within their own environment.¹⁹⁸

This proposition builds on the work of researchers such as Rudd who have focussed on the implementation of strategies overtly aimed at reducing the complexity of information, processes, systems and care pathways for consumers.¹⁹⁹⁻²⁰⁰ In 2009 Rudd identified a number of key recommendations based on best practice strategies to address health literacy at the environmental level¹⁹⁹ including:

- improving patient provider oral communication by simplifying language, using the Teach-Back method,²⁰¹⁻²⁰² providing simplified dosage instructions and encouraging questions²⁰³
- ensuring information and materials are developed so that they are accessible for all patients including providing information that is personalised and involving user groups in their development¹⁶¹
- using new and available technology to communicate with patients such as phone, computers and kiosks to deliver information and reminders.^{161,201} Web based materials and tools are also suggested as technological tools to address health literacy¹⁹⁹
- integrating health literacy into healthcare education and training courses.²⁰⁴⁻²⁰⁵

Rudd also suggests performing a health literacy assessment of healthcare facilities²⁰⁶ as a key step in understanding the types of environment barriers each organisation may need to focus on.

Outcome 3.0.4 Consumers are involved in a meaningful way in the governance of healthcare organisations

Involving consumers in the governance of healthcare organisations is an important and highly valuable aspect of being a patient-centred organisation. Consumers have a unique position and perspective which can help to identify opportunities for improvement at an individual and organisational level, which otherwise might not have been identified through usual processes.²⁰⁷⁻²⁰⁸ For example, research has shown that consumers can readily identify adverse events and incidents which occur in hospitals.²⁰⁹⁻²¹⁰

Partnering with consumers in governance is about listening to and using consumer knowledge, skills and experience in a systematic way, to make the health care that is delivered better. These partnerships can be demonstrated in a variety of ways. They can involve establishing consumer advisory committees, working with patients and using their experiences to shape safety and quality initiatives or co-opting consumers into the planning and design of health services, among other strategies.

Seeking and using patient and family feedback through surveys, focus groups, committees, compliments and complaints processes and incident management systems is increasingly being seen as useful mechanisms for establishing partnerships, informing quality improvements and improving patient experience.²¹¹ There is now emerging evidence of an association between poor quality experience and poorer health outcomes.²¹¹ In addition, feedback on consumer's experience of healthcare organisations has been shown to strongly correlate with measures of clinical quality, such as mortality and infection rates.^{152,212}

There has also been an increasing interest and research into partnering with consumers through co-design or experienced-based design. There is now emerging evidence that involving consumers in the planning and design of healthcare environments and services can have significant benefits in terms of strengthening relationships and empowerment of both staff and consumers,²¹³⁻²¹⁴ as well as contributing to the reorientation of services to the needs and preferences of the consumer.²¹⁴

In addition, the Kings Fund has found that an experience-based design project improved staff and consumers skills and communication, and also improved patient's experience of services. However the evaluation also noted that staff commitment, engagement, leadership and support for systemic change were important factors in achieving these improvements.²¹⁵

It is assumed that patient-centred practices and partnerships with consumers are common. However, feedback from the Commission's consultation on the *Patient-centred care: Improving safety and quality through partnerships with patients and consumers* discussion paper²¹⁶ and from piloting the National Safety and Quality Health Service Standards identified that many healthcare professionals and organisations are unsure about what partnerships in governance might mean. They are also equally uncertain about how to go about implementing strategies to support partnerships in governance, and engaging and involving consumers in their organisations safety and quality processes in a systematic and organised way.



3. Changes from consultation paper to final proposed Goals

There have been changes made to the Goals and priority areas since the first draft set of Goals was proposed in November 2011 for consultation. The most significant changes are that recognising and responding to clinical deterioration has been included as a priority area within Goal 1: Safety of care, and type 2 diabetes has been removed as a priority area within Goal 2: Appropriateness of care.

Type 2 diabetes was included as a potential priority area initially because it is the fastest growing chronic disease in Australia. In 1999–2000, it was estimated that one million Australians had diabetes.²¹⁷ It is estimated that by 2031, 3.3 million Australians will be living with type 2 diabetes.²¹⁸ In addition, there is evidence that many patients are not achieving the targets for metabolic control, and that this is associated with not being prescribed recommended pharmacological treatments or not being treated to the recommended intensity.²¹⁹⁻²²²

Not including type 2 diabetes as a priority area does at this point in time not diminish the importance of these issues. However it became clear during the work to identify potential outcomes, measures and actions for this priority area that the management of type 2 diabetes is a very complex issue, with a wide range of stakeholders and interests. More work is needed to reach agreement on the appropriate outcomes to be sought as part of a national goal for type 2 diabetes. As discussed in the next section, it is proposed that this work be conducted as part of the ongoing work to promote and maintain the Goals.



4. Further development of the Goals

It is important to note that the proposed set of Goals and initial priority areas reflect only a small proportion of the processes and issues in which improvements are needed for people in Australia to receive safe and high quality care. The intention of the Goals is to set out some of the key safety and quality challenges where a national approach to coordination would bring benefits over the next five years. This does not mean that all national or local attention will, or should, only be on the areas included in the Goals.

The priority areas within the Goals are likely to change as progress is made and new information becomes available. Details about the proposed processes for monitoring and review of the Goals are in Section 6, and these include a process of formal review of the Goals after five years. In the meantime, it is proposed that the Commission continue work to facilitate the development that would be needed for a topic area to be included as a priority area within the Australian Safety and Quality Goals for Health Care. As well as the need for the topic to be one where there is a significant burden on the health system and for there to be a significant safety and quality problem, it is important that:

- there be agreement about the key outcomes where improvements are being sought among key stakeholder groups
- there is a body of work that can be used as the basis of improvements, with broad agreement about clinical guidelines or other evidence based strategies
- the topic is amenable to national action and collaboration at multiple levels of the health system.

Given the work that has already been done to include type 2 diabetes as a priority area within the Goals, it is possible that this will be one of the first areas to be explored in this way. Other topics raised during the consultation process will also be considered for further development.

Part B: Policy context and implications

The Australian Safety and Quality Goals for Health Care have been proposed in an environment where there are significant changes to the way in which the health system is organised. They have also been proposed in the context of significant investment in safety and quality in Australia over many years. It is intended that the Goals should be built into new and existing systems, structures and processes to highlight specific priority areas where a coordinated approach would bring improvements over the short to medium term.

The purpose of this section is to describe how this integration process can occur, and how the Goals can operate within the Australian health system to improve the safety and quality of care.

5. How can the Goals be used to improve care?

It is intended that the Goals should be integrated into the systems, processes and structures that already exist, or are developed to improve safety and quality of care. The value they bring to existing efforts will be to highlight a small number of nationally agreed priorities that can be the basis of coordinated safety and quality improvement action and reporting.

The Goals have been proposed in an environment where many initiatives and organisations already exist that aim to improve the safety and quality of care. To avoid duplication and maximise the benefits that the Goals can bring, it is important to be clear about how the Goals fit within this context, and how they can influence the levers that exist to improve safety and quality. Within the new health policy environment created by the health reform process there are new responsibilities, relationships and bodies. All of these have a role in improving safety and quality and taking action to achieve the Goals.

The broad policy framework for the Goals and mechanisms for improvement can be summarised as follows:

- The overarching vision for safety and quality in Australia is described in the Australian Safety and Quality Framework for Health Care, which states that safe and high quality care is always consumer centred, driven by information and organised for safety.
- The Australian Safety and Quality Goals for Health Care set out a small number of specific high priority areas that would benefit from a coordinated national approach to improvement over the next five years. Improvements in these areas will move the Australian health system closer to achieving the vision described in the Framework.
- One of the ways in which the improvements in safety and quality described in the Goals can be made is through taking action to meet the National Safety and Quality Health Service Standards.
- There are many other programs, activities and initiatives from the Commission and other organisations that will support improvements in the safety and quality of care in the areas identified in the Goals.
- The Goals can provide direction regarding health policy and planning in the new environment that is currently developing from the health reform processes. Of particular importance will be the National Health Performance Authority and the Independent Hospital Pricing Authority.
- The Goals can also contribute to planning processes within and between jurisdictions, Local Hospital Networks and Medicare Locals.
- It is not intended that any new processes be established specifically as part of the development of the Goals, or for reporting achievements against the Goals. Where possible, existing reporting processes will be used to monitor progress towards the Goals (such as meeting the Standards).

The links between the Framework, Goals and Standards are illustrated in Figure 1, and more detail about these points is provided in this section.

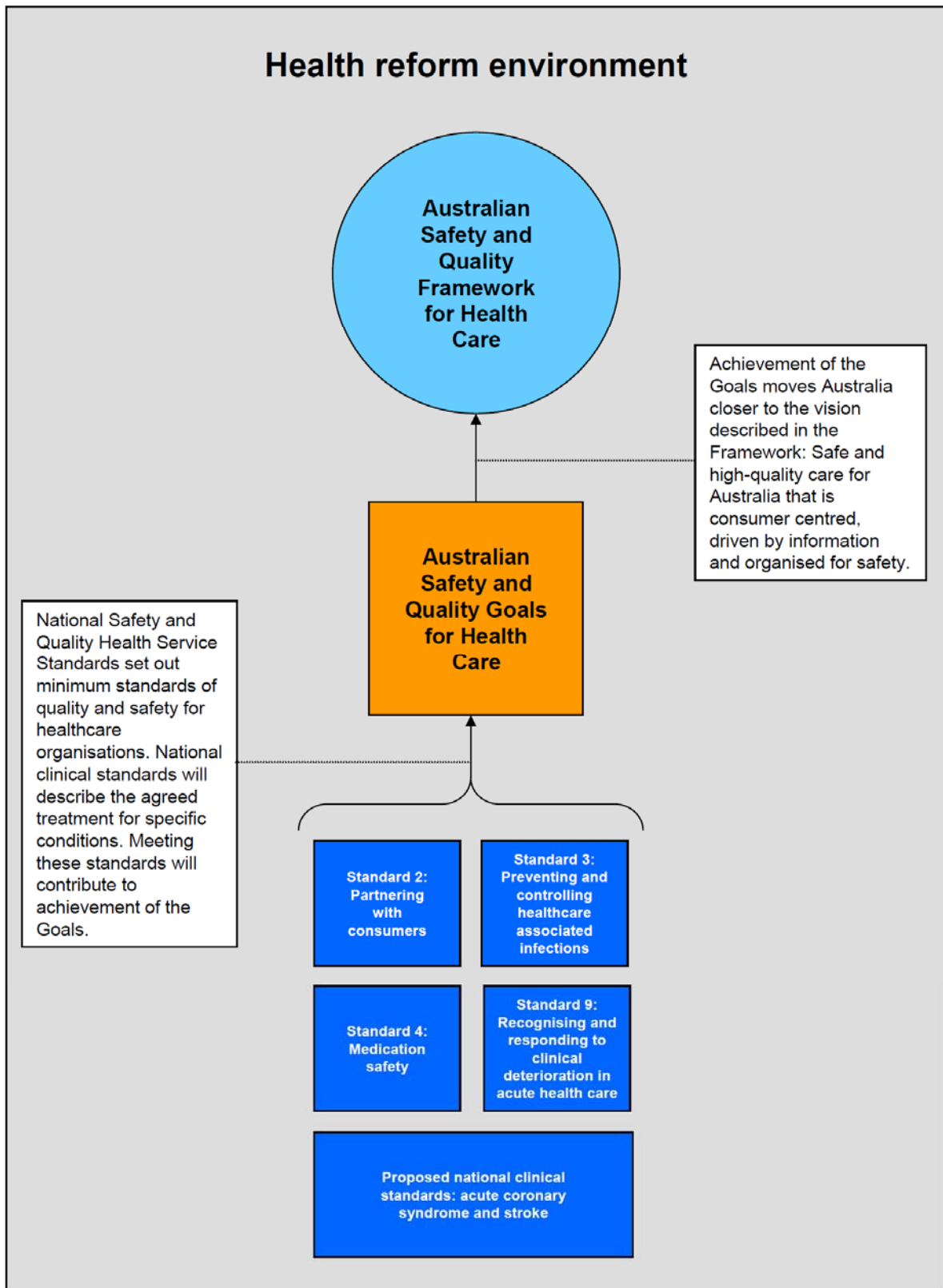


Figure 1: Relationship between the Australian Safety and Quality Framework for Health Care, Australian Safety and Quality Goals for Health Care and National Safety and Quality Health Service Standards

5.1 Australian Safety and Quality Framework for Health Care

The Australian Safety and Quality Framework for Health Care describes a vision for safe and high-quality care, and sets out the actions that are needed to achieve this vision. The Framework specifies three core principles for safe and high-quality care. These are that care is consumer centred, driven by information and organised for safety. The Framework also identifies 21 actions people within the health system can take to improve the safety and quality of care. Health Ministers endorsed the Australian Safety and Quality Framework for Health Care in 2010.

The Framework describes broadly the ideal state that everyone is trying to achieve through their efforts to improve quality and safety. The Goals, however, identify specific priority issues for coordinated national action to improve safety and quality in three to five years. The dimensions in the Framework cut across all of the Goals and priority areas.* Achievement in the areas described by the Goals will move Australia closer to the vision described in the Framework. In addition, the actions described in the Framework are known to contribute to safer and high-quality care. These can be undertaken in the areas described by the Goals to achieve safety and quality improvements.

5.2 National Safety and Quality Health Service Standards

The ten National Safety and Quality Health Service Standards were developed by the Commission in consultation and collaboration with jurisdictions, technical experts and a wide range of stakeholders, including health professionals and patients.⁷⁸

The primary aims of the Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals. Health Ministers have agreed that assessment against the Standards will be mandatory for hospitals and day procedure services from January 2013.

The Standards cover the following areas:

1. Governance for safety and quality in health service organisations
2. Partnering with consumers
3. Preventing and controlling healthcare associated infections
4. Medication safety
5. Patient identification and procedure matching
6. Clinical handover
7. Blood and blood products
8. Preventing and managing pressure injuries

* It is noted that one of the dimensions in the Framework, that care is consumer centred, maps to Goal 3, Partnering with consumers. It is recognised that partnerships between patients, consumers, carers and healthcare providers are essential for safety and quality improvements in all aspects of healthcare delivery. However the Commission considered that this issue is so important, and is in such need of development, that it should also be a goal in its own right.

9. Recognising and responding to clinical deterioration in acute health care
10. Preventing falls and harm from falls.

The Goals and priority areas highlight four of the Standards (Standards 2, 3, 4 and 9). The criteria and actions included in these Standards are also reflected in the outcomes and actions recommended in the Goals. Putting in place the systems and processes described in all of the Standards will contribute to achievement of the Goals. In addition, the reporting mechanisms being established as part of the Australian Health Service Safety and Quality Accreditation Scheme will provide information that can be used to monitor progress towards achievement of the Goals.

5.3 Interface with national health reform bodies

Since 2010 a program of national health reform has been underway in Australia to address the challenges facing the health system and ensure its sustainability and continued delivery of world class health care.²²³ Considerations about safety and quality are embedded in all aspects of the health reforms, and the Australian Safety and Quality Goals for Health Care have the potential to inform the work of national and local bodies established as part of the health reform processes. Alignment of the Goals with the health reform processes and work of these national bodies is important to ensure that the priorities and actions identified in the Goals are built into structures at a system level in an ongoing way.

The main national organisations established as part of these processes are the Commission, the National Health Performance Authority (NHPA), the Independent Hospital Pricing Authority (IHPA) and the National Lead Clinicians Group (LCG). The development of the Goals will contribute to the work of these organisations, and their work will also contribute to processes to achieve and monitor progress towards the Goals. Of particular relevance are the following:

- Actions have been identified for the Commission within each of the Goals and priority areas. Together with the roles and functions for the Commission identified in the *National Health Reform Act 2011* and the National Health Reform Agreement, these actions have been, and will continue to be used to inform the development of the Commission's work plan.
- Functions for the Commission include the formulation and recommendation of national clinical standards. This is a new activity for the the Commission and provides an opportunity to lead and coordinate improvements in the priority areas described in Goal 2: Appropriateness of care.
- The Performance and Accountability Framework will set out the performance indicators that the NHPA will report against, and the processes for determining appropriate performance criteria.²²⁴ The Goals will provide guidance about the nationally agreed safety and quality priorities that could be reflected in these indicators.
- The processes for performance reporting that will be established by the NHPA will provide a basis for monitoring progress towards achievement of the Goals. Some of the indicators that have already been developed by the Commission are relevant to the priority areas identified in the Goals (such as in-hospital mortality rates for stroke).

- The main functions of the IHPA are to determine the national efficient price for health care services provided by public hospitals funded on an activity basis, and to determine the efficient cost for health services provided by health services that are block funded.²²⁵ In performing these functions the IHPA must have regard of the need to ensure safety and quality in the provision of health services.²²⁶ The Goals can inform these considerations.
- One of the roles of the National LCG is to provide clinical advice on prioritising the development and implementation of national clinical standards and guidelines that will maximise health outcomes for patients.²²⁷ The Goals provide guidance about high priority areas that should be considered within this advice.

5.4 Interface with jurisdictions and local governance bodies

Within the current health reform processes there are new arrangements and bodies at a local level for which the Goals are also relevant. The new bodies that will be working with the jurisdictions in their role as system managers include the Local Hospital Networks (LHNs), Medicare Locals (MLs) and local LCGs.

Achievement of the Goals will require action across the different parts of the health system, and it is potentially at this local governance level of service delivery and coordination that there is the greatest potential to work towards achievement of the Goals. At jurisdictional and local governance level the priorities described in the Goals can be reflected in:

- agreements between the jurisdictions and the LHNs
- strategic, operational and safety and quality plans of LHNs
- plans and processes for MLs regarding integration, coordination and support for primary health care services
- shared governance and planning arrangements between LHNs and MLs
- advice provided by local LCGs to LHNs and MLs.

5.5 Other ways to integrate the Goals within the health system

As noted earlier, it is intended that the Goals should be built into existing and new systems, processes and structures to highlight specific priority areas that would benefit from a coordinated approach to improvement over the short to medium term. In addition to the mechanisms described earlier, there is a range of additional levers that can be used to achieve the outcomes specified in the Goals. Many of these levers reflect the principles and processes that are necessary to embed safety and quality improvement in the health system generally, not only in the priority areas described in the Goals. These include the need to actively engage clinicians, develop the capacity of the workforce, and establish effective clinical governance structures.

Other ways to integrate the Goals within the health system could include, but are not limited to, having the priorities and actions specified in the Goals reflected in:

- undergraduate and postgraduate education and training curricula

- accreditation requirements for education and training programs
- leadership and workforce development programs at a national, jurisdictional and regional level
- continuing professional development, orientation and other training delivered by health services to healthcare providers
- competencies, standards and guidelines for professional practice
- planning and governance processes of private hospitals
- agreements between insurers, private hospitals and individual healthcare providers
- specifications for new electronic systems and technologies to support the delivery of health care
- registration and credentialing arrangements for healthcare providers
- guidelines for funding of health research.

5.6 Role of consumers in supporting achievement of the Goals

Goal 3 is focussed on partnerships between consumers and healthcare providers and organisations. However, consumer groups and networks and individual consumers, patients, carers and family members also have an important role in contributing to achievement of all of the Goals. These roles vary considerably, and can include:

- For individual consumers, patients, family members, carers and support people:
 - participating in discussions with healthcare providers about needs and preferences and the care being provided
 - undertaking behaviours that will contribute to their own safety, such as following hand hygiene guidance, or carrying a list of medicines being taken
 - providing feedback about services through participating in patient surveys and other mechanisms, providing comments to staff, and where necessary making a complaint through appropriate channels
 - participating in planning and decision-making processes within health services, including being a member of committees, family advisory councils and similar groups
 - contributing to the development of information targeted at consumers.
- For consumer and community groups:
 - advocating for individual consumers, safety and quality generally and specific clinical issues
 - providing resources and information about safety and quality issues and specific clinical issues to consumers
 - supporting and training consumer representatives

- providing training for healthcare providers about partnerships with consumers
- providing expert input, and coordinating input from a range of consumers into planning and policy developing.
- For the general community:
 - understanding safety and quality and the importance of these issues to the Australian health system
 - advocating for improved safety and quality
 - participating in planning and other consultation processes.



6. Monitoring improvements

The purpose of the Goals is to describe priority areas that would benefit from a coordinated approach to improvement in a three to five year timeframe. To determine whether there has been progress towards the Goals in this timeframe it is important to be able to monitor performance and track changes in the safety and quality of care.

This process of monitoring performance should include both a focus on whether recommended processes of care are being followed (such as hand hygiene rates), as well as changes to outcomes for patients (such as rates of *Staphylococcus aureus* bacteraemia).

As noted earlier, it is not intended that any new processes be established specifically as part of the development of the Goals, or for reporting achievements against them. This means that where possible, existing reporting processes should be used to track changes and monitor progress towards the Goals.

There are a range of existing data sources and reporting processes that could be used to examine whether there has been progress towards the Goals. These include, but are not limited to:

- information collected by accrediting agencies and provided to regulators about whether hospitals are meeting the National Safety and Quality Health Service Standards
- information reported by the COAG Reform Council regarding performance of the jurisdictions under the National Healthcare Agreement and other agreements
- information reported by the Productivity Commission such as in the Report on Government Services
- information reported by the Australian Institute of Health and Welfare
- information reported on the MyHospitals web site
- information reported by the Australian Bureau of Statistics
- information that will be coordinated and reported by the NHPA under the Performance and Accountability Framework
- information collected by non-government organisations through registries, audits and other processes
- information about incidents and complaints collected and reported by jurisdictions and health care complaints commissioners.

In some cases there may not yet be mechanisms in place to collect the data that is needed to show improvement, or to aggregate data that is collected locally (often using a wide variety of processes). In some cases recommended actions within the Goals may focus on the need to develop new data collection systems. While these will be useful for monitoring progress towards achievement of the Goals, the primary purpose of such recommendations is to highlight the data and system development that is needed to ensure that safe and high quality care is provided.

Further work will be undertaken to refine the measures that could be used to measure progress towards achievement of the Goals, and to ensure they align as

much as possible with existing data sources and reporting processes. Work will also be necessary to examine how the necessary data to monitor progress can be obtained and displayed in a meaningful way.

In terms of reporting on progress towards achievement of the Goals, it is possible that:

- progress towards the Goals and activities that have been undertaken to pursue them would be included in reports about safety and quality released by the Commission
- there be a formal review after five years regarding achievement of the Goals. This should include an assessment of whether the priority areas identified as part of the Goals should be changed.



Part C: Consultation feedback

As part of the development of the Australian Safety and Quality Goals for Health Care a consultation process was undertaken between November 2011 and March 2012. The purpose of this section of the report is to describe the consultation process and summarise the feedback that was received. The feedback received from this consultation process has contributed to the final set of Goals and priority areas, recommended actions within the Goals and consideration of how the Goals should fit within the Australian health system.

7. Consultation process

The primary aim of the consultation was to obtain the views of consumers, healthcare providers, clinical professional bodies, governments and other organisations and individuals about the Australian Safety and Quality Goals for Health Care.

The Commission developed a consultation paper for feedback and discussion. The paper provided the evidence for inclusion of each of the chosen draft goals and the rationale for their selection. The paper asked a set of nine questions that respondents to the paper were asked to address. The paper was published on the Commission web site and stakeholders were asked to provide feedback to the consultation paper either by completing an online survey by providing a written submission.

The nine questions asked in the consultation paper were:

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?
2. Do you agree with the topics that have been included as Goals and priority areas? Are there other areas that should be considered?
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?
5. How do you see the Goals applying in different healthcare settings or for different population groups?
6. What systems, policies, strategies, programs, processes and initiatives already exist that could contribute to achievement of the Goals?
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?
9. What barriers exist in achieving the Goals? How could these be overcome?

In addition, a series of consultation workshops were conducted. These were held in Melbourne, Canberra and Sydney during February 2012, and in Brisbane, Adelaide and Perth during March 2012. Invitations to participate in the workshops were sent to consumer groups, colleges and other professional bodies, Medicare Locals, Local Hospital Networks and state, territory and national government organisations. The purpose of the workshops was to discuss how the Goals could be used, gain a better understanding of the context of the Goals, and explore the key opportunities for action.

7.1 Submissions

The Commission received 90 submissions in response to the draft Australian Safety and Quality Goals for Health Care. Twenty were provided through the online survey and 70 were provided as a written submission. Table 2 provides a summary of the

individuals and organisation from which submissions were received. A list of organisations and individuals who made submissions is provided at Appendix 2. Submissions are numbered from 1 to 90 based on the order in which they were received by the Commission. Bracketed numbers throughout this report refer to the submission provided by this numbered respondent. Full submissions are available on the Commission web site.

Table 2: Submissions received for the Australian Safety and Quality Goals for Health Care consultation by type of organisation

Type of organisation	Number of responses
Individuals, clinicians, consumers and researchers	29
Consumer or community organisations	6
Commonwealth, state and territory governments, government organisations, complaints commissioners	15
Public and private hospitals, Local Hospital Networks, Medicare Locals	9
Colleges, clinical societies, networks and other disease-specific organisations	25
Other	6
Total	90

7.2 Workshops

One hundred and twenty five people participated in the six consultation workshops. Table 3 provides a summary of the types of organisations represented at the workshops.

Table 3: Number of participants at consultation workshops by type of organisation

Type of organisation	Number of participants
Consumer or community organisations	17
Commonwealth, state and territory governments and other government organisations	33
Public and private hospitals, Local Health Networks	42
Medicare locals	2
Day procedure services	9
Medical and nursing colleges	13
Clinical networks	5
Other	4
Total	125

8. Overall consultation findings

This section provides details about the overall findings, including the feedback received from both the online survey and the written submissions (to be classified together from this point onwards as “responses”), and the issues discussed in the workshops. Sections 9 – 17 are structured according to the nine questions included in the consultation paper, and are based solely on the responses from the written submissions. The workshops were not structured around the nine questions in the consultation paper, however similar issues emerged from both sources of feedback, particularly regarding the common themes reported in this section.

The written responses received varied greatly. Some provided comprehensive answers to the nine questions asked; some chose to provide general comments; some respondents provided comment on just one specific Goal such as stroke or medication safety; some provided a response to just one question; a small number advocated for an additional or alternate goal. The length of responses varied from half a page to 45 pages. Some organisations went to considerable lengths to develop a whole-of-organisation response, with one government department administering an internal survey, conducting a number of workshops and consulting with key clinical groups in order to develop their whole-of-department response. Some submissions provided detailed information and references about potential strategies and indicators, and made recommendations for improvement. The details of all of these topic-specific initiatives and recommendations are not included in this report. This information has been reviewed and considered by the Commission as part of the development of the action guides for each priority area, and is available on the Commission web site.

8.1 Common themes

There were several common themes in the responses and workshops. These themes or common issues were raised in different ways and in different places, and so did not necessarily relate to one or other Goal or consultation question.

The responses received were in general very positive; they supported the attempt to develop a set of national safety and quality goals or priorities. The common themes are as follows.

Uncertainty about connections

There were many comments about where these Goals sit in relation to both the Australian Safety and Quality Framework for Health Care and the National Safety and Quality Health Service. Comments included:

- concern that these Goals were duplicating the Standards
- questions about why some Standards were to be prioritised over others: in terms of patient safety, it was argued that falls and pressure ulcer prevention could be considered to be as important if not more important than infections and medication errors
- concern that focus on these Goals will reduce the focus on the remaining Standards

- the Goals need to be explicitly aligned to the Framework, the order changed to reflect the same order as the components of the Framework and the language used, to be consistent with the Framework.

On the positive side however, comments included:

- the Goals will support health service progress towards achieving the Standards
- work on achieving the Standards will support health services efforts towards reaching the Goals.

A need for co-operation and collaboration

Many respondents commented that an essential requirement for success of the Goals is strict inclusion of, collaboration with and engagement of the National Healthcare Performance Authority, the Independent Hospital Pricing Authority and the National Lead Clinicians Group to ensure that, among other things, jurisdictions are not required to deal with duplicate or conflicting reporting requirements. The reporting required in relation to the Goals should correlate with that required for the “My Hospital” performance reporting. Further comment was received about the need for collaboration on these goals between the Commission, health services, non-government organisations, consumer groups and government departments.

The scope of the Goals

A common theme arose around the scope of action across the continuum in order to achieve the Goals. Some respondents expressed concern that the Goals (especially 1 and 2) are very acute services focussed and should be expanded to better include prevention and primary health care. Others, however, commented on how well the Goals, if implemented correctly, will require the cooperation of Medicare Locals, the Local Hospitals Networks and the Local Lead Clinicians Groups. Indeed it was suggested that the Goals could form the basis upon which these groups and organisations commence co-operative action.

These are not new!

Comments about the fact that the areas that have been identified in the draft Goals and sub-goals are not necessarily new were both of a positive and not-so-positive nature. There was concern expressed that over the past 10 years there has been quite a lot of focus on all the components of these goals; especially medication safety, infection control, diabetes, stroke and acute coronary syndrome management. Some responses considered that it would be difficult to engage healthcare providers any further on these.

To the contrary, however, there was acceptance that these are problem areas worthy of additional focus, and if past focus has not deleted them from the list of priority areas yet, all the more reason to place additional focus on these problem areas now. The greatest challenge for health services will be for secondary services to integrate with primary health care in order to achieve the best results.



Inter-relatedness

Many respondents commented on the inter-relatedness and cross over that exists between the Goals and priority areas. Goal 3 was especially considered to be a Goal that is relevant to and essential for the achievement of Goals 1 and 2. Work on achieving medication safety, for example, will assist in achieving better management of patients with diabetes. People with mental health conditions and other high risk and disadvantaged groups also create a linkage between the goals. A large number of respondents talked of the need to work on health literacy in order to achieve any of the goals. Many respondents commented on the personally controlled electronic health record (PCEHR) being an important tool for connecting the Goals and contributing to their achievement.

Implementation focus

The final common theme relates to the need expressed by many respondents that if the Goals are to be achieved there will need to be a well-organised, well-articulated, comprehensive national implementation plan. All affected sectors of the health sector will require a substantial level of information and perhaps education to achieve success.

It was recognised that more detailed work would be needed about:

- how the recommended actions could be applied in specific settings and for specific groups
- refinement of proposed measures of success, including potential indicators and sources of data
- how the Goals would contribute to the work of national and local health reform bodies, jurisdictions and clinical groups in an ongoing way.

There were requests from many specialty groups, colleges and professional organisations for the Commission to include them in further discussions and development of the Goals.

9. Question 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?

This question was answered specifically by 60 of the 90 respondents. The respondents who did answer the question varied in the way in which they provided their answers. Some answered the question directly, some indirectly. Forty two respondents expressed their agreement with or support for the Goals; some explained how they could add value in their work to the success of the Goals; others explained how the Goals could add value to the work they presently undertake in relation to patient safety and quality.

Nine respondents did not agree with the draft Goals that the Commission had suggested in the consultation paper and a further nine respondents answered “yes, but” to this question, meaning that they agreed with them, but there were certain caveats or qualifications associated with that agreement.

9.1 Comments

The following summarises the responses, which have been grouped under the three broad categories identified above.

On the positive side

There were several reasons given for supporting the Goals as proposed in the consultation paper and for agreeing that the Goals could add value to existing efforts to improve safety and quality in health care.

The first was that the Goals will allow an organisation to see what are **priorities** and what are not. It was expressed that it will be beneficial to have a reference point external to the organisation, that researchers and patient safety managers can point to when in discussion about their organisation’s priorities. The Goals could provide the context for many current initiatives and enable a revised approach to staffing and management strategy based on nationally relevant priorities. The Goals would facilitate alignment between local and national priorities. They would provide the focus for attention on the key safety and quality challenges facing Australia over the next five years. Some respondents suggested that the Goals offer groups such as the NHPA and the IHPA and the National LCG with agreed priorities for the planning, funding and performance review of health care services. One respondent expressed considerable support for the Goals suggesting that she would be able to use them to increase resourcing for her Pharmacy Department in order to address the medication safety priority areas.

Secondly, it was stated that the Goals will provide **consistency** across LHNs. They will allow appropriate resourcing to ensure the Goals can be implemented and improved, which will result in improved care for consumers.

The **connection and collaboration** between health care providers and organisations was also expressed as a value add. For example:

- The Goals align with all of the strategic objectives for which Medicare Locals are accountable.

- The Goals provide challenges which will benefit greatly from a collaborative approach incorporating the strengths of organisations such as the State Therapeutic Advisory Groups and the National Prescribing Service.
- It was noted that the Goals will provide a foundation and direction for the service delivery and business rules of services funded by Medicare Australia through other mechanisms. Several others commented on the beneficial connection with Medicare.
- A national focus on specific Goals enhances a coordinated approach to research, in terms of project support and aims, to policy development and implementation, to national education strategies and to building work capacity.
- Value can be added to existing efforts to improve community health and well-being via capacity building strategies targeting primary care and community health service providers.
- Many respondents expressed both the considerable value that the Goals can add to the work of the clinical networks that are established in most states and territories and the value that the networks can add in achieving the Goals.

The Goals will provide context for discussion between and within Medicare Locals, primary health care services and Local Hospital Networks. They may provide the impetus for shared treatment guidelines and more timely delivery of services.

Submission #27

Establishment of Goals for the whole of the country would enable hospitals to gain a realistic understanding of their performance against the Standards for the purposes of **benchmarking** and **quality improvement**.

Finally, the Goals were seen to be able to add value as any public reporting of achievement of the Goals will increase the **accountability** that health services have for providing high quality care.

On the not-so-positive side

Only nine respondents explicitly expressed a negative attitude towards or a lack of approval for the draft Goals. The reasons given for this are summarised as follows:

- The most frequently expressed concern was that by selecting some areas for national attention, there is a risk that focus will be diverted from other critical areas. For example, “it could be inferred that safety and appropriateness are less important in areas outside the suite of goals”. (17)
- Much of the information contained in the Goals is already incorporated into the Standards. It was expressed that there is no value additional to the Standards, which are considered to be very good. Similarly, respondents expressed the view that the Goals are a restructure of the Australian Safety and Quality Framework for Health Care and so only add value in providing a framework for decisions on future areas of work.
- The Goals were considered by some respondents to be self-evident. They are already what every hospital and all health services are striving to achieve. Respondents expressed that these are of course valuable goals that must be addressed, but “whether the Commission needs to and whether they need to be couched within a new set of goals is debatable”. (35)

“Yes, but!”

The eight respondents who expressed support for the Goals but with caveats attached, raised the following qualifications to their support of the Goals as they stand. “The evidence for their choice is strong, but the following reservations are held.”

In summary, these respondents would support the Goals if:

- the implementation of the Goals was adequately resourced
- the Goals are connected to other frameworks
- the Goals are connected to and explained in terms of the Standards
- there is a robust implementation plan for the Goals that defined a comprehensive process, outcome measures and targets.

One respondent (80) stated that there certainly is a need to better balance the current focus on safety to other domains of quality, particularly including appropriateness and patient experience. However, there is also a real need in the short to medium term to align the goals to current strategy rather than create a new, additional program of work. The ten Standards and the associated national accreditation program are the core driver of change at the clinical coalface in the acute sector for the next three years. The change required at the clinical front line right now is already overwhelming and focus for the next three years should be on achieving what have already been set as minimum standards in this area.

10. Question 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 majority of respondents expressed support for the topics that have been included as Goals. As could be expected, disease specific advocacy groups and organisations such as the Heart Foundation, the National Stroke Foundation and The Pharmaceutical Society of Australia were very supportive of the disease or topic area they represent being included as a priority. Conversely, there were representations from other such advocacy groups for the inclusion of other diseases as priorities, for example from the National Trauma Research Institute. There was overwhelming support for Goal 3: Partnering with Consumers, and the need to increase consumer representation and satisfaction.

10.1 Comments

Respondents expressed that the Goals and priority areas have synergies with the priorities set through other frameworks and by other organisations for example through the National Health Priorities and the National Health and Medical Research Council. Some respondents were supportive of the Goals that have already been established through these other mechanisms, most especially through the Standards and the Framework, because there will be no need to create a whole new area of focus and activity in their health service(s). However others were critical of the Goals and priority areas for the same reason. These respondents expressed that nothing additional would be achieved if different goals were not established.

A number of common themes emerged in the answers to this question.

- It is appropriate that these chronic diseases are a focus as there is evidence that there are considerable gaps between the research evidence and practice and associated evidence that health outcomes would improve and health care utilisation would be substantially decreased by consistent delivery of evidence based care.
- Common to all of the Goals are patients with mental health problems, especially those suffering from schizophrenia and depression. This should therefore be a focus of activity across all Goals. People with mental illness have a greater incidence of physical health problems than the general population and the prevalence of heart disease, metabolic disorders, respiratory disease, cancer, infection and obesity is significantly higher in this group.
- With similar reasoning many respondents suggested that the Aboriginal population should have a stronger focus.
- Several respondents requested that Goal 2, priority 2 not be stated as “People with acute coronary syndrome or stroke”, but that it be restated as “People with acute coronary syndrome **AND** stroke”. As with diabetes, stroke and acute coronary syndrome should be separate priorities. Two respondents requested that the Goals and priorities include not only people who have these diseases, but also people who are at risk of these diseases.

- Similarly, there were many comments about the need to refocus the Goals towards prevention of these diseases rather than the treatment of the conditions.
- The definition of the term appropriateness, as a dimension of quality was argued. Appropriateness has more traditionally been associated with over- and under-servicing and not so much the effectiveness of the treatment provided. In this context, the issues of appendectomies and hysterectomies should be priorities for action. Further, in relation to the dimensions of quality, some respondents requested the inclusion of goals that focus on access to, and equity of services.
- While there was little disagreement that chronic diseases are a major issue confronting the health system, many mentioned that the reality for people with chronic illness is that they have multi- morbidity. The setting of these safety and quality Goals provides the opportunity to focus on patients with these complex multi- morbidities.
- Several respondents added to this chronic diseases discussion by suggesting that obesity should be the prime concern of Goal 2, as if this were tackled more comprehensively, less focus would need to be placed on the treatment (and prevention) of diabetes, ACS and stroke.

True patient centredness would start with the multimorbid patient in mind. Health care delivery in non-acute settings including for chronic illness, requires a different way of thinking....not merely an extrapolation of research results from acute care populations to other populations.

Submission #28

10.2 Suggested additional Goals or priority areas

Although it was generally considered that the three Goals are appropriate and relevant to advancing quality and safety, many respondents added comments to the effect that other priority areas could be equally justified for inclusion. It should be noted that some of the points in the list below have been included in the proposed set of Goals, priority areas and outcomes.

The following list represents the majority of suggestions:[†]

- falls and falls prevention (the most common additional suggestion)
- health literacy
- sepsis
- asthma
- dementia
- pressure ulcers
- patient identification
- improving pathology services and the gap between forensic pathology and the Departments of Health

[†] Other than the first suggestion, the other issues are not in order of frequency.

- a number of pathology specific goals were suggested
- improvement of emergency services (ambulance)
- cancer services
- health care for Aboriginal patients
- people sustaining serious injury
- malnutrition as both a cause and consequence of ill health
- the establishment of a congenital diseases registry
- the national rollout of a decision support tool for the appropriate ordering of imaging
- prevention and management of delirium
- pain management
- end of life care, including advance care directives and dying at home
- healthcare infrastructure, including workforce, telemedicine and systems for ensuring continuity of care.

There were also several suggestions for the inclusion of specific issues under the proposed Goals and priority areas, including:

- inclusion of the detection of adverse events that are associated with the correct use of medicines for their intended therapeutic purpose
- use of antipsychotics as a medication safety issue
- inclusion of *Clostridium difficile* infection within the healthcare associated infection priority area



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

The responses provided in the survey to this question were equivocal. The responses can be categorised along a five point Likert scale where the ratings are that the Goals and priority areas are:

- too broad
- appropriately broad for cross-health service relevance
- just right
- appropriately specific enough to be well understood
- too specific

Again a number of respondents commented on the Goals being a repetition of either the Framework or the Standards. Goals 1 and 3 attracted several comments about their similarity and one respondent also stated that Goal 2 is included in the Standards under the governance standard: “Under Governance in the national Standards one could interpret that every health care provider is responsible for delivering evidence based care in these and a range of other high priority disease areas. So, the appropriateness of care goal is probably covered to some extent in the national Standards”. (24) Further, there is a risk that Goal 2: Appropriateness of Care will be perceived as being irrelevant to services and in settings working with diseases other than diabetes, acute coronary syndrome and stroke. While the need to have specific national priorities and targeted action is apparent, it was considered that the Goals should reinforce the need for appropriate evidence based care across all healthcare settings and disease types.

A number of respondents provided suggestions for specific strategies that could be used or implemented to achieve the goals.

One respondent (35) suggested that these Goals and priority areas do describe a number of key quality and safety challenges and that the Commission has stated that these are not the only challenges that face health services in relation to quality and safety. Therefore the Goals may change over time. The respondent remarked that this will “dilute” the power of the Goals.

One benefit that was noted by respondents was that the identification of these goals will enhance the work of the many advocacy groups and non-government organisations working in these specific areas, such as the Stroke Foundation and the Health Foundation, as has been the case in the past when specific diseases were established as National Health Priorities.

11.1 Comments

The reasons respondents categorised the Goals under the five categories identified above are summarised below. Although only one reference is provided for each issue, these statements generally reflect a number of responses.

Too broad

- The Goals are too broad in their present form to be effective. Specific areas within the Goals need to be identified (28). Many respondents noted that Goals 1 and 2 are very specific but Goal 3 is too broad and requires a set of measurable sub-goals. (38)
- The Goals are like mission statements and cannot be achieved in the three to five year time frame suggested. (44)
- Comment was provided (80) that more specific goals, fashioned on the SMARTS method (specific, measurable, achievable, reliable, time-based, sustainable) may provide greater leverage through tighter language. For example, a goal may be expressed as follows:
 - measurable reduction in harm from medication adverse events by <year>
 - measurable improvement in patient experience by <year>.
- Such statements would also facilitate the development or identification of suitable measures of success.
- A number of comments about the Goals being very broad were provided by advocacy groups that see benefit in being more focussed around population or disease specific groups.

Appropriately broad

- Goals 1 and 3 are relevant across many, if not all areas and specialties of health care, so these Goals are appropriately broad for effect. (23)
- The Goals are broad enough to meet the scope of differing health services. (22)

Just right

- The principles and issues raised and discussed apply across the whole of the health system. They are equally applicable to Local Hospital Networks, primary health care and Medicare Locals. The specifics will need to be identified later in order that implementation strategies are appropriate to the healthcare setting in which they are being utilised. (27)
- The goals are reasonable and have general appeal especially if they are reviewed and expanded over time. (73)
- The goals are not too broad but sufficiently specific to clearly outline the required outcomes with solutions on how to achieve these outcomes. (46)
- It is necessary to start somewhere, the recommendations put forward appear appropriate...the selection is common to all. (9)
- Comments such as “Just right – well done” were not uncommon.

Appropriately specific

- The goals are considered appropriate and relevant to advancing quality and safety. While specific enough to guide priorities and practice they are considered

to be broad enough to allow for local contexts and adaptation, which is important. (68)

Too specific

- There is risk in selecting a small number of areas that may be perceived as being “more important” than other quality and safety areas. (86) The priority areas are very specific and may produce an opposing incentive for health services to focus on these goals to the detriment of other priority problems. (24)
- Additional comments about the specificity of the Goals, related to the Goals being specifically aimed (at present) at the acute sector and that they should be broadened to include prevention and the primary care sector.
- The remoteness of many Australian health services will result in non-achievement of the Goals if the strategies to be implemented remain as specific as they have been stated in the consultation paper. (24)
- As stated earlier, the need for more detail to be provided about the Goals and priority areas was expressed by many respondents. If these draft Goals are to be selected as the final Australian Safety and Quality Goals for Health Care, effective implementation will require the identification of the specific strategies and actions that are required and the timeframes within which they are required.

I would suggest that the breadth versus the specificity issue is answered by the balance between the conditions which are specific and the interventions which are broad, and this is correct.

Submission #28

12. Question 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?

This question was answered by 51 of the 90 respondents. The respondents who did answer the question varied in the way in which they provided their answers. Some answered the question directly, some indirectly.

Thirty seven respondents expressed their agreement with either the allocation of targets to the Goals and priority areas or the need to measure achievement in some way. Seven respondents did not agree with the allocation of targets and a further nine respondents agreed, but there were caveats or qualifications associated with that agreement. There was clear support however for measurement of some kind.

Of greatest note in relation to this question was the confusion or at least lack of clarity expressed by many respondents, in their use of the terms “measures”, “indicators”, “KPIs” and “targets”. Many respondents used the terms interchangeably. Some respondents would state that a target was a good idea and provide an example that was more accurately an indicator, but with no specific target identified.

Where terms have been used somewhat liberally, the word “measure” will be used in this report. Many responses however also appropriately discussed the benefits and disbenefits of setting targets.

Aligning the Goals to the National Safety and Quality Standards will provide the best chance of achieving agreement on targets and their associated data definitions, meanings, reliability and comparability.

Submission #80

12.1 Comments

The following summarises the responses, categories according to whether they were positive, not so positive or had concerns about the idea of targets.

Positive responses

- The most commonly expressed statement in favour of measurements (and not necessarily therefore of targets specifically) was the need to have “something” that establishes a baseline against which improvement can be measured. Without these measurements and also targets, there will be no way of knowing if the Goal has been achieved.
- The Goals require targets to ensure that there is pressure placed on health services to make improvements and there are incentives to achieve these targets over agreed timeframes. Measurement will also promote routine monitoring and reporting, with active quality improvement activities being linked to the monitoring and reporting process.
- Two levels of measures were suggested by a number of respondents. It would be appropriate to require specific process and outcome measures at both the national and organisational level. For example an indicator of the number of organisations using the national inpatient medication chart would be appropriate at the national level and an indicator of the number of inpatient charts where

prescription has been compliant with defined requirements would be appropriate at the local level.

- Many respondents expressed the benefit that measures and targets can provide in ensuring accountability of health services for the quality of care provided to consumers. Equal to this was the expression of the accountability that governments have for providing an adequate response when health services are not achieving the targets that have been set. Such a response would appropriately be the provision of additional resources and/or assistance to the health service that is not meeting these targets.
- Data should be collected centrally to allow benchmarking across the country, both inter-organisational benchmarking and inter state benchmarking.
- Respondents expressed a concern that there are many KPIs and indicators in the health system already. As far as possible, these indicators should be used for measurement of these Goals and priority areas. Effort should be made not to create new indicators and establish new targets that differ little from existent measures but will require new collection and reporting systems. Data collection in health systems is sufficiently burdensome. Goal targets should, as far as possible, not add to that.
- Identifying targets can be viewed as a positive and natural step following the establishment of goals and priority areas.
- Targets need to be realistic and relevant to the different healthcare areas and settings. If targets are set around the quality of care, set at a minimum level initially and incrementally increased they will be effective in facilitating continuous improvement. If targets are used, it is essential that there are adequate systems in place (top level processes) to support health services and clinicians to meet the targets.
- Many respondents provided comment on the relative ease with which measures and targets can be established for Goals 1 and 2 and the difficulty that there will be in identifying targets for Goal 3. Some respondents provided recommendations for indicators and targets for specific Goals.

Not so positive responses

- Many respondents agreed that there should be outcome measures linked to any investment made to address the Goals and priority areas in order to ascertain if resource allocation into these areas is making a difference. However, it was also stated that targets can tend to over-focus those having to report on very specific targets, causing organisations to lose perspective on their real purpose, that is, caring for patients and instead become consumed by a target achievement which in the end may have little relevance in improving patient outcomes. If a target is not absolutely correct, it can create perverse incentives.
- Respondents suggested that it would not be appropriate to allocate targets at this stage; it would be more appropriate to gather the evidence about current practice and trends and then establish targets. This should allow the analysis of cause and effect and the development of cost-effective strategies for maximum impact.

We agree, but!

- Some respondents agreed that measurement is essential to identify areas to improve, inadequacies in care and to assess the impact of interventions. However, it can often be difficult to find an appropriate variable, and so process measures or easily recorded variables are measured instead. Measurement is essential for benchmarking and while benchmarking can set standards at which hospitals can aim, the achievement of these targets and standards should not be enforced in a punitive way. There are difficulties adjusting for differences between hospitals such as case mix and provider mix. Instead, hospitals should aim to improve their own standards, within their own services, as the definition of events and measures within the one hospital or service will be constant.
- The definition of meaningful indicators will be difficult across the continuum of the health system. If used, indicators and targets will need to be developed collaboratively through the groups that are responsible for the planning, funding, delivery and performance review of healthcare services in Australia. This would include the Commission, the NHPA, the IHPA, the LHNs, the MLs, the national LCG and Medicare Australia. This approach is likely to ensure that incentives are agreed, aligned and not perverse. This could take a considerable length of time to achieve.
- Targets will need to be continually updated in line with the outcomes that are being achieved, government policy and resource allocations.
- Targets should only be set if there is evidence to support the target and a reliable and agreed process for routinely reviewing the target.
- Targets require clear baseline performance to be known, and at this time a significant amount of work would be required to ensure that there is agreement of data definitions and the meaning, reliability and comparability of such data are acceptable. However, if the Goals were to align with the Standards, this would provide the best opportunity to achieve this.

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

There was substantial agreement amongst respondents that the Goals and priorities will apply differently in different healthcare settings and to different populations.

The key themes related to:

- the geographic diversity of health services, including metropolitan, regional, rural and remote
- the many types of services across the care continuum, community care, primary care, acute care, post acute services, residential and supported care environments
- the different population groups, including the aged, people suffering from a mental health condition, Aboriginal and Torres Strait Islander peoples, people from a culturally and linguistically diverse background, people with a disability and the young.

Many respondents suggested that specific attention should be placed on the population groups identified above across all of the three Goals and priority areas. Not only are these groups at greater risk of suffering from diabetes, ACS and stroke, but because of their polypharmacy requirements they are also at greater risk of medications errors. Further, they are at greater risk of contracting an infection. The importance of partnering with these population groups in their care is relatively self evident.

In summary, systems and processes will need to be implemented and monitored in ways that are relevant to all these specific settings and communities. A “one-size-fits all” approach is unlikely to be effective and there is a risk that particular communities and vulnerable consumers will be disadvantaged unless a systematic approach is taken to ensure the Goals are implemented and monitored in all settings. This will require the establishment of specific measures and targets for different settings and population groups.

13.1 Comments

The responses have been summarised according to the three broad categories identified above.

Geographic diversity

The following are some issues identified by respondents that relate to geographic diversity:

- It is important that the goals consider and clearly distinguish the differences in geographical settings and the impact this has on resource allocation, safety and quality and the actual delivery of services.
- There may need to be some variation in the application of strategies or type of strategies across different settings in order to address the issue that people

living in rural and remote Australia may not receive the same quality of care as their metropolitan counterparts. Each Goal should be analysed to determine if disparity exists and the specific strategies that can be used to improve safety and quality of care in these areas and for specific populations.

- The appropriate management of ACS broadly spans the continuum of care beginning with the vital recognition of ACS signs and symptoms by the individual and the prompt activation of emergency services through to treatment, then cardiac rehabilitation and secondary prevention through general practice. Given this breadth, a common goal for ACS requires a unified approach, incorporating systemic collaboration and formal linkages across various health services.
- In relation to stroke, the appropriateness and ability of rural and remote services to establish stroke units will need to be considered.
- Responses identified the importance of the involvement of ambulance services in the achievement of the Goals so that appropriate patients are able to be transported to the right care as quickly as possible.

Different healthcare settings

The following are some issues identified by respondents that are specific to different healthcare settings:

- The Goals should be generic, high level and flexible enough to apply to primary care, community care and acute care settings. Healthcare providers in the various settings would then take it upon themselves to create specific objectives and activities to reach these Goals, using tools to relay the Goals into their particular setting/context.
- Pharmacist respondents reported that the Goals, especially those that require medication management (not only Goal 1), will be far easier to achieve in metropolitan areas, simply because there are more adequate numbers of clinical pharmacists in metropolitan hospitals. Medication reconciliation, medication reviews and counselling are already occurring in metropolitan settings. Many rural and semi-rural hospitals are able to provide minimal medication review, some are able to provide nothing at all. There cannot therefore be an expectation that rural services will be able to achieve the Goals in the same way that metropolitan hospitals will.
- In relation to stroke it will be more difficult to achieve this priority in regional and remote areas. Accessing specialist stroke services is more difficult and the time taken to get to health services for treatment can affect the outcome for the patient.
- Appropriateness of care for ACS as stated in the consultation paper cannot be achieved in rural and remote environments. The timeframes required are not achievable. Closure of smaller rural hospitals which were the only source of after hours care has resulted in increased ambulance transport times.
- Many variables that cut across health care settings such as differences in infrastructure, culture, workforce and clients should be considered, as these all have an impact on the safety and quality of health services.

- All settings require effective data management and information technology systems to be established that are consistent across the different state and territory boundaries and healthcare settings and that are comparable between settings. Quality data are essential.

Different population groups

The following are some issues identified by respondents that are specific to different population groups:

- In addition to the accepted fact that the diseases that have been identified in Goal 2 affect Aboriginal and Torres Strait Islander peoples at much higher rates than non-indigenous Australians, there is evidence to show that Aboriginal and Torres Strait Islander people who are hospitalised for suspected ACS do not receive the equivalent level of care received by other Australians.
- One respondent (86) requested that health care for Aboriginal patients be considered as an additional integrated priority area across all the Goals, with evidence-based targets linked to existing national Aboriginal health performance measures.
- Older people are disproportionate users of health care and are at greater risk of stroke and the adverse outcomes of poly-pharmacy.
- To achieve the Goals as they apply to older people across all sectors there is a need to include residential aged care and home and community care services. This would require the concomitant commitment from the Department of Health and Ageing and highlights the need for a common system wide approach to setting priorities and targets.

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

It was acknowledged in the responses received that the draft Goals and their associated priorities are not new. Health services have been endeavouring to address these problem areas of healthcare delivery for many years. It can be expected therefore that there will be many resource materials that have been developed over those years within the health system, that can be utilised in the effective implementation of strategies to achieve the Goals.

Many submissions provided lists of suggestions for inclusion. These included:

- guidelines
- alerts
- registries
- quality improvement strategies
- curricula
- decision aids
- programs
- models of care
- frameworks
- committees, groups and coalitions including clinical networks
- standards
- manuals
- information sheets
- web sites
- accreditation programs
- various indicators and indicator programs, most specifically the clinical indicators that have been developed by the various medical colleges and auspiced by the Australian Council on Healthcare Standards.

A comprehensive list is provided in Appendix 3 of this report.

14.1 Comments

Most respondents who addressed this question simply listed the various tools and strategies that they have produced or that they are aware of, that could contribute to achievement of the Goals. Few comments were made about the tools and strategies. The following is a summary of these comments:

- A formal audit should be undertaken and publicly reported on existing work in the proposed areas to avoid a perception of “takeover” and/or unnecessary

duplication in efforts and/or promoting activities that are already underway. Final decisions on safety and quality goals should not be made until a greater understanding of the existing and planned commitment in the proposed areas across public and private services is undertaken. This will support the necessary linkages and collaborative activity that is likely to be needed to ensure consistency, resource sharing and to reduce the possibility of duplication. (50)

- The systems already in place are often difficult to enforce, compliance is difficult to ensure and can sometimes act as a barrier by inhibiting reform to improve safety and quality. Often, time pressures restrict the health sector from taking advantage of the tools, mechanisms and processes that already exist. So it is important to explore where the current blocks exist and whether they inhibit innovation. (73)
- Not only do there need to be clear guidelines, but there also needs to be an incentive to comply, noting the issues with rewards systems. Strategies to encourage clinicians to comply with quality improvement activities are needed.
- One of the key strategies that was raised by many respondents was the existence of clinical networks in many if not all the states and territories. These clinical networks should be and can be used to further the development of the Goals and to facilitate their implementation and achievement across the country.
- Full implementation of Australia's National Strategy for Quality Use of Medicines will greatly assist achievement of Goal 1. Increasing the uptake of existing funding for home medication review by community pharmacists may also contribute to achievement of this Goal.
- If there is serious consideration of the Standards being considered as the national Goals, a logic model already exists. This model provides the ideal environment for commitment to the Goals. This will help ensure that the compliance elements of the Standards will also lead to an outcome focus in terms of the measurable quality of patient care.

A tool that was commonly mentioned in submissions as having a key role to play in the implementation and achievement of all the Goals was the personally controlled electronic health record (PCEHR) which is being developed and implemented across the country. The PCEHR is an electronic health record that will contribute substantially to the attainment of the Goals in the following ways:

- E-health and in particular the PCEHR will provide a fundamental change to the way in which consumers engage with the management of their health condition and treatments. Having access to information about their health care, controlling access to that information and being able to share the information with a variety of healthcare providers will place the consumer at the centre of their healthcare management.
- There is a strong focus on people with chronic and complex conditions such as type 2 diabetes and ACS, where it is acknowledged that the sharing of information between healthcare providers will improve the coordination of care. Diabetes in particular, is a chronic condition which results in considerable use of a variety of health services.
- E-medication management is one of the key e-health solutions contained within the PCEHR which will contribute to improved medication management and

reduce adverse drug events. Across all e-health capabilities including the PCEHR, e-medication management is estimated to be the greatest individual driver of a reduction in adverse drug events.

- The following components of the PCEHR will contribute to the achievement of all of the Goals:
 - healthcare identifiers
 - Australian medicines terminology
 - shared health summary and event summary
 - other clinical documents within the PCEHR including e-referral, specialist letters, discharge summaries, and e-prescriptions.



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

Many respondents provided suggestions for initial priorities for action under the Goals. These responses varied between suggestions for starting with:

- “generic”, non Goal specific system wide strategies
- one particular Goal, or a strategy within a Goal
- specific population groups and healthcare settings.

One respondent (27) suggested that as there are such strong connections between all the Goals, they should be commenced and conducted simultaneously. For example, the strategies discussed in the management of ACS and stroke require, and would be strengthened by, individuals having access to strategies discussed in medication safety, discharge planning, home medicine review, patient based strategies, pharmacist review of medications on admission and initiatives for managing high risk medicines such as heparin and warfarin. It was further stated that healthcare providers will perhaps be more likely to act if strategies and services can improve one or more of the stated Goals.

15.1 Summary of responses

The following summarises the responses provided by respondents. Responses have been grouped under the most common categories identified above.

System wide initiatives

Respondents suggested the following system focussed actions to be taken:

- Start by exploring the patient view.
- Identify the connection, correlation and differences between the Goals, the Standards and the Framework. It will be difficult to develop enthusiasm and motivation for the Goals amongst front line workers if these distinctions and connections are not drawn and very clear. The first priority could be to implement the Standards.
- Develop a clear plan for the effective implementation of the Goals.
- Identify SMARTS targets/objectives then identify strategies that have been proven to address the gaps in clinical practice.
- Develop working parties of diverse membership from representative stakeholder groups, covering areas involved in each Goal, to work together to further develop the Goals and strategies for implementation. Groups should be reasonably small but inclusive of all required personnel.
- Establish timelines.
- Make health literacy a major Goal and start with this. It crosses over all the Goals and will assist in achieving all the other Goals.
- Develop and implement a communications plan for the whole of health so that all who need to be involved in achieving the Goals are aware of the content of the

Goals and priorities and the strategies to be implemented to achieve them, and the timelines within which they are to be achieved.

- Ensure awareness, educate and develop motivation for the implementation of the Goals amongst health workers and consumers.
- Undertake a gap analysis of the resources that are available, beyond those that have been identified through this consultation process, so that there is little chance of duplication, then develop tools and strategies to fill the gaps.
- Precede any other action under all of the Goals with support for system redesign and culture change.
- Look at options to provide tools for training and development to build leadership capacity and a consumer driven focus of the health workforce.
- Establish nationally agreed areas of focus where developing and setting targets will have the greatest impact, be able to be generalised for all patient subgroups and regions and have the greatest evidence of practice gaps.
- Develop targets to improve the delivery of evidence based care.
- Consider the infrastructure and systems available and required to support actions and develop a framework to ensure this is available.
- Support national data collection activities to ensure targets are able to be measured and reported.

Health literacy and improving communication are suggested as a priority because they apply to all healthcare settings and sectors, disease groups and population groups. While low literacy is a particular concern for the illiterate, elderly, young people, low socio-economic groups, culturally and linguistically diverse and those with chronic and complex conditions, it is relevant to all population and socio-economic groups.

Submission #43

A Goal or a strategy within a Goal

- With regard to the **healthcare associated infection** priority area, standardise definitions for the collection of surveillance data nationally and standardise education for anti microbial stewardship.
- With regard to **infection control**, the initial priority would be to determine the next suite of hospital acquired infections to be published on the “My Hospital” web site. Measurable reduction targets should be established and the philosophy of “zero tolerance” of HAIs should be considered.
- With regard to **ACS**, the initial priorities for action should be the development and implementation of a national capability framework. The framework should include the components of: workforce, infrastructure, connections, evidence based guidelines, universal data elements, performance monitoring and auditing and systems-based research. Further, a high initial priority for ACS is to establish mechanisms for increasing access to and participation rates in secondary prevention programs.

- The initial priority should be to accurately monitor health outcomes in high risk areas using clinical registries. Acute cardiac care is the most pressing because of the high relationship between quality of care and downstream costs.
- Start by improving access to after hours care for patients.
- The **medications** priority area affects the highest proportion of the population. A very large percentage of the overall population takes one or more medication with many people taking multiple medications. It is essential that the population is well informed on why, how and when they need to take their medications and on the potential adverse effects and other issues relating to their medications.
- Commencing with **medication safety** will engage general practitioners in the Goals from the start. “Medication safety is one of the major areas of general practice care in which improvement is needed”. (51) Specifically, the focus should be on improved infrastructure and education on management of drugs of addiction and antibiotic stewardship.
- When partnering with **patients and consumers**, considering carers in the equation was suggested as an initial priority. First steps would involve a mapping exercise to identify the current status of carer identification across healthcare settings and the development of methods for inclusion and recognition of carers in all models of care.
- In relation to **stroke** management, the best place to start is with the development of an integrated IT system. Stroke care does not have such an integrated system in place to enable the timely reporting of reliable national data for many important aspects of routine clinical care.
- Establish a standard consumer experience measuring tool across jurisdictions as a means to monitor improvements.
- Ensure patient experience information (such as satisfaction or compliments/complaints) is more readily available across and within jurisdictions, with potential for peer comparisons.
- Engage health consumer advocate groups, including those working with cultural and linguistically diverse populations, to establish specific targets that can be supported at a national or state level.

A population group or healthcare setting

- The first priority should be to focus on issues that affect population groups identified as the most disadvantaged: Aboriginal and Torres Strait Islander people and people from cultural and linguistically diverse backgrounds, people with a mental health problem, the young, the aged and people with a disability. One mechanism suggested for addressing the issues of these groups first was the development of continuity of care models to ensure engagement and improvement across numerous specialties and sectors.
- Start in hospitals with Goal 1; simple, cheap and achievable actions.

16. Question 8: How could the different stakeholders within the healthcare system be engaged in working towards achievement of the goals?

Respondents identified the many stakeholders who will need to be engaged across the health system in order to ensure successful achievement of the Goals and any associated targets that may be established. These included:

- clinical networks
- peak representative bodies
- non-government organisations
- Medicare Locals
- Lead Clinicians Groups (national and local)
- Local Hospital Networks
- private health funds
- medical and nursing colleges
- Australian Health and Hospitals Association
- Australian College of Health Service Managers (ACHSM)
- healthcare providers (doctors, nurses and allied health professionals)
- health service managers.

16.1 Comments

The most common themes that appeared in the submissions were:

- the importance of and suggestions for engaging general practitioners
- the importance of clinical networks for engaging healthcare providers and achieving quality improvement, including traditional disease specific networks plus local and national LCGs and Medicare Locals
- engagement strategies must be multifaceted
- effective communication is essential for achieving engagement
- clinical leadership must be developed, recognised and utilised.

The following statements summarise the suggestions provided by respondents.

- State and territory clinical networks must be included in the ongoing consultation process. Clinical networks have in recent years been drivers for improving the quality of care for patients and developing local solutions. It will be advantageous to engage and consult with all relevant clinical networks across jurisdictions to:

- map current strategies and objectives
- understand the barriers and enablers to improving care, based on jurisdictional experiences
- obtain buy-in from jurisdictions to working towards a national goal.
- Stakeholders could be engaged by including performance indicators in accreditation standards, national minimum data sets and performance accountability reporting. The requirement to report on performance against the Goals will encourage participation and a desire to achieve the Goals and targets set. Reporting will also encourage health services to include the Goals in their strategic and operational plans.
- Specific working groups could be established in health services to achieve each of the Goals and to report regularly to the executive.
- The Medicare Locals could be the mechanism through which general practitioners will become engaged. A dedicated Medicare Local funded program in safety and quality care in primary care would support greater interest and uptake of safety and quality initiatives.
- General practitioners could be engaged by the Commission, working closely with the Royal Australian College of General Practitioners National Standing Committee on joint initiatives to improve general practice. This could involve activities such as providing input into and conducting research into infrastructure and systems of care in general practice to improve patient safety, supporting data aggregation to facilitate benchmarking of general practices, and conducting a consumer audit on patient safety in primary health care.
- What is needed is visible leadership to influence people across all levels of the health system, around the priorities.
- A key consideration in achieving effective engagement is how the Goals can best be resourced and integrated with existing systems and priority programs. The need for integrated and timely mechanisms for exchanging information within and between services is pertinent in this respect.
- One respondent (73) stated that the Commission already has strong connections with stakeholders, so it is important to harness these relationships. They made the suggestion that what the Commission needs to do to engage the right people is simply to ask them to participate – invite and engage them on a personal and professional level.
- Clinicians will become more engaged through research, consumers will become engaged through the development of clinical practice guidelines and standards, and policy makers will become more engaged in the implementation of research into policy and practice through partnering with researchers to address specific issues in their healthcare setting.

When intensive support is provided by the Medicare Local (GP Divisions in the past) effective clinical governance encompassing review, practice accreditation, adherence to clinical guidelines, patient management audits and registers and recall systems, among others, is most likely to occur

Submission #50

- Engagement will be achieved through the introduction of strong levers that will ensure the stakeholders “have skin in the game” (80). Such levers would include financial levers that reward the achievement of the outcomes and mandatory compliance mechanisms with clear consequence on their business. These are just as relevant to primary/community care and aged care as they are in the hospital sector. These levers are considered at present to be either non-existent or not strong enough to change behaviour.
- There are roles for people, organisations and structures in all parts of the health system, but the key will be clear communication between all the parts of the system to avoid duplication of effort. One key tool to be used to achieve this is e-health. Although success so far has been varied, there is sufficient success to support ongoing investment for this purpose.
- Linking the Goals with the Standards will provide great opportunities to engage with stakeholders, as health services will be focussed on improving safety and quality primarily through the Standards.
- Similarly, linking any targets, measures and reporting to existing reporting and measurement frameworks will increase engagement and reduce the burden of reporting for health services.
- Reporting and measurement linkage opportunities exist under the Standards, NHPA, National Health Agreement funding and service agreements and state and territory performance monitoring.
- People will be more engaged if they better understand the roles that each healthcare provider plays in the health system. This could be achieved through roundtable discussions or education programs.

Merely setting a Goal will not be sufficient to achieve behaviour change at scale without strong drivers and levers.

Submission #80

17. Question 9: What barriers exist in achieving the goals? How could these be overcome?

The responses provided to this question dealt equally with the barriers that exist in the health system to achieving the Goals, and with the mechanisms or strategies that can be used to break down these barriers to bring about success.

17.1 Summary of barriers

The barriers identified can be broadly categorised under six key headings:

1. funding and resources
2. data and measurement
3. culture and accountability
4. communication and understanding
5. geography
6. privacy and ethics.

As a country, we continue to reinvent the wheel, insisting on proof of a concept in each jurisdiction, for specific sectors or for specific patient populations.

Submission #27

The following points summarise the key points that were raised under each of these headings.

Funding and resources

- A major barrier relates to the way services are prioritised and funded. Many initiatives to improve care are funded through project monies and the service is withdrawn when ongoing funding cannot be found through the usual budget process. The example given was the current funding model for home medicines review which actively impedes timely service provision post-discharge from hospital.
- Lack of core funding. Recurrent funding ensures sustainability of efforts and allows clear co-ordination of national efforts. Most programs have time limited funding. Core funding for critical infrastructure is needed.
- The greatest barrier exists in the resourcing of the implementation of the Goals. This is particularly true where vulnerable populations are identified and the primary drivers of poor health outcomes are socio-economic. When this is matched with resource hungry high technology solutions there is a risk of increasing the gap in these vulnerable populations. So any target or goal-based program cannot always afford to focus on rewards for compliance but must also invest in an analysis of failure to comply and consider how to resource improved compliance in the areas of greatest compliance failure.
- A lack of funding to be able to target specific diseases.
- Lack of resources for strategies such as education and training programs

Data and measurement

- The lack of comprehensive data and data collection, and the inconsistencies between jurisdictions and different settings, makes it difficult to assess the healthcare environment and monitor progress and performance.
- Clunky reporting systems and insufficient resources to integrate with a variety of existing IT systems in different hospitals to make transfer of data more convenient for staff.
- Data custodians in various jurisdictions apply different rules and requirements to accessing and using their data to link to external data sources. This can delay important analysis work and the timely feedback of information to healthcare providers.
- Lack of a universally defined data set.
- The inability to measure improvement in relation to the Goals.

Culture and accountability

- Some respondents suggested that there is a lack of accountability required of healthcare providers for engagement in initiatives such as this.
- Others suggested that a barrier exists in the competing priorities that healthcare providers are dealing with and the accountability that comes with these priorities. There is a great deal going on right now. Can healthcare providers be accountable for another set of priorities? The risk of doubling up on current expectations or increasing work demands with another different or new focus is a barrier to success.
- The lack of engagement of end users.
- Apathy, most especially amongst healthcare providers. This can be related to arrogance or autonomy in one's own practice.
- A lack of engagement of the community for various reasons, including cultural and socioeconomic barriers.
- Resistance to change, inadequate resources, understaffing, lack of clear protocols for procedures and clear standardisation, lack of communication, lack of co-operation between healthcare providers, lack of ongoing staff education.
- Poor cross-fertilisation and generalisation of ideas and strategies across sectors and between healthcare providers.
- Cultural factors are a key barrier to achievement of Goal 1 in relation to infection control. Safety and quality is reliant on individuals taking personal responsibility for something as simple as washing their hands.

Communication and understanding

- Ignorance of the Goals by consumers will be a barrier if the Goals are not adequately publicised. The public and healthcare providers need to understand the rationale and the evidence base for the Goals in order to participate fully.

- At present there is no defined pathway or method for involving all the groups that are essential to the achievement of the Goals. Connecting primary care and acute services presents the greatest barrier.
- Lack of formal communication and reporting of national efforts. Facilitation of communication between appropriate organisations, government departments and sectors, individuals and groups that are focussed on improving data monitoring and quality of care.
- Low literacy and poor health literacy can make it difficult for patients to understand safety risks and follow treatment plans.
- Lack of consumer empowerment and influence.

Geography

- The health sector needs to ensure that the same quality of health services is provided regardless of the setting. To achieve equitable outcomes across settings, consideration needs to be given to infrastructure needs in rural and remote settings. Additional resources may need to be allocated to achieve this.
- Lack of access to services in rural and remote areas.
- Lack of expertise in rural and remote areas.

Privacy and ethics

- Ethical clearance requirements for collection of patient healthcare and follow-up data are complex and vary across the country.
- Strict privacy and confidentiality provisions in all jurisdictions make the release of information challenging.

17.2 Summary of solutions

The solutions identified can be broadly categorised under six key headings:

1. education and resources development
2. culture change
3. incentives
4. performance monitoring and reporting
5. funding and funding models
6. governance and accountability

The following points summarise the key points that were raised under each of these headings.

Education and resources development

- The development of national education programs associated with each of the Goals will help.

- Providing user-friendly, easily accessible resources for achieving the Goals is crucial.
- Australia needs a system where evidence-based strategies, no matter how they are identified, are supported and resourced at a national level across all sectors and across the continuum of care.
- With respect to medication safety, a successful barrier breaker will be the 100% adoption of electronic transactions in respect to medication prescription and dispensing, to match medications with existing treatments to ensure adverse interactions are avoided.
- Specific well structured strategies to improve health literacy and communication to embed principles and practices into the everyday life of health care workers.
- A greater focus on research translation is required to enable outcomes to be translated into policy and practice.

Culture and change

- A culture change program will be helpful in breaking down the barriers.
- Identification and development of clinical leaders to champion change may be a long term strategy for the management of change. The science of practice change is under-appreciated. Clear, consistent and simple messages are essential to facilitate uptake and achievement of the Goals and can be communicated and encouraged by strong leadership.
- Sufficient time needs to be given to bedding down current initiatives before introducing yet another change or initiative. People take time to change and seldom is sufficient time allowed for this.
- If organisational culture encompassed a belief in striving for zero healthcare acquired infections, many of the barriers to success would be substantially removed.

Incentives

- Using incentives to ensure agreed targets are a focus for all.
- Providing financial rewards will be important.
- A strategy including reward funding for successful implementation, combined with regular educational opportunities for healthcare providers on site could be considered.

Performance monitoring and reporting

- Although the mechanisms for monitoring performance and reporting are not clear, there will be great benefit in reporting on performance and aligning the goals within the appropriate context for a variety of stakeholders, including consumers, healthcare providers, health service managers and organisations.
- There should be clear measurement of performance and comparison of performance and publishing quality and safety ratings.

- It is important that the jurisdictions and health services that can enforce adoption do not leave the initiatives lying around gathering dust but actually take on board the key points for implementation.
- Measurable targets and goals are needed and these must be evaluated.

Funding and funding models

- An opportunity exists for the Goals to assist Medicare Australia, the Independent Hospital Pricing Authority and health service managers to identify services that have a proven evidence based impact and to develop an appropriate funding mechanism for these services. It is hoped that the national efficient price will include services that should be delivered, rather than just services that are currently delivered. Managers at the LHN and the hospital level will then be responsible for ensuring that services that are required (and funded) are available and delivered.
- Establish recurrent funding streams for national clinical quality disease registries and associated quality improvement initiatives.
- Provide funding and resources for the implementation of the Goals initiatives.

Governance, leadership and accountability

- The aim in establishing the Goals should be for all within the health system to work together to achieve the same set of goals. This should be complemented by a governance framework that:
 - includes different levels and settings of care
 - achieves a balance between imposing national targets and acknowledging local capabilities to meet these targets
 - acknowledges that services should offer the same level of safety and quality, regardless of location
 - encourages and rewards participation in quality improvement activities.
- Ensuring that correct information and evidence reaches healthcare providers.
- Compulsory participation – mandating certain activities and routine reporting.
- Strong leadership and the impetus for change need to exist if these Goals are to be achieved.

Systems

- Support for system redesign and culture change must be provided to health services and this must take place simultaneously with the introduction of the Goals, at the local level, to ensure that innovative approaches, practices and policies are adopted in a timely manner by healthcare providers and organisations. We cannot expect different results from the same systems, procedures and attitudes.
- Simplifying how data are collected in the health sector and avoiding manual collection.

- Investing in research and development to ensure optimal systems of data capture and potential for data linkage.
- Developing national agreements for data sharing and ethical approval for usage of data.
- Developing systems for adverse event reporting in general practice. The implementation of electronic health records could assist in addressing this.
- Expressly supporting patient and consumer influence over healthcare safety and quality it will be important to:
 - ensure robust systems are in place at the national level to involve patient and consumer groups in safety and quality in health care
 - provide mechanisms to develop patient and consumer expertise in safety and quality that empowers them to support the planning and implementation of relevant programs and initiatives
 - ensure patients have access to available information on the redress available to them if they or one of their family members is harmed by health care.



18. Summary

Ninety submissions were received by the Australian Commission on Safety and Quality in Health Care to the consultation paper on Australian Safety and Quality Goals for Health Care, and six workshops were conducted to discuss the Goals.

In summary, there was overall support for both the development and implementation of the Goals but at the same time, confusion and concern about the connections these Goals have to the Framework and Standards. Some responses considered that the effort and focus required by health services to implement the Standards over the coming years may distract health services from applying effort to the Goals. The Goals, however, do provide a significant opportunity for all parts of the health sector to work together to achieve better outcomes for consumers. Responses considered that it was important that specific attention be paid to marginalised population groups and to tailoring of the Goals and targets for rural and remote health services.

The information from the consultation process has been used to finalise the Goals, develop action guides for the priority areas and describe how the Goals can be used to improve safety and quality within the Australian health system. Regarding the issues described as common themes in Section 8, the following points are made:

- The relationship between the Goals, Standards and Framework has been described more fully in Section 5. The Framework describes the overarching vision for safety and quality in Australia. The Goals set out specific priority areas where there is national agreement that safety and quality efforts should be directed in a coordinated way. The Standards are one of the key mechanisms for making systematic improvements in safety and quality in the areas specified in the Goals.
- It is not intended that new systems or processes would be established as part of the Goals that would add to the work of health services in Australia. Rather, it is envisaged that the Goals will be integrated into existing systems and structures so that they influence the way in which care is delivered at a systems level. This means that collaboration between and within national and local bodies and consumer groups is essential for improvement to occur.
- The priority areas described in the Goals are not new: they reflect areas that have a significant impact on the health system, and where there are known safety and quality problems that need to be addressed. This is deliberate: the timeframe for making progress in these areas is five years, and it is hoped that with the Goals there will be an increased focus and impetus for improvement with coordination at a national level.
- Further work is needed to fulfil the potential of the Goals, and build on the opportunities and support that were seen for them in the submissions and workshops. This will include exploration of the way in which progress towards the Goals will be assessed, how the actions recommended for the Goals can be put into practice, and how the Goals will integrate with national and local health reform processes.

Acknowledgements

The Commission wishes to acknowledge the following staff members for their work in developing the Australian Safety and Quality Goals for Health Care: Ms Naomi Poole, Ms Leslie Trainor, Ms Justine Marshall, and Dr Nicola Dunbar.

The Commission would like to thank the 125 participants in the six consultation workshops that were held in February and March 2012, and the 90 organisations that provided written submissions about the Goals. The information gained through these processes was very useful in conceptualising how the Goals fitted with other current health reform and safety and quality initiatives.

The Commission would also like to thank the members of the various advisory panels and groups who provided expert advice about the development of the Goals in general, as well as specific priority areas and actions. These individuals provided detailed and well-considered advice in short time frames. This advice was particularly useful for the development of the action guides for each priority area. The members of these groups are listed in the tables in this section.

The Commission would also like to acknowledge the work of Ms Maureen Robinson, Quorus Consulting, who prepared the first draft of Part C.

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Dr Tony Burrell	Director, Patient Safety	NSW Clinical Excellence Commission
Prof Wendy Chaboyer	Adjunct Professor	Griffith University
Ms Darlene Cox	CEO	Health Care Consumers ACT
Dr Cathy Crock	CEO	Australian Institute of Patient and Family Centred Care
Prof Paul Glasziou	Professor of Evidence-Based Medicine	Bond University
A/Prof Michael Greco	Director	Client-Focused Evaluations Program
Prof Russell Gruen	Director, National Trauma Research Institute	Monash University
Mr Peter Hibbert	Program Manager	Australian Institute of Health Innovation, UNSW

Prof Rick Iedema	Professor of Communication	University of Technology
Ms Michele Kosky	Executive Officer	Health Consumers Council WA
Dr Karen Luxford	Director, Patient Based Care	NSW Clinical Excellence Commission
Dr Meredith Makeham	Senior Lecturer in General Practice, School of Public Health and Community Medicine	University of NSW
Ms Sue McKean	Director, Risk and Quality	UnitingCare Health
Ms Jenny McMillan	Senior Program Officer	Australian Institute for Primary Care & Ageing
Ms Stephanie Miller	Executive Officer	Health Consumers Alliance of SA
Dr Robert Mitchell	Deputy Chair, AMA Council of Doctors in Training	AMA Junior Doctor's Forum
Ms Stephanie Newell	Consumer advocate	Patients for Patient Safety
Dr Charles Pain	Director, Health Systems Improvement	NSW Clinical Excellence Commission
Dr Annette Pantle	Group General Manager, Clinical Governance	St Vincent's Health Australia
Dr Grant Phelps	Medical Director, Safety and Quality	Department of Health and Human Services, Tasmania
Dr Donella Piper	Lecturer	University of New England
Ms Christy Pirone	Principal Consultant, Safety and Quality	SA Health
Ms Jill Porteous	Director, Clinical Governance for Country Health Services	WA Country Health Service
Dr Tim Schultz	Technical Director	Australian Patient Safety Foundation
Ms Jo Travalglia	Acting Director, Masters Health Management Program	University of NSW
Prof Marilyn Walton	Professor of Medical Education (Patient Safety)	University of Sydney
Ms Maureen Willson	Director	Maureen Willson Quality & Risk Consulting P/L

Partnering with Patients and Consumer Technical Advisory Panel		
Name	Position	Organisation
Ms Jacqui Bear	Manager, Patient Safety and Quality Unit	ACT Health
Ms Katja Beitat	Communications and Stakeholder Relations Manager	NSW Health Care Complaints Commission
Mr Jason Boyd	Senior Researchers	NSW Bureau of Health Information
Ms Tanya Boston	Director, Regulatory Policy and Governance Division	DoHA
Ms Alison Brown	Clinical Governance Consultant	Victorian Healthcare Association
Dr Catherine Crock	CEO	Australian Institute for Patient and Family Centred Care
Ms Tere Dawson	Senior Project Officer	Heath Issues Centre
Ms Anne Donaldson	Director	WA Office of Health Review
Ms Mary Draper	CEO	Health Issues Centre
Mr Marcus Dripps	Director	Barwon Health
A/Prof Michael Greco	Director	Client-Focused Evaluations Program
A/Prof Cheryl Herbert	CEO	Health Care Complaints Commission QLD
Dr Sophie Hill	Head	Centre for Health Communication and Participation, La Trobe
Ms Lidia Horvat	Policy and Strategy, Quality, Safety and Patient Experience Branch	Department of Health Victoria
Prof Rick Iedema	Professor of Communication	Centre for Health Communication, UTS
Ms Cathy Jones	National Manager, Quality and Compliance	Healthscope
Ms Michele Kosky	Executive Director	Health Consumers' Council WA
Ms Rae Lamb	Aged Care Commissioner	DoHA
Ms Sarah Lamb	Policy Officer, Patient Safety Directorate	WA Health
Dr Karen Luxford	Director, Patient Based Care	NSW Clinical Excellence

		Commission
Ms Jenny Macmillan	Senior Project Manager	Centre for Health Systems Development, La Trobe
Ms Michele McKinnon	Director, Safety and Quality	SA Health
Ms Stephanie Miller	Executive Director	Health Consumers' Alliance of SA
Ms Stephanie Newell	Consumer advocate	Patients for Patient Safety
Dr Donella Piper	Lecturer	University of New England
Ms Leena Sudano	Health and Community Services Complaints Commissioner	SA Health and Community Services Complaints Commission
Ms Sue Taylor	Coordinator, Clinical Quality and Projects	Epworth
Ms Kylie Wake	Executive Officer	National Mental Health Consumer and Carer Forum
Ms Christine Walker	CEO	Chronic Illness Alliance
Acute Coronary Syndrome Expert Advisory Panel		
Dr David Brieger	Dr Jacquie Garton - Smith	Dr Tom Briffa
Prof John French	Dr Christine Connors	Dr Robert Grenfell
Ms Karen Lintern	Dr Paul Garrahy	Dr Ian Dey
Prof Richard Harper	Dr Ian Scott	Dr Yusuf Nagree
Dr Tim Baker	Dr Stephen Rashford	Dr Alex Brown
Ms Hella Parker	Dr Alex Brown	
Dr Derek Chew	Dr Andrea Driscoll	
Dr Phil Tideman	A/Prof Robyn Clark	
Mr Steven Bloomer	Prof Patricia Davidson	
TIA and Stroke Expert Advisory Panel		
Ms Brenda Booth	Mr Adrian O'Malley	
A/Prof Dr. Helen Dewey	Dr Chris Levi	Prof Sandy Middleton
Ms Janelle Devereux	Dr Annie McCluskie	A/Prof Dom Cadilhac
Dr Rohan Grimley	Mr Mark Longworth	A/Prof Julie Bernhardt
Dr Chris May	Dr Helen Castley	Prof Geoffrey Donnan
Dr Jim Jannes	Dr Alasdair MacDonald	Kelvin Hill
Prof Hugh Grantham	Dr Erin Godecke	Chris Price
Ms Sandra Lever	Erin Lalor	Pip Galland

In addition to these panels that were established specifically for the development of the Goals, the following existing Commission expert advisory groups reviewed and provided feedback on the Goals:

- Antimicrobial Stewardship Advisory Committee
- Health Services Medication Expert Advisory Committee
- Healthcare Associated Infection Advisory Committee
- Medication Continuity Expert Advisory Group
- Medication Reference Group
- National Hand Hygiene Advisory Committee
- Recognising and Responding to Clinical Deterioration Advisory Committee.

Appendices



Appendix 1: Australian Safety and Quality Framework for Health Care

Safe, high-quality health is always:	What it means for me as a consumer or patient:	Areas for action by people in the health system:
<p>1 CONSUMER CENTRED</p> <p>This means:</p> <p>Providing care that is easy for patients to get when they need it.</p> <p>Making sure that healthcare staff respect and respond to patient choices, needs and values.</p> <p>Forming partnerships between patients, their family, carers and healthcare providers.</p>	<p>I can get high-quality care when I need it.</p> <p>I have information I can understand. It helps me to make decisions about my health care.</p> <p>I can help to make my care safe.</p> <p>My health care is well organised. The doctors, nurses and managers all work together. I feel safe and well cared for.</p> <p>I know my healthcare rights.</p> <p>If something goes wrong, my healthcare team look after me. I receive an apology and a full explanation of what happened.</p>	<p>1.1 Develop methods and models to help patients get health services when they need them.</p> <p>1.2 Increase health literacy.</p> <p>1.3 Partner with consumers, patients, families and carers to share decision making about their care.</p> <p>1.4 Provide care that respects and is sensitive to different cultures.</p> <p>1.5 Involve consumers, patients and carers in planning for safety and quality.</p> <p>1.6 Improve continuity of care.</p> <p>1.7 Minimise risks at handover.</p> <p>1.8 Promote healthcare rights.</p> <p>1.9 If something goes wrong, openly inform and support the patient.</p>
<p>2 DRIVEN BY INFORMATION</p> <p>This means:</p> <p>Using up-to-date knowledge and evidence to guide decisions about care.</p> <p>Safety and quality data are collected, analysed and fed back for improvement.</p> <p>Taking action to improve patients' experiences.</p>	<p>My care is based on the best knowledge and evidence.</p> <p>The outcome of my treatment and my experiences are used to help improve care.</p>	<p>2.1 Use agreed guidelines to reduce inappropriate variation in the delivery of care.</p> <p>2.2 Collect and analyse safety and quality data to improve care.</p> <p>2.3 Learn from patients' and carers' experiences.</p> <p>2.4 Encourage and apply research that will improve safety and quality.</p>
<p>3 ORGANISED FOR SAFETY</p> <p>This means making safety a central feature of how healthcare facilities are run, how staff work and how funding is organised.</p>	<p>I know that the healthcare team, managers and governments all take my safety seriously.</p> <p>The health system is designed to provide safe, high-quality care for me, my family and my carers.</p> <p>When something goes wrong, actions are taken to prevent it happening to someone else.</p>	<p>3.1 Health staff take action for safety.</p> <p>3.2 Health professionals take action for safety.</p> <p>3.3 Managers and clinical leaders take action for safety.</p> <p>3.4 Governments take action for safety.</p> <p>3.5 Ensure funding models are designed to support safety and quality.</p> <p>3.6 Support, implement and evaluate e-health.</p> <p>3.7 Design and operate facilities, equipment and work processes for safety.</p> <p>3.8 Take action to prevent or minimise harm from healthcare errors.</p>

Appendix 2: Written submissions received

The following is a list of organisations and individuals who provided a written submission to the Commission in response to the consultation paper.

1. Individual
2. Individual
3. Individual
4. Individual
5. Individual
6. Individual
7. Individual
8. Individual
9. Individual
10. Individual
11. Individual
12. Individual
13. Individual
14. Individual
15. Individual
16. Individual
17. Department of Health and Human Services Safety and Quality Unit, Tasmania
18. Individual
19. Individual
20. Individual
21. The Royal Australian and New Zealand College of Psychiatrists
22. Individual
23. Health and Community Services Complaints Commissioner, South Australia
24. Mater Health Services Brisbane
25. Individual
26. Individual
27. Society of Hospital Pharmacists of Australia
28. National Lead Clinicians Group
29. Individual
30. Australian Stroke Clinical Registry
31. WentWest Limited
32. Individual

33. Sansom Institute, UniSA
34. West Moreton-Oxley Medicare Local
35. Western Australia Department of Health
36. Australian Society of Anaesthetists
37. Australian Dental Association
38. Health Quality and Complaints Commission, Queensland
39. Consumers Health Forum of Australia
40. Diagnostic Pathways Steering Committee
41. St John of God Health Care
42. Heart Foundation
43. Tasmanian Department of Health and Human Services – Population Health
44. NSW Therapeutic Advisory Group
45. Individual
46. Individual
47. Queensland Centre for Mothers & Babies, University of Queensland
48. The Royal Australian and New Zealand College of Ophthalmologists
49. Royal College of Pathologists of Australasia
50. General Practice NSW
51. The Royal Australian College of General Practitioners
52. Welch Allyn Australia
53. National Trauma Research Institute
54. Australian & New Zealand College of Anaesthetists
55. Individual
56. Pharmaceutical Society of Australia Ltd
57. Dietician Association of Australia
58. Becton Dickinson Pty Ltd
59. Department of Cardiac Surgery, The Royal Children's Hospital, Melbourne
60. Australian Society of Plastic Surgeons
61. Optometrists Association Australia
62. Carers Australia
63. National Medicines Policy Committee
64. Australian Private Hospitals Association
65. Australian College of Mental Health Nurses
66. Health Consumers' Council WA
67. Australian College of Midwives

68. NSW Clinical Excellence Commission
69. Asthma Australia
70. NEHTA – National E-Health Transition Authority
71. Gold Coast Medicare Local
72. ACT Health
73. National Health and Medical Research Council
74. Royal College of Nursing, Australia (RCNA)
75. Australian Stroke Coalition
76. National Stroke Foundation
77. CareFusion
78. Centre of Research Excellence in Patient Safety, Monash University
79. Individual
80. Queensland Health
81. The Royal Australasian College of Physicians
82. Australasian College of Podiatric Surgeons
83. National Prescribing Service
84. Baxter Healthcare
85. SA Health
86. Department of Health, Victoria
87. Individual
88. General Practice Network South
89. Health Consumers Alliance of South Australia
90. Agency for Clinical Innovation, NSW

Appendix 3: Information about key strategies provided in submissions

The following key strategies, tools, policies and documents were identified in the submissions as resources that are available for consideration in the development and implementation of the Australian Safety and Quality Goals for Health Care. While some of these documents have been used to inform the development of the specific action guides for each Goal and priority area, the resources in this list have not been systematically reviewed.

- **Resources mentioned in a number of submissions:**
 - National Safety and Quality Health Service Standards
 - National Inpatient Medication Chart and associated resources
 - National reporting on sentinel events in public and private hospitals
 - Antimicrobial Stewardship in Australian Hospitals, ACSQHC January 2011
- **Submission 30: Australian Stroke Clinical Registry**
 - Australian Stroke Clinical Registry established 2009
 - Clinical guidelines for stroke 2010
 - Primary Prevention Guidelines (currently being established) via the National Vascular Disease Prevention Alliance
 - Australian Stroke Coalition
 - National Stroke Foundation Strokeline Program
 - Stroke 123 Project to start 2012
- **Submission 34: Medicare Local West Moreton Oxley**
 - Client Focussed Evaluation Program 2006
 - Advanced Development Program for Clinicians
 - Co-creating Health Support Program
 - Co-creating Health Programme UK based
- **Submission 38: Health Quality and Complaints Commission**
 - Queensland's regulatory framework for the conduct of root cause analysis
 - HQCC's complaint management process
 - Australian Charter of Healthcare Rights
- **Submission 40: Diagnostic Imaging Pathways Steering Committee**
 - Diagnostic Imaging Pathways (DIP)
- **Submission 42: The Heart Foundation**
 - Proposed set of clinical performance indicators for a national Australian ACS Registry
 - Heart Foundation Guidelines for the Management of Acute Coronary Syndrome 2011

- ACS registry initiatives e.g. GRACE, ACACIA, CONCORDANCE, ACPR to collect and monitor clinical data
- National “Snapshot ACS” initiative in May 2012
- Secondary prevention programs e.g. cardiac rehabilitation
- Discharge Management of ACS (DMACS) Project 2008-2009
- Heart Foundation Quality Use of Medicines Strategy 2011
- Guidelines for the Diagnosis and Management of Familial Hypercholesterolaemia 2010
- **Submission 43: Tasmanian Dept of Health and Human Services – Population Health**
 - Communication and Health Literacy Plan (currently implementing)
 - Self Management Framework
 - Working in Health Promoting Ways Framework
 - Consumer and Community Engagement Framework
- **Submission 44: NSW TAG**
 - Safety alerts
 - Medication Safety Self Assessment Program
 - State based resources e.g. Clinical Excellence Commission, NSW TAG, CATAG, NPS
- **Submission 45: WA Cardiovascular Health Network Clinical Leads/Development Officer**
 - ACS model of care
 - Secondary prevention/cardiac rehabilitation programs
- **Submission 47: Queensland Centre for Mothers and Babies**
 - Having a Baby web site www.havingababy.org.au has many tools including “Sharing Your Story”, Birthplace, Decision Aids, Patient Information Sheets that are in line with the Queensland Maternity and Neonatal Clinical Guidelines Program
 - Parent information sheets
- **Submission 49: The Royal College of Pathologists of Australasia**
 - Quality assurance program
 - Key Incident Monitoring and Measurement Systems 2007
- **Submission 51: The Royal Australian College of General Practitioners**
 - Standards for General Practice (4th Ed)
 - RACGP Quality Framework
 - RACGP Quality Indicator Strategy
 - RACGP Curriculum for Australian General Practice 2011

- **Submission 52: Welch Allyn**
 - Disposable Blood Pressure Cuff
- **Submission 53: National Critical Care and Trauma Response Centre**
 - Australian Trauma Quality Improvement Program
- **Submission 54: Australian and New Zealand College of Anaesthetists**
 - PS 51 Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia
 - PS28 Guidelines on Infection Control in Anaesthesia
 - ANZCA community representation policy
 - Curriculum revision 2013
- **Submission 56: Pharmaceutical Society of Australia**
 - Pharmacy Recording of Medication Incidents and Services electronic documentation system (PROMISe)
- **Submission 62: Carers Australia**
 - Carer Recognition Act 2010
 - The Australian Government National Carer Strategy
 - The Australian Government Social Inclusion Strategy
- **Submission 63: National Medicines Policy Committee**
 - National Strategy for Quality Use of Medicines
- **Submission 66: Health Consumers' Council WA**
 - The Adverse Medicines Event Line
- **Submission 67: Australian College of Midwives**
 - National Maternity Services Plan 2011
 - ACM National Guidelines for Consultation and Referral 2nd Edition 2008
 - NHMRC Guidelines on Collaborative Maternity Care
 - Safety and Quality Framework for Privately Practicing Midwives Attending Homebirths
 - Midwifery Peer Review
 - Community based models of care in a number of jurisdictions
- **Submission 70: National eHealth Transition Authority**
 - The e-health record and specifically the personally controlled electronic health record (PCEHR)
- **Submission 73: National Health and Medical Research Council**
 - Consumer and Community Engagement Framework (developing)
 - NHMRC projects/health advice/guidelines/resources e.g. Australian Infection Control Guidelines, Joint National Plan on Antimicrobial Resistance, Guidelines on Diabetes, cardiovascular risk and acute stroke

- NHMRC products e.g. NHMRC stroke bundle for emergency clinicians, NHMRC pain manual for emergency care
- National Guideline Developer Network
- National Aboriginal and Torres Strait Islander Health Plan (being developed)
- Resources for GPs on complimentary and alternate medicines (in development), genetic testing, genetics and family medicine
- The NHMRC and Consumer Health Forum's Joint Statement on participation of consumers and the community in health and medical research (currently under revision)
- McKinsey Pacific Rim Inc Review Understanding eHealth Readiness Feb 2011
- The NSW Patient Safety and Clinical Quality Program
- CARPA Manuals
- Queensland Primary Clinical Care Manual
- Medicare Benefits Scheme and Pharmaceutical Benefits Scheme
- Australian General Practice Accreditation Limited
- The Australian Primary Care Collaboratives Program
- **Submission 75: Australian Stroke Coalition**
 - Quality in Acute Stroke Care (QASC)
 - Statewide Stroke Clinical Networks
 - Many professional bodies and jurisdictional agencies writing standards and guidelines and providing training to ensure appropriateness of care
 - Australian Stroke Guidelines Program
 - Australian Stroke Services Framework 2011
 - National Stroke Audit Program 2007
 - The Australasian Rehabilitation Outcomes Centre Initiative 2002
 - SA Stroke Services Plan 2009-2016
 - Stroke care strategy for Victoria 2007
 - (and others mentioned in Submission 30)
- **Submission 76: Stroke Foundation**
 - Know your Numbers Program 2007
 - Guidelines for the Management of Absolute Cardiovascular Disease Risk 2012
 - Stroke Connect Program
 - The National Prescribing Service better use of medicines information and training services
 - Australian Council of Health Care Standards clinical improvement program

- National Stroke Education Framework
- (and others mentioned in Submission 30 and Submission 75)
- **Submission 77: Carefusion**
 - Data Error Reduction Software DERS
- **Submission 83: National Prescribing Service**
 - NIMC Online Training Course 2007
 - Medicines in Health Ageing Education Program 2013
 - Support standardised labelling of medication led by TGA
 - Support e-health initiatives e.g. PCEHR
 - Antibiotic Resistance Campaign
 - NPS Training Program for GPs to access local antimicrobial sensitivity data (future program)
 - Sneeze Safe Campaign in schools
 - Type 2 Diabetes: priorities and targets Program Aug 2012
 - Quality Use of Anti-platelets and Anticoagulants in Stroke Prevention 2009-2010
 - National drug use evaluation program to improve discharge management of ACS
 - Education program on the best use of anti-thrombotics 2013
 - Therapeutic program work supports partnering between consumers and health practitioners
 - Health literacy strategies
 - NPS provides health information via web based tools and channels
- **Submission 84: Baxter**
 - Baxter identified many very helpful tools and initiatives that support the achievement of Goal 1
- **Submission 86: Minister for Health Victoria**
 - VSCN Regional Transfers Project 2012
 - Specialist Advice Lines (under discussion)
 - Telemedicine/stroke imaging expert advice and support
 - Victorian Health Services Act 1988
 - Drugs Poisons and Controlled Substances Act 1981
 - Health Services Regulations 2002
 - Public Health and Wellbeing Act 2008
 - Victorian Health Priorities Framework 2012 -2022
 - Victorian Clinical Governance Policy Framework 2008

- Initiatives within the QUM framework e.g. Tallman Lettering, High risk medicines Alerts, Falls Prevention and Antimicrobial Stewardship
- National Safety Priorities in mental health – a national plan for reducing harm 2005
- Australian Guidelines for the Prevention and Control of Infection in Healthcare 2010
- HAI surveillance VICNISS
- Hand Hygiene Australia steering Committee
- Integrated Chronic Disease Management Guidelines
- Diabetes Self Management – Guidelines for providing services to people newly diagnosed with Type 2 Diabetes
- Hospital Admission Risk Program
- Improving the physical health of people with mental illness – no mental health without physical health 2011
- Victorian Government Cardiac Clinical Network
- Victorian Government Cardiac Outcomes Registry
- Strengthening Cardiac Rehabilitation and Secondary Prevention for Aboriginal and Torres Strait Islander Peoples Guidelines
- Stroke Care Strategy for Victoria 2007
- Doing it with us not for us: Strategic Direction 2010-2013
- Improving Care for Aboriginal Patients Program
- Cultural Responsiveness Framework
- Victorian Patient Satisfaction Monitor
- Caring Together: an action plan for carer involvement in public mental health services 2006
- Strengthening consumer participation in Victorian Mental Health Services: Action Plan 2009
- Chief Psychiatrist Guidelines: Working together with families and carers 2005
- National Standards for Mental Health Services 2010: Consumer and Carer Participation Standards Framework for Recovery Oriented Practice 2011

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