RACGP Submission to the Australian Commission on Safety and Quality in Health Care

Response to the Commission’s Consultation Paper on Australian Safety and Quality Goals for Health Care.

8 February 2012
1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Australian Commission on Safety and Quality in Health Care (ACSQHC) for the opportunity to respond to the Commission’s Consultation Paper on Australian Safety and Quality Goals for Health Care.

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

Since foundation in 1958, the RACGP has demonstrated its commitment to improving the quality and safety of patient care. While the RACGP training programs are principally concerned with the quality of individual general practitioner’s clinical knowledge and skills, the Standards for General Practice, RACGP Practice Management Toolkit and related resources draw attention to the systemic factors which determine the quality and safety of patient care. This includes setting benchmarks for clinical facilities, equipment, business systems and processes, and the performance of general practice teams - not just general practitioners.

This submission is made in response to the Consultation Paper prepared by the ACSQHC, titled Australian Safety and Quality Goals for Health Care – 9 November 2011.

2. Stakeholder details

<table>
<thead>
<tr>
<th>Name of Organisation</th>
<th>The Royal Australian College of General Practitioners (RACGP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postal Address</td>
<td>1 Palmerston Crescent, South Melbourne, 3205 Melbourne Victoria</td>
</tr>
<tr>
<td>Legal Status</td>
<td>Not for profit</td>
</tr>
<tr>
<td>ABN</td>
<td>34 000 223 807</td>
</tr>
<tr>
<td>Key Contact Person and Contact Details</td>
<td>Helen Bolger-Harris Manager Clinical Improvement Unit 03 8699 0432 <a href="mailto:helen.bolger-harris@racgp.org.au">helen.bolger-harris@racgp.org.au</a></td>
</tr>
</tbody>
</table>
3. **Overview of response**

The RACGP provides the following responses to the questions of the ACSQHC as listed below:

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 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?**

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

As stated in the RACGP submission to the ACQSHC in October 2010 in its response to the discussion paper on Patient Safety in Primary Health Care, the work that the College is involved in regarding patient safety, is grounded on the notion that ‘clinical risk management systems’ for general practices are driven by evidence based interventions, and a strong patient safety culture. Interventions include:

- clinical governance arrangements
- business infrastructure, systems and processes
- patient information management systems
- staff training
- funding incentives.
The RACGP has well developed frameworks such as the RACGP Quality Framework (see appendix 1) to support patient safety and quality within General Practice, which are enacted through the RACGP standards for General Practice, College guidelines, research, and education programmes. The quality agenda is further being progressed with the current development of a RACGP Quality Indicator Strategy designed to drive safety and quality aspects of clinical care provided by GPs and general practices.

Thus national safety and quality Goals provide a framework which supports the various quality and safety initiatives the College is currently involved in and ensures our work is in line with relevant national policy.

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

Whilst the RACGP supports the topics included as the Goals and priority areas, especially medication safety, other topics the College is currently considering include issues with delivery of cancer services. The RACGP suggests this should also be addressed nationally within the Goals in addition to a focus on preventative health care.

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

In terms of the Goals themselves, the College believes they are reasonable. Improving safety; ensuring that care is appropriate; and improving partnerships are all worthy but broad aims. In regards to medications and infections, the focus appears to be on what is easily measurable. Diabetes and stroke/coronary events are high prevalence and high in terms of cost and burden of disease, so a focus on these conditions is supported by the College.

With regards specifically to the medication safety priority area of Goal 1: Safety of Care, the College suggests there should be a focus on opioids, narcotics cases and antibiotics governance. The Goals should also specifically address the need to revert to chemical name prescribing rather than brand name, in order to address the difficulties patients are experiencing with frequent generic brand name changes.

Whilst a focus on type 2 diabetes as a priority in Goal 2: Appropriateness of care, is to be supported as stated above, an important causal factor in the development of
diabetes and its course, is major changes in the food supply, which this goal does not address.

With Goal 3: Partnering with patients and consumers, the College supports an emphasis on supporting patient self-management, and promoting the use of feedback systems. However, there should be more detail provided on how outcomes of this Goal will be measured.

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

The RACGP strongly advocates for a quality improvement framework to underpin attainment of these proposed Goals and priority areas.

Potential targets relevant to general practice in regards to medication safety, include ensuring discharge medication summaries exist and the provision of education regarding patient self-monitoring. However, these may be difficult to implement and measure. Underpinning these targets is the requirement for reporting of adverse events (medication or otherwise) to be made easier for GPs.

In terms of health care associated infections, the severe infections mentioned (CAUTI and CLABSI) are hospital infections; hence the processes to reduce them (checklists, bundles of care, etc.) are not relevant to general practice. The other strategies mentioned (antibiotic stewardship, collection of data) are also hospital based strategies. The most relevant aspect to general practice is antibiotic prescribing habits in the community. Research should be undertaken to investigate the degree to which GP antibiotic prescribing habits have an impact on rates on antibiotic resistance and nosocomial infections. If a high correlation is ascertained, then strategies such as education programs can be designed to address this.

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

In general, the Goals apply to all health care settings and population groups, in that in each setting, they will be made relevant to suit the particular context in terms of population groups or settings and will provide a basis for developing organisation-specific goals.
3.6 **What systems, policies, strategies, programs, processes and initiatives already exist that could contribute to achievement of the Goals?**

As indicated in response to Question 1, there are currently a range of initiatives/resources the RACGP has established to support achievement of the Goals, which include the Standards for General Practice (4th ed), the RACGP Quality Framework and the RACGP Quality Indicator Strategy; and various specific education/quality improvement tools and resources to guide improvements in quality and safety within general practice and its interface with the broader primary health care environment.

The RACGP has also recently updated its *RACGP Curriculum for Australian General Practice (2011)*, which emphasises patient safety as a core competency of GPs, and the importance of clinical governance and clinical leadership, as central to reform in the areas of quality and safety with general practice.

The RACGP has also developed clinical audit tools that interface with electronic patient records and decision support programs. This allows practices to analyse their clinical activities and patient outcomes, thus identifying risks and opportunities for clinical improvement in relation to quality and safety.

3.7 **What do you think should be the initial priorities for action under the Goals?**

The College advocates for medication safety to be the initial priority for action under the Goals, as this is the one of the major areas of general practice care in which improvement is needed. Specifically, the focus should be on improved infrastructure within general practice in order to improve medication safety; and education and training programs regarding management of drugs of addiction and antibiotic stewardship.

Another of the greatest contributions to safety in health care would come from implementation of the personal electronic health record and implementation of electronic prescribing in all healthcare settings. A partnership with consumers in implementing the record would then have a measurable outcome. An electronic health record would prevent the massive duplication of tests that currently occurs e.g. blood tests, thus increasing efficiency.
3.8 How could the different stakeholders within the healthcare system be engaged in working towards achievement of the Goals?

The RACGP invites the ACSQHC and other relevant stakeholders to work closely with a number of its National Standing Committees on joint initiatives to improve general practice care in relation to safety and quality measures. As stated in the RACGP submission to the ACSQHC discussion paper on *Patient Safety in Primary Health Care (October 2010)*, 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, involving consumers, the Productivity Commission and the RACGP.

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

The greatest barrier in achieving the Goals within the general practice setting is currently inadequate funding for infrastructure and resources to improve patient safety systems in general practice.

Specifically, *Goal 1: Safety of Care* is problematic in that the systems for adverse event reporting in general practice are largely absent, yet many hospital-generated adverse events are detected within the general practice setting. Again, a system incorporating an electronic health record could assist to address this. General Practice needs to be funded to record its own critical incidents in a non-judgemental way. These critical incidents need to be reported for analysis of patterns of care which can then be addressed by education and training. The College already monitors quality and standards through practice accreditation and quality assurance programs. However, there exists currently a gap in the next step of critical incident reporting of adverse effects on patients.

With regards to *Goal 2: Appropriateness of Care*, diabetes, stroke/coronary events: the barriers to this include patient barriers such as ignorance and apathy and doctor barriers e.g. failing to schedule regular follow-ups for lack of time. Studies into finding effective strategies to address these are much needed.
4 Conclusion

Since foundation in 1958, the RACGP has demonstrated its commitment to improving the quality and safety of patient care through the development of the General Practice Training Program, its Quality Improvement and Continuing Professional Development Program, Standards for General Practices (fourth edition currently) and a wide range of other resources discussed throughout this submission.

Given the RACGP’s established history and ongoing commitment to the development and delivery of patient safety solutions in general practice, the College is central to any future developments in this field. The RACGP has much to offer in partnership with organisations involved in the funding, regulation, management, delivery and receipt of general practice services in Australia.

The College welcomes future opportunities for engagement and progression of the issues discussed in this paper and intends to provide representation at the upcoming key stakeholder workshops to be held in relation to this.
Appendix 1: The Royal Australian College of General Practitioners Quality Framework diagram