STRATEGIC PLANNING

Report of focus groups and interviews with healthcare providers

July 2014
INTRODUCTION

The Board of the Australian Commission on Safety and Quality Care (the Commission) has committed to the development of a new strategic plan that describes strategic priorities for the Commission over the next five years. To inform the strategic planning process the Commission undertook a number of activities to inform Board Members about the healthcare landscape in Australia and the issues facing stakeholders.

One of these activities involved Commission staff conducting 52 focus groups and interviews with over 350 staff from 14 hospitals or health services. The sites were selected purposively to give a mix of different jurisdictions; metropolitan, regional and rural locations; and public and private facilities. Within the sample two day procedure services and one ambulance service were involved. Participants included nurses, allied health practitioners, paramedics and ambulance officers; junior medical officers and consultants; primary and ambulatory care providers; nurse unit managers and other management staff; educators; safety and quality professionals; senior executives; chief executives; and board members. Grand round sessions were held at two hospitals to obtain feedback from a wide range of participants.

The aim of these focus groups and interviews was to explore the views of healthcare providers regarding safety and quality in Australia, focussing on the challenges and key priorities, and how the Commission, as a national body, could best assist healthcare providers deliver safe and high-quality care.

Feedback from participants has informed the development of the Commission’s new strategic plan. This document provides a report on the findings of the interviews and focus groups.
KEY FINDINGS

Overall, the feedback received from healthcare providers indicated that while many recognised the importance of ensuring safety and quality in their day-to-day work, there were a number of challenges that limited their ability to ensure the delivery of safe and high-quality care. The main challenges related to maintaining a stable workforce and ensuring that staff have the capacity and capability to deliver safe and quality care; issues associated with accreditation; communication and engagement and the breaking down of existing silos.

In relation to key priorities for safety and quality, while many related to overcoming the identified challenges, a general theme was that in order to improve the safety and quality of the health system, a more holistic approach needed to be taken at the organisational, sector and system level. The building of stronger linkages across the health system as well as with the community was therefore a priority identified in a number of interviews.

When considering how the Commission may best assist healthcare providers deliver safe and high-quality care, a number of suggestions were made about the facilitation and sharing of information and knowledge, developing tools and resources, influencing and delivering training and education and having a larger role in advancing the health literacy of the community. The potential of data, eHealth and new technologies was also recognised as being able to greatly assist and improve the delivery of care; however there appeared to be a lack of confidence amongst participants about whether these new innovations could be effectively implemented.
DETAILED REPORT

The detailed views of the participants of the interviews and focus groups are presented according to key questions asked during the focus groups and interviews:

- views of participants about safety and quality
- challenges and priorities for delivering safe and high-quality care
- what the Commission can do to help healthcare providers deliver safe and high-quality care.

1. Views on safety and quality

Participants were asked about their role, their responsibilities relating to the provision of safe and high-quality care, and how they viewed safety and quality as part of their everyday practices.

“[Safety and quality] is all encompassing. That’s what we are about. At the end of the day that’s what we are here for.”
Manager, day procedure service

“The fact is that safety and quality is what we do in everyday life with patient care, but [they are seen as] two different [things], the national standards and patient care. It means the same thing, but it’s actually about joining it together and making it everyday easy language for people to understand...I think that it my level I am trying to get what executives say to staff; it’s really tricky.”
Nurse unit manager, public hospital

“One of the big issues is trying to solve the disconnectedness between all sorts of things – between levels, between the floor and the executive and everything in between. And also disconnectedness between what they are doing and why they are doing it, and how it all connects together.”
Safety and quality professional, public hospital

All participants recognised the importance of safety and quality in the delivery of health care, however how safety and quality translated into everyday practices differed depending on the role individuals had within their particular health service.

In general, executives, managers and safety and quality professionals viewed safety and quality as ensuring that there were effective systems and processes in place to ensure safe and high-quality care, ensuring that healthcare providers had access to these systems and were aware of their responsibilities and accountabilities. Other roles for safety and quality professionals included providing education and training to frontline staff about the National Safety and Quality Health Service (NSQHS) Standards, conducting audits and reports and developing policies.

For frontline staff (including doctors, nurses and allied health professionals), many spoke about the principle of doing no harm and doing the best they could for their patients in the safest possible way. The concepts of safety and quality were therefore not as clearly defined for frontline staff, but seen more as principles underlying how care is delivered to the patient. When asked to consider safety and quality at an organisational level, it was evident that there was a general feeling of ‘disconnect’ with how reporting, auditing and policies related to their day-to-day practice, or even linked with their ability to provide safer, higher-quality care.
care. Similarly, many executives and managers felt that safety and quality was viewed by their frontline staff as just ‘more paperwork’, or ‘something special’ and an ‘add-on’ to their core business (which is the provision of clinical care). Managers expressed frustration about building staff understanding about how reporting, policies and risk management frameworks contribute to the bigger and long-term picture of improving the safety and quality of the service, and therefore how it linked to the safety and quality of care provided to their patients. One senior executive stated “[there is] very little connection between these beautiful documents and what’s actually happening out there at the bedside.”

While the challenge of embedding safety and quality into the ‘core business’ of frontline staff was considered by many participants to be in its infancy, it was acknowledged that the introduction of the mandatory NSQHS Standards had played a significant role in increasing the profile of safety and quality. Additionally, for some health services, participants noted that because the NSQHS Standards are more clinically based, they had experienced a greater willingness by clinicians to be engaged and meet with the safety and quality team. One participant commented that historically accreditation was seen to be just a paper exercise, whereas now clinicians could refer to and name each of the NSQHS Standards.

2. Challenges and priorities for delivering safe and high-quality care

Participants were asked about the challenges they faced in providing or ensuring the delivery of safe and high-quality care and the priorities for improving safety and quality both within their service and the health system generally. Many of the priorities identified related to overcoming the described challenges; however a general theme appeared to be that for safety and quality to be improved, the health system needed to be looked at more holistically, at both an organisational and sector level. For example, a number of priorities identified related to improving communication, linkages and engagement between staff and other health professions, as well as between primary, acute and residential aged care.

2.1 Staff capability, capacity and other workforce issues

“Being on the floor there is very minimal time to embrace a lot of these activities or step away from your work to be able to do [things for the standards].”
Nurse unit manager, public hospital

“There’s not enough time…they are having to juggle a whole heap of things…it comes back to the issue around how you manage the workforce in a way that you can guarantee the safety of the patient but also be able to meet all of the organisational requirements”
Educator, private hospital

“number one challenge for me over the last 20 years is to get stable, high-quality medical staff…and with stability comes consistency and that’s a really key thing to maintaining the quality and safety of what you do”
Executive, public hospital

Almost all participants considered staff capability, capacity and other workforce issues to be a major challenge in delivering safe and high-quality care. Many participants spoke about staff being overwhelmed, time poor and over worked; with resources not matching the workload or patient expectations. For frontline staff, time and fatigue seemed to be the greatest concerns, with some commenting that because their work environment was so busy
and complex, staff did not have the time to think or discuss what may be best for their patients, or how best to facilitate this.

Many executives and managers also discussed the difficulties of recruiting and retaining a stable workforce. A number of participants spoke about the transient nature of junior doctors and visiting medical officers (VMOs), where VMOs were often seen to be on the outer edge of the organisation. Some noted that employment of VMOs differed significantly between private and public hospitals and that professional education and performance management of VMOs was difficult to maintain. In addition, a number of participants felt that the constant turnover of staff made it very difficult to achieve consistency in practice, particularly given the large number of policies and procedures in place, which differ from health service to health service.

There was also an emphasis in the focus groups and interviews on the importance and need to build staff capability and to provide staff support. This included ensuring proper training of staff, effective staff orientation, appropriate and supportive supervision, mentorship, caring for staff wellbeing and allowing staff the time to consider and embed policies and processes into their practice.

Ensuring a safe work environment for staff was also raised as a priority. In particular, the issue of aggressive patients and the need for processes to be in place to protect staff. Examples included having adequate resources to have a 24/7 security guard in the emergency department, training of staff working in mental health wards and safety precautions for staff conducting home visits.

### 2.2 Burden of accreditation and system changes

“*My concern is that we lose sight of [our] core business which is that person in that bed and we become a box-ticking culture*”

Safety and quality coordinator, public hospital

“I think what it all comes down to is change. We are having a lot of change at the moment…No one is saying we don’t want change, but things are being thrown at us that are taking us away from our clinical care and the focus on what we really should be doing…”

Nurse manager, private hospital

“The agility of the system to actually make change [is an issue]. It’s really quite hard or things take a lot longer and things are happening and we are still sort of chasing behind to make sure we have got policies, procedures, staff, whatever, because things are moving so quickly at the moment that it is hard to keep up and the system just doesn’t seem to have that flexibility or adaptability to keep up with things that are changing.”

Executive, public hospital

For the majority of participants, the administrative burden of accreditation was a major challenge and limitation to the delivery of safe and high-quality care. Many felt that there were too many audits, checklists and reporting requirements that took up the majority of their time and away from the bedside and from teaching. Many described it as ‘box ticking for the sake of box ticking’ and there was a real concern that the focus on completing a checklist or audit sometimes meant that care for the actual patient was missing. In particular, a number of participants felt that junior staff were becoming so ‘checklist orientated’ that their ability to think critically on their own and undertake complex decision making was being diluted.
Another concern raised was that while a vast number of audits and reports were being completed, results from these processes were not necessarily fed back to the frontline. As noted above, there appeared to be a feeling of disconnectedness with why there was a need to continually audit and report and to how this translated into improved patient outcomes. It was felt that the focus on accreditation, in addition to external factors (such as political and financial issues), had caused system-wide changes that resulted in services being redesigned, reconfigured and restructured. The difficulty in managing these multiple changes in an already complex, busy and resource limited environment was felt by a number of participants.

A recurring theme in relation to accreditation was that healthcare providers felt that the increased focus and burden of implementing new systems, policies, processes to meet accreditation requirements, had come at the cost of delivering patient care and achieving best patient outcomes. Further, workforce issues and increasing workloads have made it more difficult for health services to manage the change effectively and to achieve stability and consistency of work practices.

2.3 Embedding the NSQHS Standards into practice

“…we did so much work to get them to this level, it would be nice to have at least one cycle where we can actually focus on embedding them and making sure that [the staff] are evaluating [the impact].”
Safety and quality manager, public hospital

“It is important to properly get at least two or three cycles through…We are going for the basics and then next time we will try and build on that because there’s no way we could go for the gold standard for our first survey against these because it is so different from the old accreditation.”
Safety and quality coordinator, public hospital

A number of participants noted that a key priority should be to allow health services the time to embed and consolidate the NSQHS Standards into everyday practice. A major concern raised was that a lot of work and change had already occurred within health services, and therefore any further changes required as a result of any review of the NSQHS Standards would undermine the service’s ability to strengthen and build on this work. Many commented that time was also needed to undertake evaluations to see if improvements had been made. Therefore, implementing new or additional requirements, before health services have had a chance to embed the existing NSQHS Standards, risked staff experiencing change or accreditation fatigue and becoming further disengaged. This would have a negative impact on how safety and quality is viewed by healthcare providers, and the effectiveness of the safety and quality framework being implemented to improve patient outcomes.
2.4 Streamlining accreditation processes

“I think it is about streamlining and bringing it together and making it easier…The feedback we’ve had about the standards is ‘This is hard, but it’s good!’ So how can we try to embed what we need to embed so that it becomes part of practice all the time, part of the systems, without you feeling like you are filling out a piece of paper rather than caring for your patients. Because that is what we are here for, caring for patients.”

Safety and quality coordinator, public hospital

“I think the demands from the new standards are overwhelming…I think there’s too much emphasis on meeting these standards that then do take away from what we are doing. It’s like at any time [there is] an accreditation, people go crazy. It doesn’t matter how organised you are, how many years you put into planning…because of the demands from the accreditation people and for us to achieve the national standards, I think it is very overwhelming.”

Nurse manager, private hospital

“…the spot audits I think they are rather good than going through this three-year, four-year cycle where you tend to lose a little bit of momentum after accreditation then you start to build it up again, I think that having the 12 month cycle and the opportunity for just random drop-in visits…makes sure that you as an agent are keeping on top of all the standards and continue to work on those.”

Executive, public hospital

In addition to embedding the NSQHS Standards, a major priority arising from the interviews was the need to streamline the accreditation process. As noted above, it was evident from the interviews that the majority of staff were overwhelmed by the accreditation process and that many felt that the administrative workload was unsustainable. There were also a number of instances where participants commented on the pressure and stress felt by staff, with one participant noting that staff wellbeing was essential considering the strong link between good outcomes for patients and happy staff.

There were also comments relating to the need for more rigor and direction to be given to surveyors. A concern amongst health services appeared to be that they felt that the outcome of an assessment was dependent on which surveyor the service was assigned. One suggestion was that perhaps surveyors could make up a permanent workforce, where standard training was given about their role, responsibilities and how to assess against the NSQHS Standards. This would develop a more consistent approach to how surveyors review health services.

There were also suggestions about the accreditation process not being a one off event, but more like unannounced ‘spot-audits.’ The rationale behind this would be that staff and clinicians would then consider safety and quality to be part of their everyday practice, rather than just an accreditation exercise that occurs once every few years.
2.5 Stronger linkages across the health system

“[We need to] connect the dots between the tertiary setting and the primary care settings and know what’s there so you can best utilise the services for your clients while stopping readmissions.”
Manager, population health and ambulatory care service

“We look at agencies in isolation as to a set of quantitative measures. Whereas I don’t think we put enough energy into how that organisation links into the whole health system which can impact on quality and safety both upstream and downstream for the patient.”
Executive, public hospital

A general consensus in the interviews was that to really improve the safety and quality of the health system, stronger links between primary, acute, sub-acute and residential aged care needed to be established. This is because the health of a patient and the care they receive depends a lot on which health system/service the patient is coming from, or which system/service the patient is going to. One participant spoke about the difficulties of providing care for patients from a lower socio-economic background, as many healthcare providers often felt powerless in ensuring the safety of their patient, once the patient had left their care. It was felt that a lack of transitional care programs and the ability to coordinate care with other health settings was one of the main contributing factors to this challenge.

A number of participants also suggested that stronger linkages could be made by adapting or increasing the scope of the NSQHS Standards to apply across different health settings. Some noted that while the current NSQHS Standards only applied to acute settings, there were many parts of the NSQHS Standards that were also relevant and applicable to community-based services, ambulance services and aged care. Therefore, there was a potential for the NSQHS Standards to provide national guidance on what safety and quality care should look like for a patient, no matter where they lived in Australia or where their care was being provided.

2.6 Clinical leadership and medical engagement

“The doctors are highly influential in our system and yet they are frequently absent, or it is an unusual kind of doctor that is interested in safety and quality issues.”
Safety and quality coordinator, metropolitan health service

“I think traditionally it has been quite hard to get…our senior doctors engaged at the best of times.”
Safety and quality professional, private hospital

“One of the contributing factors was not just perceived but a real lack of engagement from senior clinicians on clinical governance… They need to feel engaged rather than having stuff imposed on them.”
Clinical director, public hospital

While the NSQHS Standards have increased medical engagement in some health services, a large number of safety and quality managers still found it difficult to engage clinicians in their work. A number of managers noted that as doctors are highly influential in the health system, the challenge (and sometimes failure) of getting doctors engaged, had a negative impact on their ability to influence the practice of frontline staff and put into place quality improvement strategies. A few also commented that it has traditionally always been difficult to engage doctors in this work, and therefore what was needed was a cultural shift or cultural
change in how the medical profession view safety and quality. Some, however, noted that this lack of medical engagement was not just one-sided, but a significant contributing factor was the poor or inadequate communication by the executive or management team about how safety and quality translates at the coal-face. The issue of communication is further outlined in the following section.

Good leadership and executive buy-in was also identified as being necessary to drive the safety and quality agenda. Participants spoke about the importance of senior clinicians being role models to junior staff, with one participant noting that where a senior clinician decided to support and drive safety and quality processes, the result was a ‘trickle down’ effect that positively affected safety and quality processes being implemented by frontline staff.

2.7 Communication, collaboration and existing silos

“…the clinical staff don’t always see that easily, they don’t always see that connection, that what they are doing really does have a longer-term impact on safety and quality… [And there is] the executive and management of the organisation helping, supporting and educating them… and the operational staff and all the other corporate level… so I find that quite hard, you’ve got to change your messages, so eventually they will link together”
Safety and quality coordinator, metropolitan health service

“My challenge is trying to translate what the standards are and what the risk management framework is etc to the guys on the floor, so that it is in their skin, in their world and it is relevant.”
Safety and quality professional, public hospital

Almost all participants spoke about the challenge of communicating effectively across different teams and with patients. There was a general consensus that existing silos within health services (such as between managers, nurses, clinicians, administrative team and the allied health team) often meant that there was a lack of, or poor, communication, which undermined the delivery of safe and high-quality care. Clinical handover was identified as a specific area where communication needed to be improved. Other issues included ensuring clear and accurate documentation and better communication with patients and their families.

As noted above, there was a feeling that existing silos and ineffective communication between managers and frontline staff about the purpose of continuous auditing and reporting contributed to the lack of understanding and therefore disengagement of clinicians. One participant noted that there needed to be more effective feedback mechanisms so that the results of any audits or reports were provided and explained to frontline staff. This would improve their understanding and allow staff to feel more connected and engaged with how safety and quality relates to their everyday practices, rather than feeling like policies are just imposed on them.

In relation to communicating with patients and families, almost all participants recognised the importance of good communication and patient engagement and consultation. Many noted however, that while health services were trying to improve communication with consumers, it was often very difficult to achieve in practice. Some found that they were still witnessing instances of communication being done in a very clinical way, where clinicians at the bedside talked about and above the patient, rather than alongside them.

The building of networks and collaboration between health services and other agencies was also identified as important to improving safety and quality. Some participants felt that if
stronger relationships and networks existed between health services, there would be greater opportunities to share information and to learn from one another. One participant noted the potential for different health services to work together within a region to provide services in a more consistent and standardised way. The building of networks and sharing of information and knowledge was particularly relevant to rural and remote health services, as it was noted that these services are often small, isolated due to distance and usually working with limited resources.

2.8 Vulnerable groups and rural / remote issues

“...we have got 101 different speaking nationalities so that is rather challenging in itself...You know people think that it is okay just to give them a leaflet in their language but that is not the right way to approach them”
Director of nursing, public hospital

The challenges health services experienced with Aboriginal and Torres Strait Islander and culturally and linguistically diverse people depended on the type and location of the health service being interviewed. For example, health services in the Northern Territory appeared to face a unique set of challenges due to their remoteness and the fact that most of their patients had an Aboriginal background. Some of the challenges included the difficulty of knowing and meeting patient’s needs, as often a language barrier exists and there is a poor understanding about what the patient’s specific cultural needs are. These challenges are exacerbated by the many different nations, cultures and languages within the broader Aboriginal and Torres Strait Islander groups. In addition, many Aboriginal patients have both complex health needs as well as complex social issues.

Other participants also spoke about the challenge of meeting the needs of patients from culturally or linguistically diverse backgrounds and being able to effectively communicate with them about their care. Some suggested the need for better translation documents and services, acknowledging that just giving patients or their families information in their own language was not enough to ensure safe and high-quality care.

2.9 Patient-centred care and community engagement

“So you might have a set of questions or checks and balances that you have to achieve, but that doesn’t take priority over the patient’s individuality and looking at them as an individual.”
Manager, day procedure service

“I think we need to stop sometimes and listen to what patients and families tell us…”
Nurse manager, public hospital

“Community expectations have changed dramatically...I think there is no doubt over a long period of time the expectation of the community has increased.”
Visiting medical officer, public hospital

There was recognition by health services that the movement towards patient-centred care and partnering with patients was important to ensuring best outcomes for patients, however many found it very difficult to translate these principles into practice. In particular, a recurring issue was the difficulty of implementing NSQHS Standard 2: Partnering with Consumers (Standard 2). A number of participants suggested that the Commission should provide more direction and guidance on Standard 2, to both health services and surveyors. It
was felt that there was a lot of confusion about what was required to meet Standard 2 and processes were being put into place that did not necessarily translate into genuine partnerships with consumers. One participant also noted that they found engaging senior clinicians in patient-centred care very challenging, as many senior clinicians felt that they had already been practicing ‘patient-centred care’ for a number of years (even if this was not the reality). Therefore, there was no need for them to change their practice.

An additional challenge and priority identified was the need for community engagement and education, particularly in relation to managing community expectations of the health system. In many of the interviews, staff felt that patients and their families often had unrealistic expectations about what they considered to be appropriate care and the capacity of health services to meet these expectations. It was also noted that the challenge of managing these higher expectations was compounded by the fact that health services were also trying to manage the fast changing demographic of patients, who now presented at health services sicker and with increasing number of comorbidities.

3. What can the Commission do to help healthcare providers deliver safe and high-quality care?

Participants were asked about how the Commission, as a national body, could help improve safety and quality and in particular the specific tools, resources or information that could assist them in the delivery of safe and high-quality care. While the focus of this question was to determine how the Commission could specifically help, some participants spoke more generally about what they felt was required. Therefore, while there are opportunities for the Commission to address many of the suggestions, some fall outside the scope of the Commission’s remit and perhaps could be more appropriately addressed at a jurisdictional level.

3.1 Facilitate information sharing

“I think [the Commission could help in] the sharing of information, like when a hospital or day surgery is doing something well, getting that out there… let’s not reinvent the wheel…”

Patient care coordinator, day procedure service

In trying to implement or develop safety and quality policies and protocols, many felt as though they were continually ‘reinventing the wheel’ or ‘starting from scratch’, even though they felt it was likely that another health services had gone through similar processes and had probably already implemented mechanisms or initiatives to address these issues. Other participants felt that they did not have time to go looking for information, and even if they did, there was such an overwhelming amount of information that it was difficult to identify what was relevant, or even considered to be best practice. An example given by staff at a day procedure service was a situation where they had tried to adapt a vast amount of material that was primarily meant for large hospitals and in doing so, felt they were just pulling bits of information together. They were therefore unsure about whether they were in fact putting into place a mechanism that would best improve the safety and quality of their service. Others also noted that while some jurisdictions had excellent information and resources, it was sometimes difficult to access if your health service was not located within that particular jurisdiction.
Information sharing at a national level and the ability to facilitate access to evidence-based best practice guidelines was therefore identified as an area in which the Commission could take leadership on. In particular, health services wanted to:

- have uniformity of information across sectors (so people are getting the same messages)
- share information and knowledge between health services, especially in relation to initiatives where there is evidence that these initiatives have resulted in good patient outcomes
- know where to access information, or which organisation to go to if they are struggling and need assistance
- have a repository of best practice examples, so that other services can leverage the good work that has already been done.

3.2 Tools and resources

“What I would like to see is some audit tools that are used by all hospitals in relation to the standards...[currently] we’ve all got different audit tools and we are all doing different things.”

Safety and quality manager, public hospital

As with access to information, a number of participants felt that there was an opportunity for the Commission to develop tools and resources, particularly in relation to assisting health care providers meet the NSQHS Standards. A number of tools and resources were suggested including:

- standardised audit and report tools
- standardised patient experience survey
- resources that are more meaningful to clinicians and frontline staff, for example connecting patient stories with the NSQHS Standards so that staff had a better understanding of how they translate into patient outcomes
- education tools and information for patients and consumers on what to expect when they get to hospital and also how to partner in their own care
- a consumer engagement framework for health services and more tools for Standard 2: Partnering with Consumers
- resources on how the NSQHS Standards apply to different settings
- case studies or scenarios that can be used in training
- more research/evidence-based guidelines for specific settings such as day procedure surgeries.

It was also noted that the new clinical care standards had been useful in clarifying what was expected for certain conditions and could be expanded to cover other conditions or care practices. However, some noted that many conditions could not be looked at independently, but had to be looked at in context of other considerations (such as pressure injuries and falls and incontinence and nutrition). Therefore, a risk of having clinical care standards that only address one condition may result in a narrow approach and patient care not being considered holistically.
3.3 Training and education

“…professional development in the area if quality and safety in health care for managers [on] how to effectively do audits and risk assessments and things like that, I think that helps.”

Allied health professional, public hospital

Training and education of staff was raised a number of times as being essential to improving the safety and quality of care. This included training for managers and staff on how to effectively conduct audits and risk assessments, communication and leadership skills as well as ongoing training for clinicians (both to ensure that their clinical skills are maintained and that new skills are developed). There was also a suggestion that the Commission develop webinars on specific safety and quality issues and education packages of safety and quality training materials for university medical schools as well as schools of nursing and allied health.

Some participants also felt that more focus was needed on embedding safety and quality principles and practices into the undergraduate curriculum, so that clinicians gained an early understanding of how safety and quality relates to and should inform their everyday practice, before they enter into the workforce.

3.4 Campaigning and advancing health literacy

“…rather than just working with the hospital take out a publicity campaign because I actually think that one of the biggest safeguards against medical error is having informed consumers by the time they get [to hospital]”

Safety and quality manager, public hospital

It was felt that one of the biggest safeguards against medical errors and poor patient outcomes is ensuring that consumers are informed and empowered. It was suggested that the Commission could have a larger role in informing consumers by providing the public with information about their health care and the Australian health system. Some of the suggestions included:

• taking out a publicity campaign on important safety and quality issues and getting this information out into hospitals, doctor’s surgeries and pharmacies
• engaging the media in a purposeful way about what a quality health system really looks like and examples of best practice, so that the media are able to be allies of the health system rather than just adversaries.
• tapping into patient stories and using them to improve practice and educate consumers
• developing resources and tools to educate consumers, so they understand how to be partners in their own care and have realistic expectations about the health system.

One participant also spoke about the role the Commission could play in promoting the safety and quality agenda to clinicians, suggesting that Commission staff could present at grand rounds or medical seminars and conferences.
3.5 Data, eHealth and technology

“I think one of the big ticket items is data and the availability of meaningful data...[and] the ability for clinicians to get full data...in real time”
Clinician, tertiary hospital

“...start looking at better tools, using technology in a much better way because so far we have had a lot of promises from technology but outcome wise it has been quite disappointing in some instances”
Director of nursing, public hospital

Participants recognised the potential for data, eHealth and technology as ways to greatly improve the safety and quality of healthcare. Participants spoke about electronic patient records and the potential for this to enable accurate and up-to-date information to be accessed by any healthcare provider. However, they also recognised the challenges of implementation, noting that to ensure effectiveness and reliability, the system needed to be able to link patient data across the entire health system, including across primary, specialist and acute care settings. From the interviews and focus groups, it was evident that currently a vast number of different information technology systems and data collection mechanisms were being used by health services, even within individual jurisdictions. Therefore the integration, compatibility and data comparability presented big issues for effective implementation. A number of participants also noted the importance of ensuring that any new information systems or technologies implemented were user-friendly and intuitive, so as to not add to the workload of an already overwhelmed workforce.

For remote health services, there was the recognition that innovations in online technology and telehealth could be particularly beneficial to the delivery of care in remote areas. However, a few commented that in their experience, some innovations could be very costly and that to be effective it was essential to have adequately trained staff.