australian nursing federation

Submission to consultation by the Australian Commission on Safety and Quality in Healthcare on draft National Safety and Quality Healthcare (NSQH) Standards

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1. Introduction

The Australian Nursing Federation (ANF), established in 1924, is the largest industrial and professional organisation in Australia for nurses and midwives. With Branches in each State and Territory of Australia, the ANF has a membership of over 175,000 nurses and midwives.

The core business for the ANF is the professional and industrial representation of our members and the professions of nursing and midwifery. Members are employed in a wide range of enterprises in urban, rural and remote locations in both the public and private health and aged care sectors.

The ANF participates in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, socio-economic welfare, health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The ANF welcomes the opportunity to respond to the invitation from the Australian Commission on Safety and Quality in Healthcare (ACSQHC) to provide comment on draft National Safety and Quality Healthcare Standards.

2. The nursing and midwifery professions and quality care

Nurses and midwives form the largest health profession in Australia,[1] providing health care to people throughout their lifespan, and across all geographical areas of Australia. They practice in: homes, schools, communities, general practice, local councils, industry, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional organisations.

As the largest cohort of health professionals[2] within the health and aged care workforce, nurses and midwives play a central role in the development of policies and procedures which are aimed at the delivery of safe, quality care.

The practice of nurses and midwives is governed by several factors including:

- Education: the education of registered nurses and midwives in universities aims to achieve optimal levels of quality care provision and patient safety, ensuring that registered nurses and midwives as the clinical leaders have a strong, detailed base of knowledge and set of skills before assuming direct responsibility for patient care.[3]

- Statutory regulation: currently there is legislation in each State and Territory which prescribes nursing and midwifery practice. As from 1 July 2010 there will be national registration covering all nurses and midwives in Australia. The purpose of the regulation is to protect the public.

- Professional practice framework: aspects of this are Codes of Ethics and Codes of Professional Conduct; Competency Standards – minimum and advanced practice; Decision making framework for scope of practice; and Professional Boundaries.

- Policies and procedures: health and aged care facilities in which nurses and midwives are employed have defined policies and procedures to provide guidance for clinical practice. Nurses and midwives are most often the prime movers in the development and maintenance of quality improvement processes in health and aged care facilities.

3. General comment

The ANF supports the intention of the introduction of the NSQH Standards which is to provide a standardised measure of the safety and quality of care that is applicable across all health service organisations. The ANF agrees that the Standards will provide a guide to health service organisations of the level of care expected to be provided to improve overall patient care in health settings in Australia.

For many organisations the system of accreditation that they invest in provides a framework for ensuring that they have the critical governance systems in place to provide the structures and processes required to deliver safe, quality outcomes for people. Many organisations use the accreditation framework as their safety and quality blueprint.

The ANF considers it essential that there be transparency and accountability to the public in all the activities around safety and quality improvement initiatives in health service organisations. In this regard it is vital that consumers, the organisation's constituent community, key health clinicians and other workers be involved in all aspects of a health care organisation's planning, policy development, monitoring, review and evaluation of its service activities. Accreditation should be seen as one mechanism in a suite of tools used to test the robustness of those systems in an organisation. Policies such as 'open disclosure' and comprehensive public reporting are also crucial to assuring the public that a responsive risk management approach and continuous improvement strategies are embedded in the organisation's business of delivering safe and quality care services.

3.1 Scope and application of the Standards

The ANF questions the suggested difference in treatment for high and lower risk health service facilities in relation to the application of the Standards. The ANF supports the mandatory application of the NSQH standards for accreditation and considers that this should be across all health services, regardless of perceived risk. It is the view of the ANF that non-invasive procedures can also pose very real risk to individuals utilising a health service organisation. There should therefore be no difference in treatment for high risk and lower risk health service facilities.

3.2 Role of the national co-ordinating body for accreditation

On page 13 of the consultation document the roles of the National coordinating body for accreditation and the accrediting agency are described. The ANF seeks clarification as to which body will be responsible for undertaking an educative role in assisting organisations required to implement the standards, in their understanding of the standards to be complied with, and then education where compliance has not been met. That is, the ANF deems the national standards to be a means to assist organisations to reach a nationally agreed standard of safety and quality, if this is not already apparent, for the well-being of their clientele, and not as a punitive tool.

4. Specific comments

The submission to follow responds to the questions as set out in the ACSQHC consultation paper *Draft National Safety and Quality Healthcare Standards*.

4.1 Is the language and format of the NSQH Standards appropriate?

Language: while the language is mostly appropriate, the following items are highlighted for amendment:

- there is the odd lapse into using a word which may not have universal application or understanding such as SQ: A 1 dot point 5 ‘escalation’. Prefer use of the commonly used word ‘promotion’.
- there is an inconsistent use, or interchangeable use of training and education in the document.
- Standard 3, Medication Safety (MS): MS:C 1 Under *“will be achieved by* (page 41): language used should reflect common usage, for example, “concordance” is not a common term and its inclusion does not add to the sense of the statement *“This includes the benefits, associated risks and responsibilities for concordance with the agreed treatment plan.”* While “concordance” by definition in the Australian Concise Oxford Dictionary is "agreement", the sentence would read better if simply put as *“This includes the benefits, associated risks and responsibilities under (or within) the agreed treatment plan”*

- Standard 4, Patient Identification and Procedure Matching *(PI):-*
    - Under Rationale (page 46) refer to “tests” and “testing”. More appropriate to be “investigations”; and “interactions “rather than “interventions”. One could also include “breech of privacy” as a negative result, for example, as a result of inappropriate filing.
    - Under *“Solutions to prevent patient mismatching” (page 47) “Human factors science demonstrates that the development of safety routines for common tasks (such as patient identification) provides a powerful barrier to the eventual expressions of error.”* The meaning of “human factors science’ and “expressions of error” may not be clear to the average reader. Also, more appropriate for “safety routines” to be “safety procedures”.
    - Under *“Use of patient identifiers to prevent mismatching”*: a definition for “statistical matching” would be useful (page 48).
    - Under *“Resources” (page 48)*: suggest peri operative procedures be added to the list of protocols as these have also been developed.
    - Under *Roles (page 49), Clinical staff: “To correctly identify the patient, and their care, at each healthcare transaction”.* More appropriate to use “interaction” than “transaction”.
    - Under PI:B *Transfer of Care - Rationale* (page 53): Remove “primary care” and replace with “healthcare”
    - Under PI:C, *Matching Patients and their care (page 54)*: Rationale, 2. *“Interventional procedures represent a high risk of harm to patients if the procedure is undertaken on the wrong patient or the wrong side”*. Should this be "wrong site”?

Format: It may clearer for the reader if the section which outlines the components of each Standard (page 8) included the fact that there will be an ‘Explanatory note’ and ‘Roles’. Then under each Standard perhaps the explanatory note would be better positioned after the Rationale, and the Roles would be better positioned after the elements of the Standard have been outlined in full (that is at the end of the Standard, preceding the related documents section).

4.2 Are there gaps in the NSQH Standards that should be addressed?

There does not appear to be any reference in the standards for healthcare services to be involved in research. For example, in Standard 2: Healthcare Associated Infection (HAI) there should be inclusion of the need to undertake research in order to identify, assess the risk of, and manage, new infections.

4.3 Are there unnecessary items or duplications that should be removed from the standards?

The ANF does not consider that there are any unnecessary items or duplications that should be removed from the Standards.

4.4 Is the level of detail provided adequate to implement the standards? If not, what additional information is needed?

The ANF considers that the level of detail provided is adequate to implement the Standards, with the addition of comments as outlined below for each Standard.

Standard 1: Governance for Safety and Quality in Health Service Organisations (SQ)

There is scant reference in the NSQH Standards to the various legal requirements by which health services and clinicians are bound. While these are obviously too numerous to name, in SQ:A 1, for example, the reference to relevant legislation mentioned under "will be achieved by" should be reinforced in the Rationale and then in the Process measure, with wording such as, "evidence that the organisation is abiding by current legislation".

SQ:A Under "will be achieved by", 4. Add: "…and ensuring that the risks are effectively managed"(page 15).

SQ:C (page 17) Add: words in beginning statement "…and provide staff access to (including financial investment where required) learning and development programs."

SQ:C 1. Rationale. Add: Minimises risk of patterns of performance which may lead to adverse events or other risks to patients or staff.

SQ:E (page 19)

Add a 5th item under "will be achieved by": relating to "consumer participation". That is, taking a step beyond the clinical involvement of people as patients and engaging with people from the community who can take an active role in the governance and operations decision-making of the organisation.

Rationale: Consumers of health have legitimate interest in taking an active role in the governance and operations of health and aged care facilities to improve the safety and quality of health and aged care services.

The ANF supports all other items under Standard 1.

Standard 2 Healthcare Associated Infection (HAI)

HAI:B 3 (page 28) It should be noted that along with a risk-based staff immunisation program (which can not make it mandatory for staff to be immunised) there should also be included education for staff on such a program, so that informed decisions on immunisation can be made.

HAI:D (page 30) There should perhaps be consistency in language – either use 'antiobiotic management system' OR 'antimicrobial management system'. The latter is probably preferable as it reflects the Standard heading.

HAI:E.3 (page 31) insert word 'reusable' before 'medical'

The ANF supports all other items under Standard 2.

Standard 3 Medication Safety (MS)

Under 'Roles' and 'clinical staff' third point should include 'legislation relating to medication management'

MS:A.5 Rationale: insert 'medication' before 'safety'

MS:D.5 Rationale: 'component' should read 'competent'

The ANF supports all other items under Standard 3.

Standard 4 Patient Identification and Procedure Matching (PI)

The PI Standard: Elements of the PI Standard (page 46): Reorder elements B and C so that "Matching patients and their care" comes before "Transfer of care", to give a more logical flow in the identification process.

Explanatory note: The scale of the problem (page 47): Would prefer to see the emphasis on the scale of the problem using Australian data/research rather than overseas information to increase relevance for the user of the NSQH Standards.

PI:B.2 change to read "Ensuring that all patient transfer and discharge handover documentation contains….etc"; and **PI:B.2a** to read "Proportion of transfer and discharge handover documentation that includes…etc". It would not be feasible to have (and unwieldy to implement and assess) documentation to cover less formal handovers such as those which occur every time a nurse leaves the clinical area during a shift for a meal break or other short term absence.

The ANF supports all other items under Standard 4.

Standard 5 Clinical Handover (CH)

Rationale (page 57): The statement "The quality of clinical handover impact directly on patient care and outcomes" should be altered to read reflect "may impact" as there are other factors which may effect patient care and outcomes.

The ANF does not support taped reporting for clinical handovers (page 58) and welcomes the fact that this modality is not recommended in the NSQH Standards document.

In general terms the concept of a standardised clinical handover process is welcome but the ANF is aware of recent trials which have demonstrated that these need to be standardised to the ward or unit and shift and not to the organisation as there is not one standard fits all.

On page 59 under "Solutions to minimise the risks at clinical handover", it states "Clinical handover is a group practice and a group responsibility." It is unclear as to what this means as clinical handover is not always undertaken as a group practice. It may be individual to individual health care clinician, although one would expect that all clinicians at some point in time are involved in this activity, and therefore all clinicians who may be involved in the handover practice do have a responsibility.

Under **Roles** (page 60) the role of non clinical staff in ensuring effective delivery of healthcare services is defined, in relation to the clinical handover standard, as being:- *"to actively participate in agreed clinical handover processes whenever participating in patient care"*. The ANF questions which staff could be defined as "non clinical" and yet be participating in "patient care".

CH:C. Patient and carers involvement in clinical handover *(page 62)*: Under **Rationale** it states that *"bedside clinical handover has been shown (typo in document) to enhance patient satisfaction"*. While this can be the case it should not be assumed to fit all clinical situations and settings. Bedside handover may not be appropriate for a number of reasons including: the number of clinicians involved in the handover and available space; privacy issues in shared rooms; patients from non-English speaking backgrounds, with no or poor language skills; and the content of the handover and the ability of the patient to understand, for example, those who are cognitively/intellectually impaired.

The ANF supports all other items under Standard 5.

4.5 Are there settings in which some of the elements of individual standards do not apply?

PI: A 1. This may not account for those settings where a patient is intellectually/mentally impaired or unable to communicate and with no identification available, for example, Emergency departments, dementia units. Also, in the community working with the homeless; or in a school based health clinic.

Otherwise the ANF considers that the elements of individual Standards are broad enough to be applicable across all health care settings.

4.6 Are the process measures in individual standards appropriate for the assessment of safety and quality of each of the elements?

Standard 1 Governance for Safety and Quality in Health Service Organisations (SQ)

SQ:A Process measure:4a, Add: *"Evidence of a risk assessment system"* should refer to a risk management system as a process measure.

Please note: Australian/New Zealand Standard for risk management (AS/NZS 4360:2004) for identifying, analysing and assessing risks has now been superseded by AS/NZS ISO 31000:2009 *Risk management- Principles and guidelines*

SQ:A Process measure:5a. (page 15) include that there be evidence of staff being engaged in the process throughout the quality improvement system. A top down approach will not lead to commitment to implementation and on-going maintenance of required changes to achieve improvement. That is, evidence of shared governance.

SQ:B Process measure:1a. (page 16) Add: words to the effect: Evidence that staff have the time to research evidence-based clinical information and/or have ready access to such resources.

SQ:B Process measure:2a. (page 16) Add: Evidence of staff numbers and skills mix to provide clinical leadership to support early intervention practices.

SQ:C Process measure:1a. (page 17) Add: Evidence of staff numbers and skills mix so that staff can work within scope of practice.

SQ:C Process measure:2a. (page 17) Add: Evidence that staff can access clinical educators/education programs.

SQ:C Process measure: 3a. (page 17) Add: Evidence of support for staff development both in terms of providing access to, and financial assistance of some degree.

SQ:E Process measure: (page 19) Evidence of active participation by consumers in decision-making structures of the organisation.

Standard 2 Healthcare Associated Infection (HAI)

HAI:A. Process measure:5a (page 26) Add: Evidence of staff training and regular dissemination of information on healthcare associated infection management.

HAI:B. Process measure:1a (page 27) Add: to 8th dot point 'disposal of infectious waste material.

HAI:E. Process measure:1a (page 31) Add: a dot point 'sterilization processes', and another one referring to Hospital in the Home programs where these are conducted by the healthcare facility so that the specific processes for this service are accommodated in the overall infection control management plan.

Standard 3 Medication Safety (MS)

MS:A. Process measure: Add:1c (page 38) Evidence of complying with relevant legislation relating to drugs and poisons Acts.

MS:A. Process measure:3b. (page 38) Add: "..and on-going education to maintain relevance of information."

MS:B. Process measure: 2. (page 40) Add: 'that the adverse drug reaction is clearly identified with the appropriate coloured wrist band'.

Standard B does not identify that clinical staff taking a medication history must be educated to a level which ensures they understand the implication of the history they are documenting.

MS:B.2 There can be no argument that there is a need to document adverse drug reactions but the process measure should include the use of a standard documentation form within the health service which would help prevent confusion and mistakes from occurring.

MS:C. Provision of medicines information to patients (page 41): **Process measure:** makes reference to patients being informed about their medicines etc but does not emphasise the need to ensure patients understand what has been communicated, nor is there mention of the need for this information to be transmitted in appropriate languages for non-English speaking people.

Standard 4 Patient Identification and Procedure Matching (PI)

The ANF supports process measure items under Standard 4.

Standard 5 Clinical Handover (CH)

The ANF supports process measure items under Standard 5.

4.7 Can the draft NSQH Standards be applied in your healthcare setting without modification?

Not applicable.

4.8 Should the final set of NSQH Standards be the only safety and quality requirements for accreditation or should jurisdictions and /or accrediting agencies have the capacity under the new model to add further safety and quality requirements to accreditation?

The ANF, in its submission to the review undertaken by the ACSQHC in 2007 of national safety and quality accreditation standards, noted the difficulties in credibility of accreditation of health systems in Australia, given the fact that sets of standards and the accreditation systems have not been consistent and have not covered the same aspects of service delivery that contribute to providing a safe, quality service provision system.

The development now of national standards by the ACSQHC means that all accreditation bodies will have the same overarching set of standards under which to operate. Within this framework there would be room for customising components of the standards to cover differing aspects of service delivery in individual healthcare organisations without diminishing the consistency of the standards foundation. This then gives flexibility to accommodate all aspects of differing organisations. Likewise there should be flexibility to allow for specific components of standards to accommodate for clinical specialty areas such as palliative care or mental health services (for example, evidence of risk management strategies around consumers at risk to themselves and those who potentially pose a risk to others).

Essentially the national standards should be appropriate to all organisations and then any specific components required, for example, for laboratories within health services or whole health services such as community health services or the primary care services provided by general practitioners, can be added and incorporated within this framework.

In the interests of credibility of a national approach, any additional standards developed under the overarching standards, should be developed in consultation with the National Coordinating Body for Accreditation.

5. Other considerations

The following items under this section are included as these are issues which the ANF considers should be included in the work of the national co-ordinating body.

5.1 Surveyor reliability

The ANF considers that it is worth reiterating a comment made in its previous submission to the ACSQHC in 2007 on national safety and quality accreditation standards, regarding surveyor reliability. Intra and inter-rater reliability has been a constant challenge for accreditation organisations and health and aged care organisations being accredited alike. Ensuring consistency is not down to one solution but an interplay of solutions such as:

- Credible, well educated surveyors with contemporary knowledge about, and practice within the health and/or aged care systems
- Comprehensive and well understood standards and criteria for measuring performance against those standards
- Systems to support consistent decision making, for example, electronic decision support and reporting systems
- Expert coaching, coordination and support for the surveyors and teams during surveys
- Comprehensive orientation and ongoing professional development for surveyors
- Mechanisms for testing and analysing the consistency of decision making before, during the course of, and after a survey; as well as in hypothetical situations
- Active performance management of surveyors involving feedback from co-surveyors, organisations undergoing accreditation and other relevant parties
- Merit based selection of surveyors using robust recruitment and selection processes
- Active steps to reduce the capacity for surveyors to become part of a 'club' of surveyors by having a quantum of surveyors with a constant changeover of persons in the role and a mixing of teams of surveyors

5.2 Consumer experiences

The review undertaken by the ACSQHC in 2007 raised the issue of ascertaining consumer satisfaction with healthcare systems, and referred to the tracer methodology, in particular, for external accreditation reviews.

Consumer organisations need to be actively involved in developing an appropriate model for accreditation in Australia. The experiences of the consumer (and their family and friends) are critical outcomes that have not been traditionally measured as part of accreditation. Consumer satisfaction methodologies have been around for many years, yet these have not always been useful in enabling a clear picture of consumers' expectations and needs being matched with their real experiences of the care and services provided by the health service. The tracer methodology if introduced in a meaningful and valid way is potentially a powerful tool for tracking this important outcome data.

The ANF supports the introduction of the tracer methodology as a method for gaining an assessment of consumer experiences in a health service for the purposes of testing compliance with the standards.

5.3 Evaluation

The ANF would like to see added to the potential roles of the national co-ordinating body for accreditation a process for evaluation of the implementation of the NSQH Standards.

6. Conclusion

The ANF welcomes the development of a set of national standards to be applied by accrediting bodies to assess safety and quality of healthcare organisations using a consistent approach. The draft NSQH Standards cover a comprehensive range of standards components. Comments provided in this submission are intended to strengthen the draft standards presented.

The ANF looks forward to learning of the outcome of the piloting of the NSQH Standards process and would be pleased to participate in any on-going consultations to develop and refine the national safety and quality healthcare standards.

References

1. There is a combined total of 244,360 registered and enrolled nurses actually employed in nursing in Australia, with 18,297 of these being midwives. Australian Institute of Health and Welfare 2008. Nursing and midwifery labour force 2005. Additional Material. Table 1. Available at : http://www.aihw.gov.au/publications/hwl/nmlf05/nmlf05-xx-registered-nurses-clinical-area.xls

2. Nurses and midwives comprise over 55% of the entire health workforce. Australian Institute of Health and Welfare. 2006. Australia's Health 2008. Canberra: AIHW. p 317.

3. Australian Nursing and Midwifery Council. 2008. Position Statement: Registered nurse and midwife education in Australia. Available at: http://www.anmc.org.au