

Monitoring Safety and Quality against Standards

Australian Harkness Alumni Seminar

Chris Baggoley

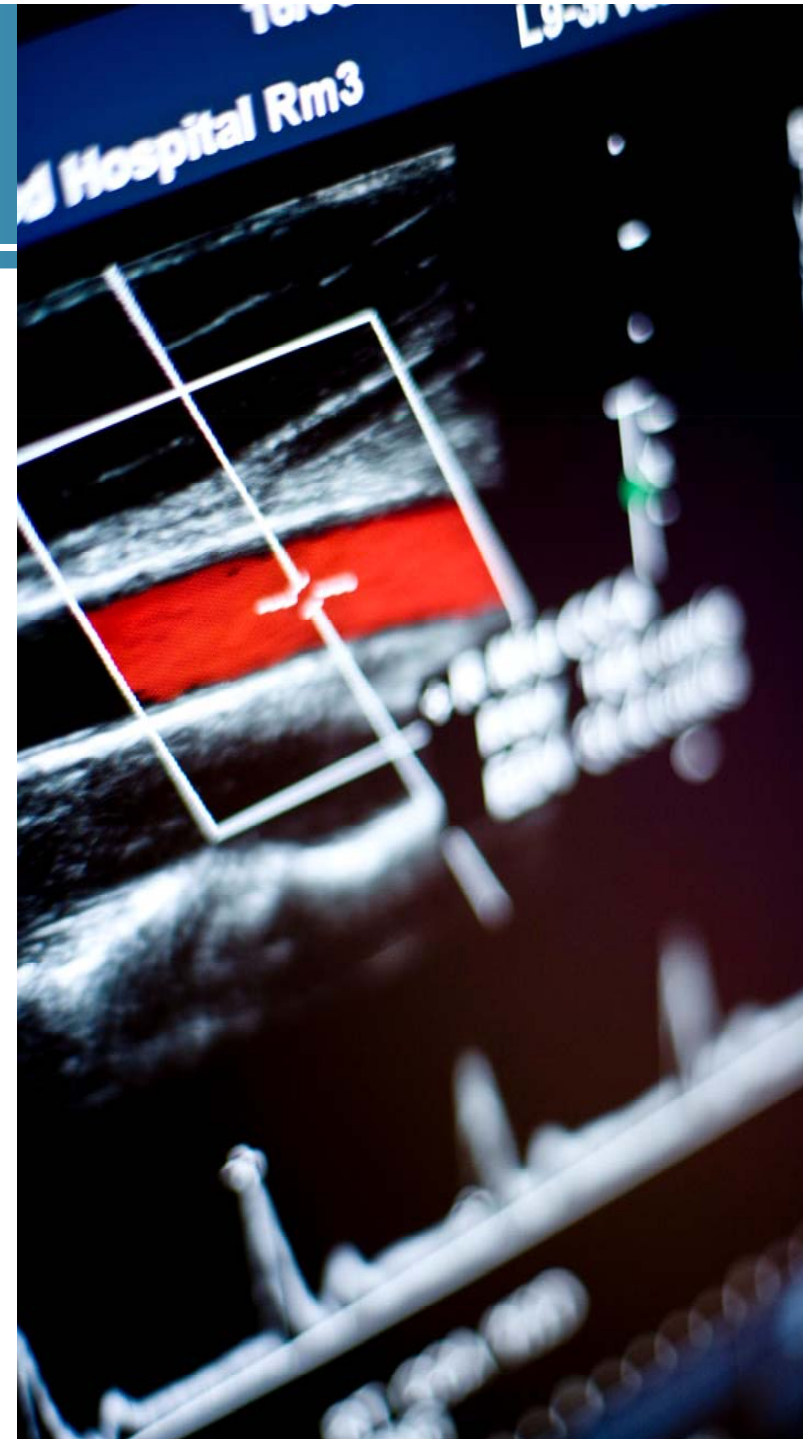
4 November 2010

► Harvard study – 17yrs on

“Although much good work has been carried out there is a sense at the coalface of hospital medicine not a lot has changed. Why not? What can be done about it?”

Scott I, Poole P, Jayathissa S. Int Med J. 2008

We don't know the real rates of harm – we don't have the data systems to enable accurate collection





THE AUSTRALIAN SAFETY AND QUALITY FRAMEWORK

▶ Australian Safety and Quality Health Care Framework

Safe, high-quality health care is always:	What it means for me as a consumer or patient:	Areas for action by people in the health system:
<p>2. Driven by information</p> <p>This means:</p> <ul style="list-style-type: none"> • using up-to-date knowledge and evidence to guide decisions about care • safety and quality data are collected, analysed and fed back for improvement • taking action to improve patients' experiences 	<p>My care is based on the best knowledge and evidence.</p>	<p>2.1 Use agreed guidelines to reduce inappropriate variation in the delivery of care</p> <p>2.2 Collecting and analysing safety and quality data to improve care</p>
	<p>The results of my treatment and my experiences are used to help 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>



▶ Framework Consultation Outcomes

What matters to consumers:

- Involve them so that they can make decisions about their care and plan their lives
- To learn from patients and carers experiences
- To take action to prevent or minimise harm from healthcare errors

▶ Framework Consultation Outcomes

What matters to those working in the health system:

- Improve access for patients
- Reduce unjustified variation in standards of care
- Restructure funding models to support safe, appropriate care

▶ Where were (are) we?

National and state reporting had few elements of **clinical quality** – they focussed on access, throughput, cost, service volumes and descriptives, population health, payments

Reporting for **safety** was generally poorly understood, with little measurable yield or benefit from the rollout of incident reporting systems across most states and private hospital ownership groups

Patient experience was not routinely and separately addressed as part of reporting

National data collections were reported **retrospectively**, with a **time lag and a lack of granularity** that did not support targeted feedback, analysis and action for improvement

▶ Where would we like to be?

- Measures of appropriateness of care – are we doing it right?
- Measures of effectiveness– are we getting it right?
- Measures of safety – are we causing harm?
- Measures of patient experience – are we listening and being patient-centred?

▶ Principle Domains for Patient Safety and Quality National Datasets

- 1. Core, hospital based outcomes indicators**
- 2. Patient safety reporting for hospitals**
- 3. Patient experience and patient satisfaction**
- 4. Practice-level indicators for primary care**
- 5. Clinically specific measures of appropriateness and effectiveness**

▶ NHHN Agreement

Performance Accountability Framework

- National Performance Authority
- COAG Reform Council
- ACSQHC
- Lead Clinicians Groups

▶ NHHN Agreement

Performance and Accountability Framework

18b: ‘national clinical quality and safety standards developed by the ACSQHC’

National Governance

19d: ‘continuation and expansion of the role of the ACSQHC to set national clinical standards for the delivery of health services’

▶ NHHN Agreement

The Australian Commission on Safety and Quality in Health Care

Objectives

E27: ‘ New national clinical standards and strengthened clinical governance will support clinicians to lead the drive towards continuous improvement in quality and safeguarding high standards of care. ’

▶ ACSQHC Legislation

9. Functions of the Commission

- (e) To formulate, in writing, standards relating to health care safety and quality matters

- (l) To formulate model national schemes that:
 - (i) Provide for the accreditation of organisations that provide health care services; *and*
 - (ii) Relate to health care safety and quality matters

Australian Parliament 29 September 2010

▶ Standards

1. Health Service Standards

- NSQH Standards, ACHS Standards
- Concerning systems and process development
- For internal service assessment or accreditation

2. Clinical Standards

- Clinical Standards for Heart Disease (NHS QIS)
- Focus on appropriate clinical practice
- Detail a clinical process
- For service specific or technical area of practice

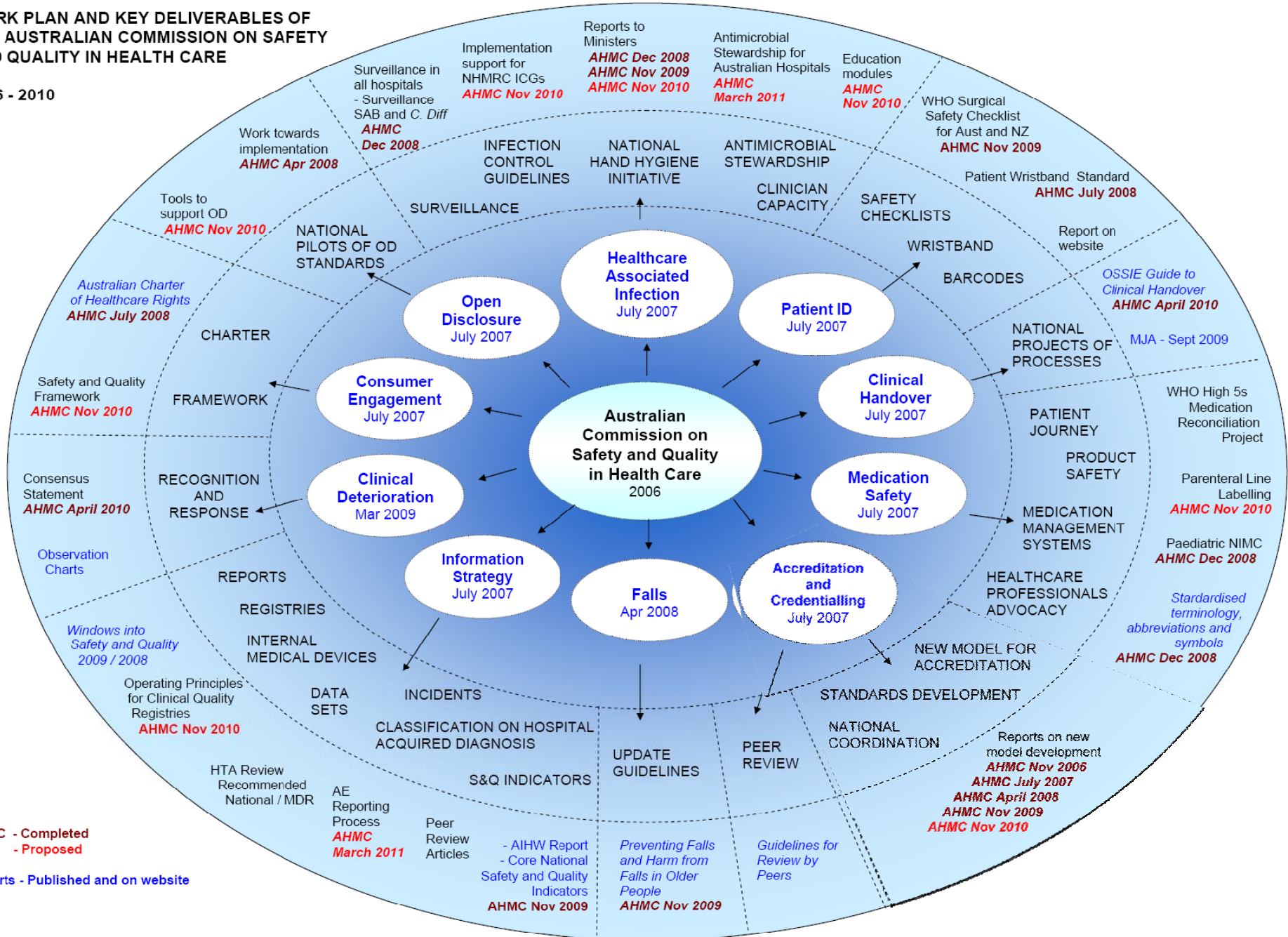
▶ AHMC Considerations

Paterson Review (2005)

“That Ministers be provided with a plan to transform accreditation arrangements to enhance the role of accreditation in both quality improvement and in the implementation of agreed national standards.”

WORK PLAN AND KEY DELIVERABLES OF THE AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

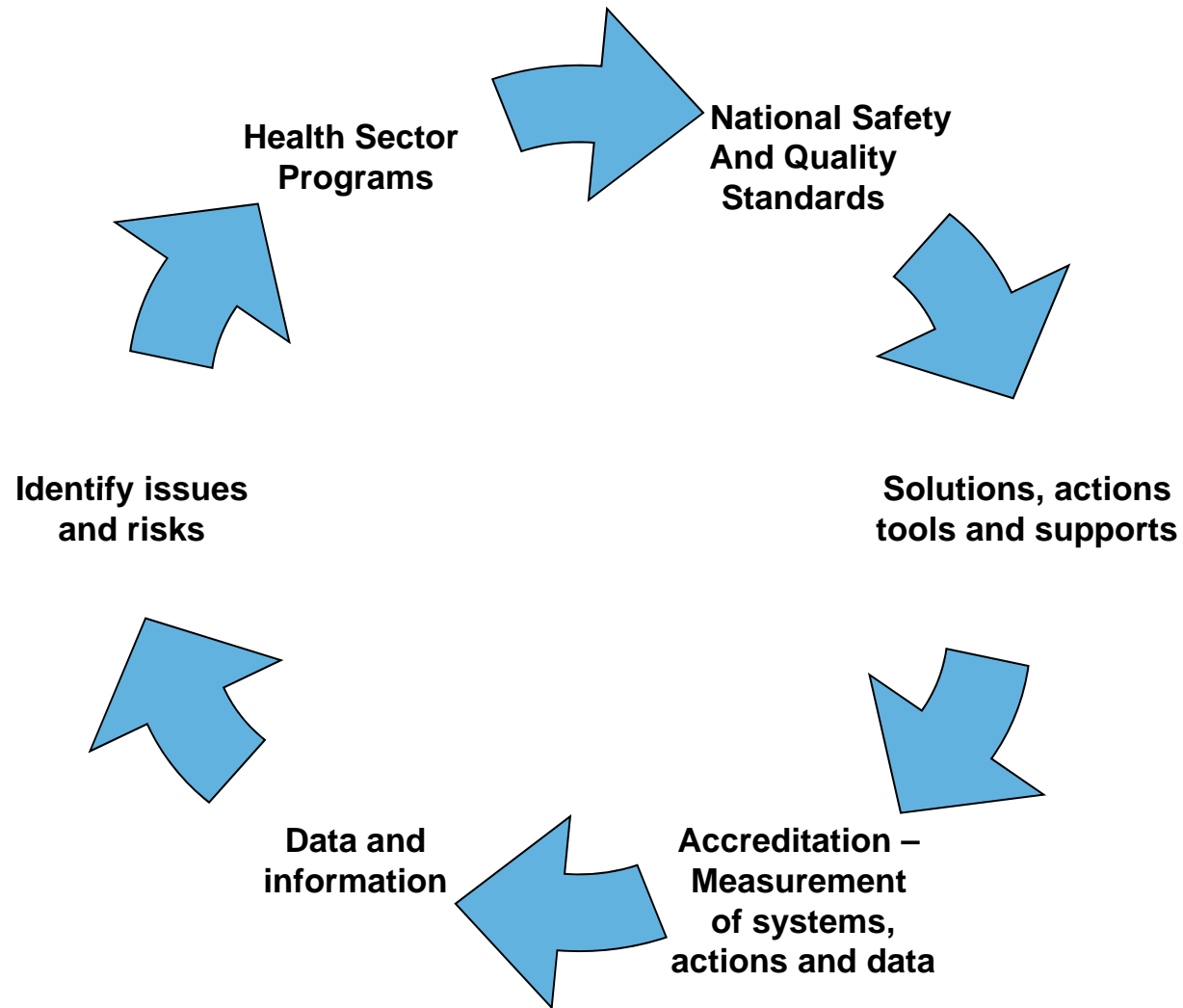
2006 - 2010



AHMC - Completed
- Proposed

Reports - Published and on website

▶ The Australian Quality Improvement Cycle



▶ NSQH Standards

Process

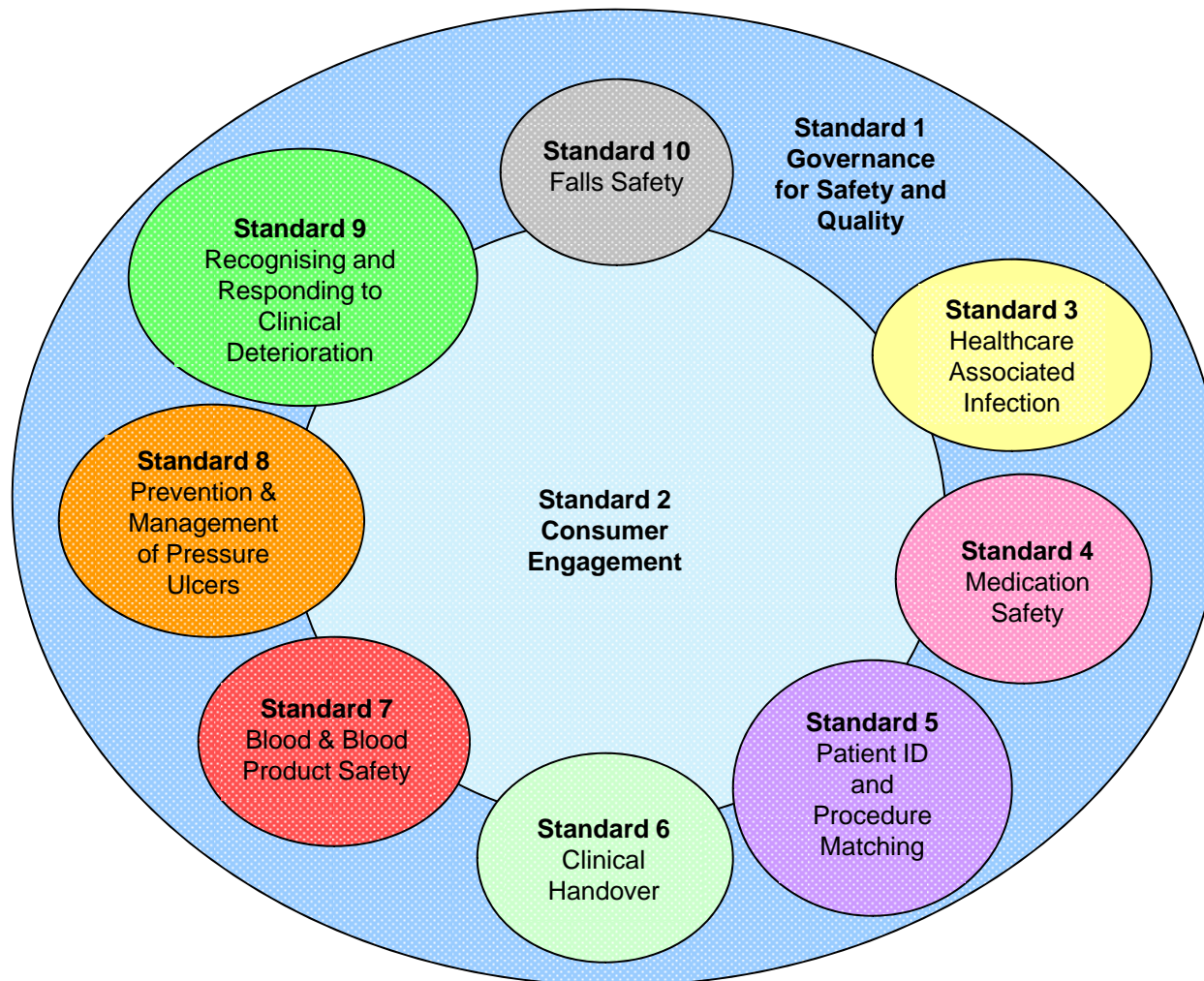
- Development occurred over the last 18 months
- Standards were selected by using international and national evidence
- Focused on the areas where:
 - ❖ Impact is on large number of patients
 - ❖ Known gap between the current situation and best practice outcomes
 - ❖ Improvement strategies exist that are evidence-based and achievable
- Development involved collaboration with jurisdictions, experts, consumers and key stakeholders

▶ Structure of Standards

- **Standard** - statement of intended actions & strategies
- **Statement of intent** - aspirational statement or desired outcome for the standard
- **Context** - statement on the context in which the Standards must be applied
- **Criteria** - the major components of the actions and strategies to meet the standard
- **Item** - the required activities to meet the criteria
- **Measure** - the requirement to demonstrate compliance to monitor the effective implementation and continuing successful operation of the standard

▶ 10 National Safety and Quality in Healthcare Standards

National Safety and Quality Healthcare Standards



▶ Measures of Health Service Standards

Structure

- Consumer participation in a range of activities
- Evidence that clinical workforce has access to medicines information at the point of care
- Evidence of policies for systems of use for blood and blood product management exist
- Evidence of documentation within discharge planning of referral to appropriate support for patients at high risk of falls post discharge

▶ Measures of Health Service Standards

Process

- Staff compliance with Infection Control Guidelines
- Evidence that a documented and structured process for clinical handover is in use
- Evidence that prevention interventions for pressure ulcers are documented in the health service record
- Evidence that recognition and response systems for clinical deterioration are monitored to ensure their appropriateness and effectiveness

▶ Measures of Health Service Standards

Outcome

- Proportion of inpatients with identification bands that accurately match the patient's identity
- Proportion of patients receiving blood where there is documented consent
- Proportion of patients with documented pressure ulcers and their state of severity
- Proportion of observation charts with complete sets of observations



Thoughts for Private

- A number of areas 'not met'
 - Agree with intent (reasonable)
 - Challenge with non-employed clinical staff
- Principles underpinning the standards apply to all health organisations
 - Recommend a risk focus to apply

▶ Quality Standards

What is a Clinical Standard?

DoHA

‘National clinical standards are used to define the levels of performance that are expected of an individual, a unit, a hospital, a practice or a healthcare system’

Davis (1997)

‘Standards are the criteria or set of rules that describe the expected levels of clinical and system behaviour as well as courses of action based on research and experience’

John Wakefield, Queensland Health:

‘A statement of a level of performance to be achieved’

▶ NICE Quality Standards

Definition

‘A NICE Quality Standard is a set of 5-10 specific, concise quality statements and associated measures that:

- Act as markers of high quality, clinically cost effective patient care across a pathway or clinical area
- Are derived from the best available evidence from NICE guidance and other sources accredited by NHS Evidence, and
- Are produced collaboratively with the NHS and social care, professionals, along with their patients and service users’

❖ National Quality Board 29 June 2010

▶ NICE Quality Standards

Typical process

- Prioritization
- Evidence gathering and synthesis
- Agreement on key components that form the standard
- Development of indicators
- Promulgation of the standard and indicators
- Implementation of the indicators as routine local quality reporting
- Monitoring the progress against the indicators

▶ NICE Quality Standards

Prioritization process

- **Based on evidence in the following areas:**
 - **Quality of care (including experience)**
 - **Potential to improve quality**
 - **Cost to and burden on the NHS**
 - **Prevalence, mortality and health burden on the population**
 - **Considering equalities implications**

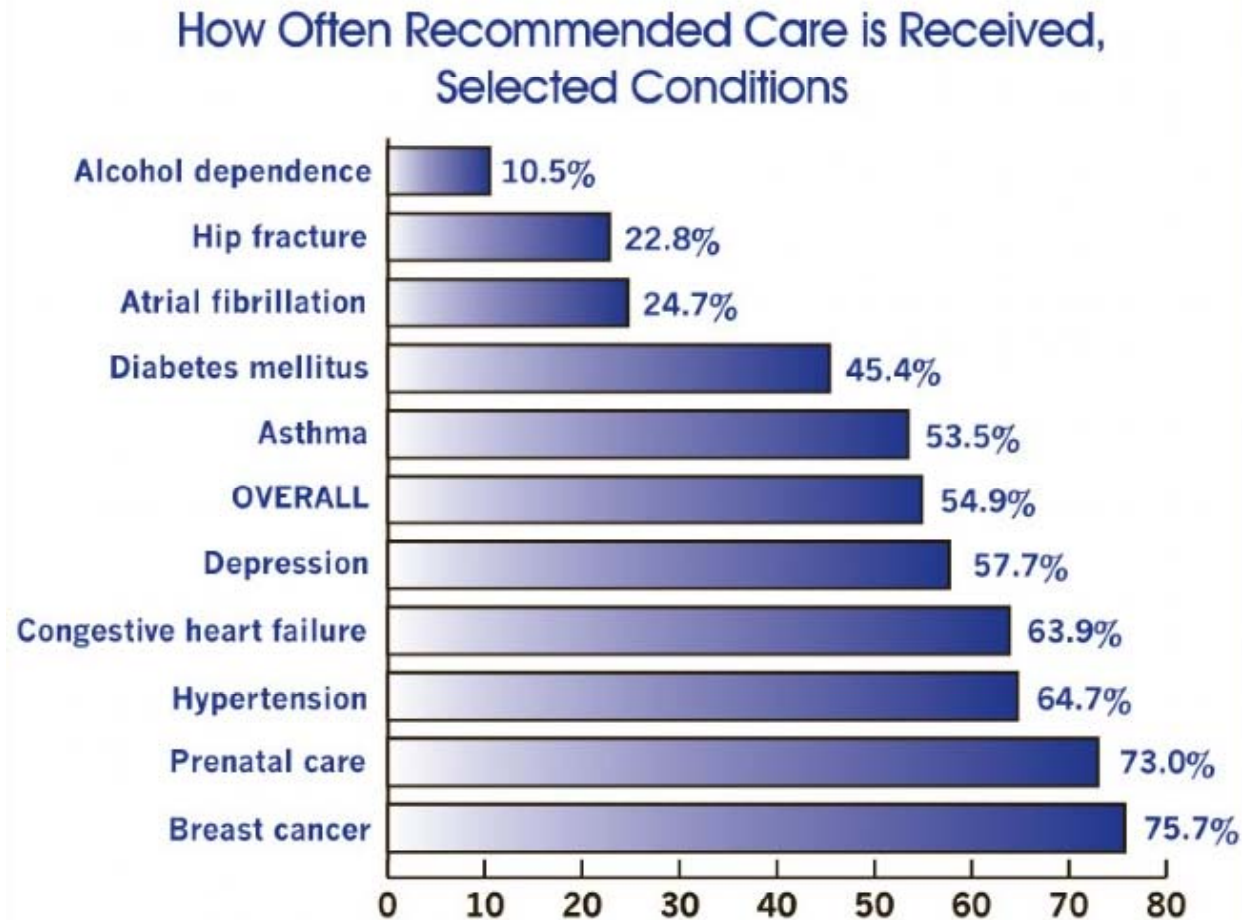
▶ NICE Quality Standards

Quality Measure

‘A key part of the Quality Standard is the measure that accompanies each quality statement. This includes advice on where or how to collect the information against it, to help organisations and commissioners in measuring and assessing their care against the NICE Quality Standard. Measures are drawn from those that already exist where possible and supplemented where required with high level indicators.’

❖ National Quality Board 29 June 2010

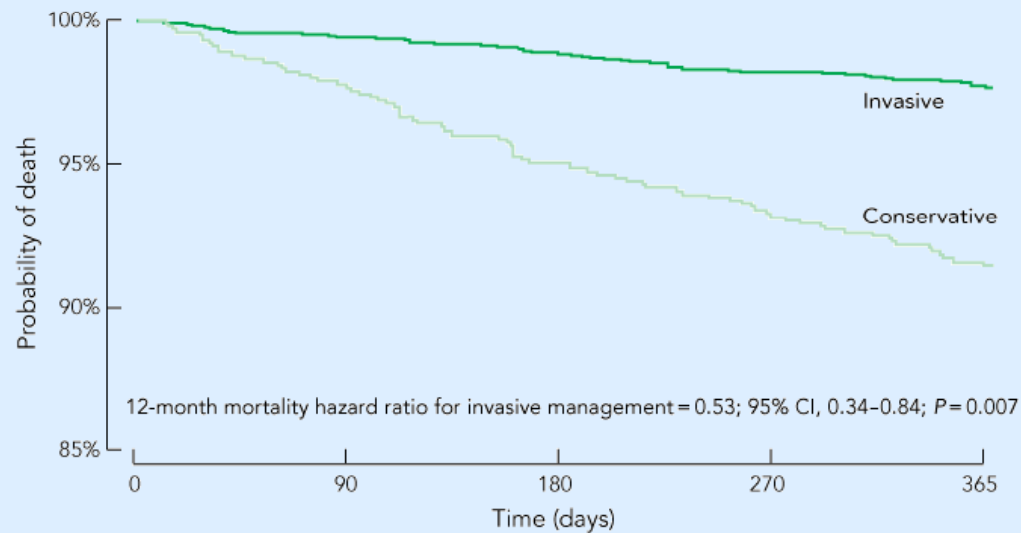
▶ APPROPRIATENESS – McGlynn: NEJM (2003)



Source: McGlynn, Elizabeth; Asch, Steven; Adams, John et al. (2003). "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine* 348; 26, June 26, p. 2643. (www.nejm.org)

▶ Appropriateness – ACACIA Registry

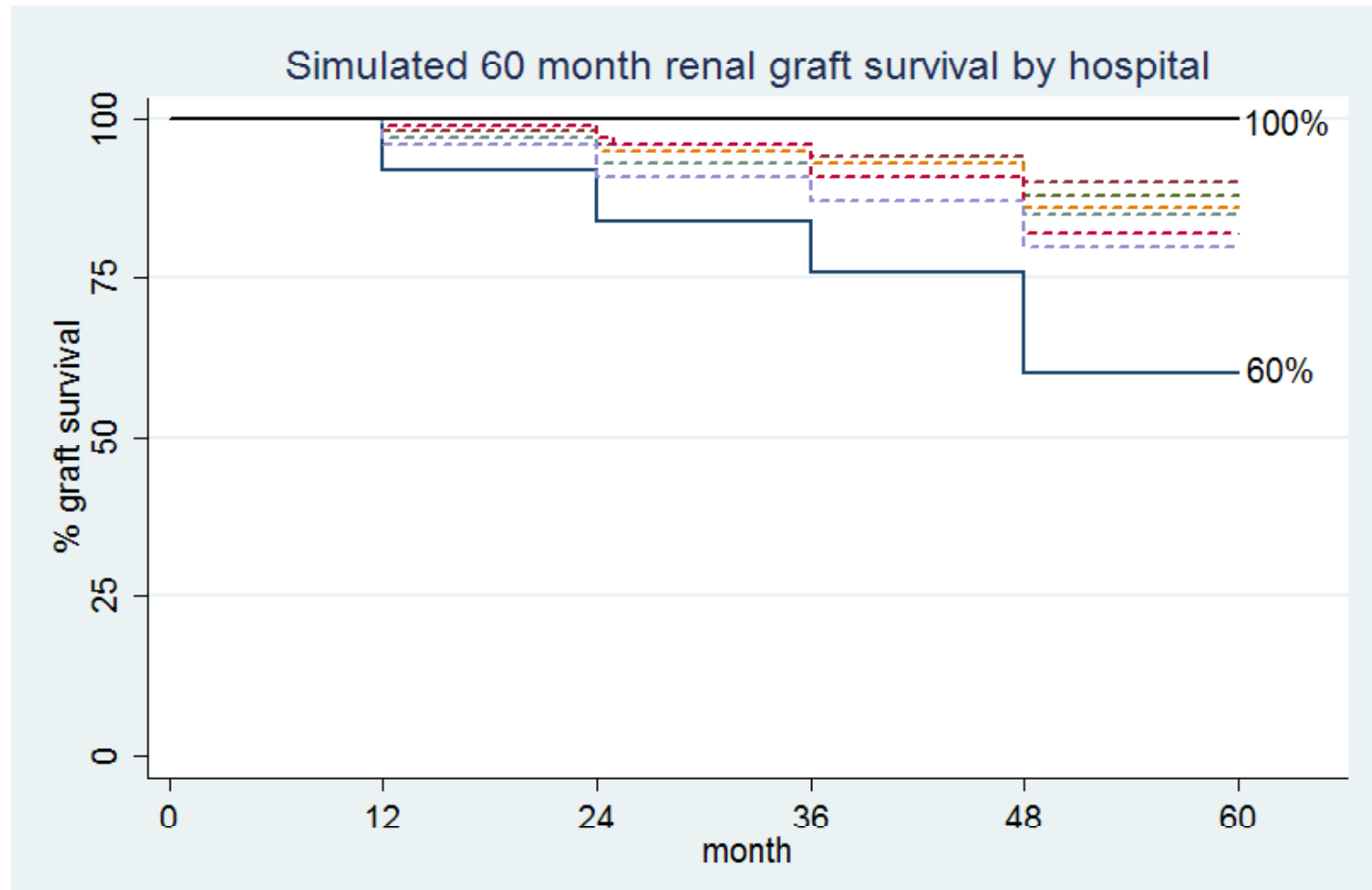
9 Kaplan–Meier survival curves for invasive versus conservative management among patients surviving to hospital discharge



Time (days)	Patients surviving				
	0	90	180	270	365
Invasive	1760	1747	1735	1716	1437
Conservative	867	846	820	800	641

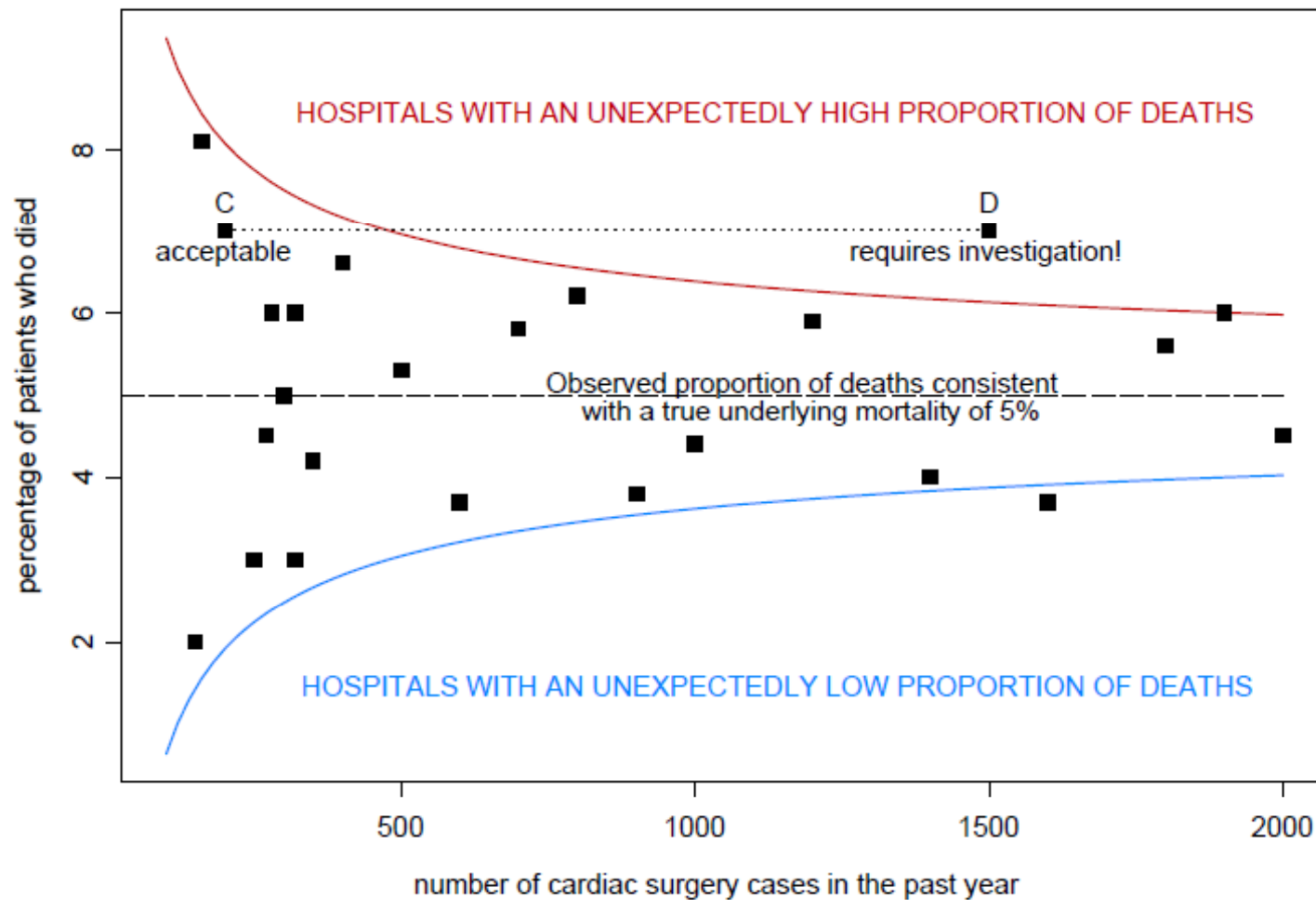
Chew D, et al, Invasive management and late clinical outcomes in contemporary Australian management of acute coronary syndromes: observations from the ACACIA registry, MJA 2008; 188 (12): 691-697

▶ Effectiveness - Outcome measurement



► Display of data – funnel plot

hypothetical example of deaths following cardiac surgery



Peter Baghurst, *Scorecards, league tables and funnel plots for comparing health-care performance against hospitals*, www.achsi.org/pdf/wed.cc.baghurst.pdf

▶ NICE Quality Standards

Sir Andrew Dillon, CE of NICE

- ‘They are as much for the public and they have been written in a way that will allow the public to get an understanding of what they can get as an individual’
- ‘It is a way that they can hold the NHS to account’

► Display of data - “funnel table”

Medical indicators

The medical indicators cover in-hospital mortality, complication of surgery, readmission rate and the rate of very long stay patients. Hospital performance for each medical indicator is outlined in the table to the right. Where a hospital's performance against an indicator has been identified as unfavourable, the results of the investigation are provided.

LEGEND
 Hospital v State: satisfactory ✓
 Hospital v State: favourable ★
 Hospital v State: unfavourable ●
 Hospital v State: indicator not applicable □

PEER GROUP	HOSPITAL	MEDICAL							
		AMI IN-HOSPITAL MORTALITY	AMI READMISSION	AMI LONG STAY	HEART FAILURE IN-HOSPITAL MORTALITY	HEART FAILURE READMISSION	HEART FAILURE LONG STAY	STROKE IN-HOSPITAL MORTALITY	PNEUMONIA IN-HOSPITAL MORTALITY
PRINCIPAL REFRERAL AND SPECIALISED	CAIRNS BASE HOSPITAL	✓	✓	✓	✓	✓	✓	✓	✓
	GOLD COAST HOSPITAL	✓	✓	✓	✓	★	✓	✓	✓
	MATER CHILDRENS PUBLIC HOSPITAL								
	MATER MOTHERS PUBLIC HOSPITAL								
	NAMBOUR GENERAL HOSPITAL	✓	✓	✓	✓	✓	✓	✓	✓
	PRINCESS ALEXANDRA HOSPITAL	✓	✓	✓	★	✓	✓	✓	★
	ROYAL BRISBANE AND WOMENS HOSPITAL	✓	✓	✓	✓	✓	✓	✓	✓
	ROYAL CHILDRENS HOSPITAL								
	THE PRINCE CHARLES HOSPITAL	★	✓	✓	★	✓	✓		★
	THE TOWNSVILLE HOSPITAL	★	✓	✓	✓	✓	✓	✓	✓
	BUNDABERG BASE HOSPITAL	✓	✓	✓	✓	✓	✓	✓	✓
	CABOOLTURE HOSPITAL	✓	✓	✓	✓	✓	✓	✓	✓
LARGE	HERVEY BAY HOSPITAL	✓	✓	✓	✓	✓	✓	✓	
	IPSWICH HOSPITAL	✓	●	✓	✓	✓	✓	★	
	LOGAN HOSPITAL	✓	✓	✓	✓	✓	✓	✓	
	MACKAY BASE HOSPITAL	✓	✓	✓	✓	✓	✓	✓	
	MARYBOROUGH HOSPITAL							✓	
	MATER ADULTS PUBLIC HOSPITAL	✓	✓	✓	✓	✓	✓	✓	
	MOUNT ISA BASE HOSPITAL				✓	●	✓	✓	
	QUEEN ELIZABETH II JUBILEE HOSPITAL	✓	✓	✓	✓	✓	●	✓	
	REDCLIFFE HOSPITAL	✓	✓	✓	✓	✓	✓	✓	
	REDLAND HOSPITAL	✓	✓	✓	✓	✓	✓	✓	
	ROCKHAMPTON HOSPITAL	✓	✓	✓	✓	✓	✓	●	
	TOOWOOMBA HOSPITAL	✓	✓	✓	✓	✓	✓	✓	

	MEDICAL							
	AMI IN-HOSPITAL MORTALITY	AMI READMISSION	AMI LONG STAY	HEART FAILURE IN-HOSPITAL MORTALITY	HEART FAILURE READMISSION	HEART FAILURE LONG STAY	STROKE IN-HOSPITAL MORTALITY	PNEUMONIA IN-HOSPITAL MORTALITY
MEDIUM AND SMALL	ATHERTON HOSPITAL				✓	✓	✓	✓
	AYR HOSPITAL				✓	✓	✓	✓
	BEAUDESERT HOSPITAL							✓
	BILOELA HOSPITAL							
	BOWEN HOSPITAL							✓
	CALCUNDRA HOSPITAL				✓	✓	✓	✓
	CHARTERS TOWERS HOSPITAL							✓
	COLLINSVILLE HOSPITAL							✓
	COOKTOWN HOSPITAL							✓
	DALEY HOSPITAL				✓		✓	✓
	EMERALD HOSPITAL							✓
	GLADSTONE HOSPITAL				✓	✓	✓	✓
	GOONDIWINDI HOSPITAL							✓
	GYMPIE HOSPITAL				✓	✓	✓	✓
	INGHAM HOSPITAL				✓	✓	✓	✓
	INNISFAIL HOSPITAL				✓	✓	✓	✓
	JOYCE PALMER HEALTH SERVICE							✓
	KINGARUY HOSPITAL				✓	✓	✓	✓
	LONGREACH HOSPITAL							
	MAREEDA HOSPITAL				✓	✓	✓	✓
	MOSSMAN HOSPITAL							✓
	PROSERPINE HOSPITAL							✓
	ROMA HOSPITAL				✓	✓	✓	✓
	ST GEORGE HOSPITAL							✓
	STANTHORPE HOSPITAL				✓			✓
	THURSDAY ISLAND HOSPITAL							✓
	TULLY HOSPITAL							✓
	WARWICK HOSPITAL				✓	✓	●	✓
YEPPON HOSPITAL				✓	✓	✓	✓	

▶ Clinical Quality Standards

Monitoring and Standards Quality Improvement

- Normal clinical variation means a standard will not always be correct for every patient
- Indicators should never be met 100% time
- Monitoring the variation is an important QI process