



Submission to the Review of Future Governance Arrangements for Safety and Quality in Health Care

1. Introduction

- 1.2. The Australian Nursing Federation (ANF) is the national union for nurses in Australia with branches in each state and territory. The ANF is also the largest professional nursing organisation in Australia. The ANF's core business is the industrial and professional representation of nurses and nursing in Australia.
- 1.3. The ANF's 140,000 members are employed in a wide range of enterprises in urban, rural and remote locations in the public, private and aged care sectors, including hospitals, health services, schools, universities, the armed forces, statutory authorities, local government, offshore territories and industries.
- 1.4. The ANF participates in the development of policy in nursing, nursing regulation, health, community services, veterans affairs, education, training, occupational health and safety, industrial relations, immigration and law reform.
- 1.5. The ANF recognises that the initiatives and strategies focusing on the imperative of improving the safety and quality of health care for the Australian community are vital to sustain. Also, ANF recognises the need for ongoing development of innovative ways to support the health workforce in this area in the future.
- 1.6. In providing this submission the following comments are made to set the scene for the ANF's position and recommendations.

2. Safety and quality in health care – a critical challenge

- 2.1. The ANF recognises that a number of recent studies, investigations and inquiries into health care in Australia and overseas have highlighted the need for clinicians (nursing, medical and allied health professionals), managers, policy makers and educators to look carefully at the quality and safety of care now being delivered by health services in Australia. This can only be done having accurate and comprehensive information about the situations where things go wrong or are just caught in time to prevent something going wrong during a person's diagnosis, treatment or care in the health system.

- 2.2 Studies in the USA, UK, Australia, New Zealand, Canada and other countriesⁱ about the level of adverse events in hospitals have found that preventable adverse events occur for approximately 10% of people admitted to hospital.
- 2.3 The 'Quality in Australian Health Care Study'ⁱⁱ found that there are clear variations in the quality of care provided. Approximately 16% of inpatients in Australian hospitals experience an adverse event, with just over half of these being preventable. Later analysis of the data suggested that 2% of all people admitted to a health service are likely to experience a serious adverse event while in the service's care. Further, 0.3% of people admitted with an acute health care problem die due to an adverse event while in the care of the health service. Studies conducted in other countries have had findings consistent with the Australian study, reinforcing that this is not merely a national aberration.
- 2.4 Interventions intended to provide diagnostic information, care or treatment for particular conditions can inadvertently produce harm to patients and this risk is particularly high in the acute hospital environment. It is interesting to note that there is at last growing recognition that the primary causes of adverse events are not in the exotic or technologically complex end of health care but can be attributed to relatively 'ordinary' situations such as medication errors, falls, and pressure ulcers – often areas that are regarded to be particularly within the domain of nursing work. The other areas where research clearly shows that failures can have catastrophic consequences for health consumers are in the areas of:
- information provision to enable competent decisions to be made by health consumers, health professionals, health policy and planning personnel; and
 - communication:
 - between the clinical team members and health consumers,
 - within the clinical team, and
 - from and to the clinical team with other key services such as diagnostic services, peri-operative services, pharmacy, nutrition and dietetic services etc.ⁱⁱⁱ
- 2.5 This research has focused serious public attention on the alarming incidence of adverse outcomes for people receiving treatment and care in the health system. With such profoundly disturbing results, there is no doubt that this research has been instrumental in advancing the emphasis on quality and safety in health care.

- 2.6 While there was some criticism of the study's results, there is consensus at Government and community level that the high personal and financial costs due to the risks to health consumers in the Australian health system deserve both close attention and considerable sustained investment across Australia. It is clear from the Australian study and the international studies that the risks are consistent in each jurisdiction therefore it is important that the initiatives to address these risks are national efforts rather than state or territory specific. While local ownership and energy are critical to the success of strategies designed to reduce risk to health consumers, duplication of wisdom, effort and lessons learnt should be shared.
- 2.7 How and who should lead the national strategies in the rather fraught arrangements that make up the federal health system in Australia is a fundamental question for this review and ANF will comment further on this below.

3. The governance of safety and quality in health care – Terms of Reference of the Review

3.1 Review of the work of the Australian Council for Quality and Safety

There is no doubt that the work of the Council to date is impressive and must be viewed in the light of the enormous challenges that confronted them. The task of making the health care system safer is not likely to be achieved overnight.

- 3.2 The health system is a complex system that has evolved over centuries and is not merely health science and technology but an intricate microcosm of society as a whole. While technology assists in treatment and care it is the human: values, traditions, capacity to analyse and make decisions, lifestyle, and endeavour, that fashion the culture of those humans working in the health system. Traditions, values, attitudes and behaviours do not transform easily and any efforts to tackle these has to be done in the knowledge that the efforts must be sustained over time, often generations, to effect the fundamental change in thinking that is required.
- 3.3 A number of the initiatives of the Council should particularly be recognised that go to the heart of changing the culture of the health system. For example:
- picking up the discourse and beginning the long term work around how workforce issues impact upon the quality and safety of health care;^{iv}

- tackling the barriers to open disclosure to health consumers around adverse events that occur while they are under the care of the health system;^v
- recognising the centrality of the health consumer and continuing the important work of the consumer focus collaboration in:
 - driving initiatives that can assist consumers being informed and in control of their health care,
 - continuing the debate on what strategies are required to assist consumers to participate in health planning, policy and evaluation decision making of the health services at national, state and territory as well as local levels, and
 - providing sensible and generic guidelines for the management and resolution of complaints in the health system, recognising their potential as consumer reported incidents for quality improvement purposes,^{vi} and
- continuing the quest to sponsor and disseminate a nationally consistent incident management system to *help to identify trends in incident types and identify and maximise improvement opportunities across the whole system.*^{vii}

3.4 The ANF is of the view that there is still much work to be done in these and many of the other meritorious areas that the Council has identified, and that effort and investment are required for the long term if they are going to make a difference to the health consumer's experience in the health system.

3.5 The ANF also takes the view that regrettably, the constituency of the Council has not included nursing or midwifery representation at the highest level. While acknowledging that several of the members of the Council have a nursing or midwifery background and have contributed significantly to the work of the Council, none of them would be regarded as representing the professions of nursing and midwifery. They do not have the extensive infrastructure and formal professional networks that enable the vital information flows and feedback throughout the nursing profession. The coalition of professional nursing organisations that make up the Australian Peak Nursing Forum have such mechanisms. The Forum constituency is:

- The Council of Deans of Nursing and Midwifery (Australia and New Zealand);
- The Australian Nursing and Midwifery Council;
- The Australian Nursing Federation;

- Royal College of Nursing Australia; and
- Congress of Aboriginal & Torres Strait Islander Nurses.

3.6 Without the support, input and links of organisations such as these the ANF has support for the view that the majority of the more than 200,000 nurses working in Australia have not been exposed directly or even indirectly to the work of the Council. Given that the nursing labour force is the largest proportion of the workforce in the health system; and taking into account their fundamental and constant role in the clinical team and providing direct care and treatment to health consumers, the ANF considers that nurses are the key to improving the safety and quality of care.

3.7 The ANF is also of the view that consumer representation and contribution should be stronger. Once again, without denigrating the very fine contribution to the consumer representatives that have sat on the Council, as the focal point of all the initiatives of Council, stronger representation from the community and links to community organisations must underpin the Council philosophy of the centrality of the consumer experience and the need for strong consumer participation in all facets of planning, policy development and evaluation of health services.

3.8 **Future Governance arrangements for leadership and coordination for safety and quality in Australia**

The ANF strongly supports the continued existence of a national organisation that has a specific role in providing leadership to support the improvement in the quality and safety of health care across Australia. A national organisation is more appropriate to relate to health professionals and their professional organisations than separate state or territory based organisations. As stated above, the issues around the quality and safety of care are not state or territory specific – the approach needs to be nationally consistent and utilise the finite expertise and resources available.

3.9 The ANF also considers that the initiatives that have already commenced require ongoing national leadership and high level government sponsorship to prevent them suffering the same fate of many other significant strategies in health have suffered when they lose their novelty and the *raison d'être* is lost in the annals of time and new government priorities.

3.10 As would be expected from the remarks made above, the ANF is very strongly of the view that nursing representation is required at the highest level and that the nurse representatives are able to both provide feedback and receive advice from nurses. We would recommend having nominees of the Australian Peak Nursing Forum appointed to the Council and that nurse representatives are included on all working groups, sub-committees and reference groups working with the Council (see details of the Australian Peak Nursing Forum at *Appendix A*).

There needs to be more effective communication with the nursing profession and nurses individually. Nursing makes up over half the health care workforce and of course nurses find themselves right at the 'pointy end' of care delivery and safety.

- 3.11 The ANF would urge that the Council establishes more formal processes for obtaining advice on their planned activities, including consultation with national consumer organisations, nursing organisations and other health professional organisations.
- 3.12 It is also strongly recommended that the Council works with the states and territories more collaboratively using the conduits of the Australian Health Ministers' Conference, the Australian Health Ministers' Advisory Council (AHMAC), the National Health and Medical Research Council (NH&MRC), health professional organisations (usually having state and territory branches), community and specific health related consumer organisations so that there is improved coordination and consistency of approaches around activities. While the commitment and resources of states and territories are essential for success in this area, the lack of consistency and duplication of effort is counter productive.
- 3.13 As far as infrastructure for the governance of safety and quality at a national level, there needs to be a substantial and ongoing commitment from government as well as a willingness to use the influence that governments have in their role as the funding and regulation agencies for the health system to make certain that reasonable systems and standards of environmental safety, treatment and care exist and are adhered to. It is therefore important that the Council is inherently linked to government to ensure a strong and demonstrable government stake in the safety and quality of care in the health system.
- 3.14 The form of the relationship requires some considerable thought as the Council will not always have a palatable political message for a government to pass on to its constituency. Yet, confronting the truths about the state of care and treatment in the health system is an imperative. The community is entitled to know the risks when they require or seek services. Therefore there needs to be the means for the Council to both work closely and effectively with government yet maintain a level of independence to be able to provide frank and fearless advice to the community, government and the people in the system about the risks, gaps and barriers in the health system, be they cultural, environmental, technological or resource based.
- 3.15 There is a need for a strong consumer voice on the Council and given that the whole focus of the work is to improve the safety and quality of care, this is going to be achieved in a far more transparent and non-paternalistic way if consumers are actively involved in all layers of the Council's work. The ANF considers that a community leader may in time be the most appropriate Chairperson for such a Council to emphasise this focus.

3.16 There is a need for the Council to be made up of a peak group of community, health, safety and quality leaders to drive the national quality and safety agenda. However, it is also vital to have the strategic and effective links to the state and territory governments, community organisations, professional organisations, quality and safety experts, research organisations as well as health service providers to get the ownership, 'buy in' and resources required to achieve the objectives of the Council.

3.17 **Priority areas for national action for transforming health care**
Clinical governance

Clinical governance is emerging as the framework for ensuring that appropriate organisational infrastructure is in place to provide safe and high quality care. Most importantly of all it recognises the human factors that come into play within that organisational infrastructure that are critical to the success or failure of care for health consumers. There is increasing recognition of the importance of developing strong collaborative relationships and partnerships between the nursing, medical and allied health clinical staff and management to build a safety culture. Such a culture requires monitoring and stewardship of the quality of health care as routinely and as diligently as the organisation's financial operations. However, while it is a term being used widely, the meaning of 'clinical governance' is not well understood.

3.18 Clinical governance is aimed at creating a culture in the organisation that enables the key people responsible for care to participate in the governance arrangements that provide the resources to provide that care – intellectual, personnel and financial resources.

3.19 Sadly, the notion of clinical governance, while being bandied about with abandon is little understood and only elements of it are evident in health organisations. An extract summarising the key elements of clinical governance is included (pages 8 and 9) as it highlights some of the critical areas that Council could continue to pursue initiatives as well as introduce innovative new strategies under a cohesive and useful umbrella:

Clinical governance covers an organisation's systems and processes for monitoring and improving services and provides a way to integrate previously disparate and fragmented approaches to quality improvement in health. It also links care and treatment improvement initiatives at the clinical team level directly to the governing body, the management and the financial divisions of the organisation.

Although efficient financial stewardship of a health service's budget is important, the focus on the quality of care and care outcomes is equally important and must drive the financial decision making. To achieve this there must be direct links between decision making at the corporate level and decision making at the clinical unit level where care is delivered to patients.

The four principles that guide the development and maintenance of clinical governance are:

- *building a culture of trust and honesty,*
- *fostering an organisational commitment to continuous improvement,*
- *establishing rigorous monitoring, reporting and response systems, and*
- *evaluating and responding to key quality and safety related aspects of organisational performance.*

Some key practical components of clinical governance include:

- *Systems to monitor and assess risks of harm and ensure that information is reviewed and analysed, lessons are learnt, critical actions taken to reduce or eliminate the risk, and the potential for improvement evaluated.*
- *Systems for organisational performance reviews, internal audits, incident reporting, consumer complaint management, risk assessment and management, clinical and peer review programs and clinical and organisational system research.*

- *Organisational decision making mechanisms such as clinical quality and review committees that review practices and act to change them if improvement is needed.*
- *Sound and well disseminated evidence based standards, policies, procedures, clinical guidelines, pathways and protocols that support safe, consistent care and are reviewed as issues arise.*
- *Staff (including VMOs) performance management, credentialing and development programs with unambiguous pathways to conduct, health and performance actions being taken by management.*
- *Targeted educational and development strategies aimed at changing entrenched cultures and embedding a culture focusing on quality improvement.*
- *Resources and information systems to support all the above.^{viii}*

All of the above is predicated upon professionals working collaboratively in a clinical team. However the reality is that health service organisations are made up of silos of health professional craft groups in a traditional power based hierarchy that do not reflect: contemporary educational preparation; professional accountability; gender equity; cultural equity; health science and technology; or the way that health services are organised. Until some of these fundamental cultural barriers to the notions of 'consumer centred care', 'team' and 'collaborate' are removed, the quest for a safer health system will be unattainable.

- 3.20 Competent clinical governance is also founded upon the proposition that there are a sufficient number of educated, skilled and experienced health professionals in the health system to provide leadership and an adequate workforce to offer the care and treatment required by health consumers across the spectrum of human conditions. Therefore it is imperative that the health workforce issues are not separated from the safety and quality agenda. There is also emerging evidence that the cultural barriers raised above have a direct bearing upon the work satisfaction and retention of particularly nurses in the health work force.^{ix}
- 3.21 The ANF is of the view that the Council would be in a strong position to drive the agenda for strengthening clinical governance in the health system, incorporating as it does many of the key elements to ensure a safe, consumer focussed organisation. Dealing with the very challenging cultural aspects is a priority and requires diplomacy and leadership at the highest level. Also the work in developing consistency in approaches to incident and complaints management must be continued.

3.22 **A 'just culture'**

There is much strength of feeling in the health system about the notions of 'blamelessness' and 'blameworthiness' yet the debate about the 'blamelessness', 'blameworthiness' and 'fairness' in the governance, safety and quality discourse has not yet been had in a meaningful way. While a fundamental element of clinical governance, this is of such importance that the ANF has identified it as a separate priority.

3.23. The ANF considers that this has become even more profoundly urgent given the recent events in NSW.

3.24 There is much work to be done across the health system in developing that '*collective understanding of where the line would be drawn between blameless and blameworthy actions*' so that individual health professionals, the community at large and the health system have an understanding of the boundaries. It is the ANF's view that the national Council could provide the leadership in facilitating this debate at the multiple levels at which it needs to occur, for example:

- across the health system,
- across the community,
- involving the media,
- involving the health 'watchdog' agencies, and
- involving the health professional registration authorities.

3.25 **Who is doing what that can be learnt from?**

It is well known that many health services initiate excellent safety and quality improvement activities that no one knows about and that are not reported back up the chain to the Council or across the system. With the excellent tool of the world wide web, the potential for a national clearing house of innovative and effective national, regional and local initiatives could be published and be accessible for a broader audience with the support of the Council.

3.26 The Clinical Information Access Project (CIAP) in NSW has proved a very valuable resource for clinicians, educators and researchers. The Council leverage and government sponsorship in the development and maintenance of such a rich information resource that is available to the public and private sectors of the health system across Australia is a way to share resources and improve the consistency of evidence based approaches to planning, policy and practice across the health system.

3.27 ***Sustaining other already commenced initiatives***

The ANF considers it critically important to continue to progress initiatives that have already been commenced, such as:

- continuing the discourse and the long term work around how workforce issues impact upon the quality and safety and safety of health care;
- continuing the work in breaking down the barriers to open disclosure to health consumers around adverse events that occur while they are under the care of the health system;
- continuing the focus on the centrality of the health consumer in driving initiatives that can assist consumers being informed and in control of their health care,
- continuing to investigate and promote strategies required to assist consumers to participate in the health planning, policy and evaluation decision making of the health services at national, state and territory as well as local levels, and
- continuing to promulgate the standards for the management and resolution of complaints in the health system, recognising their potential as consumer reported incidents for quality improvement purposes.

4. Conclusion

- 4.1 The ANF welcomes the opportunity to comment on the governance arrangements for safety and quality in Australia and is adamant that the nursing profession must have a much more significant role in future arrangements if the initiatives are going to have an impact across the clinical team and across the health system.

Endnotes

- i Brennan T, Leape L, Laird N *et al* (1991) "Incidence of adverse events and negligence in hospitalised patients: The results from the Harvard Medical Practice Study 1", 324 *New England Journal of Medicine*, 370 – 376; Leape LL, Brennan TA, Laird N, Lawthers AG, Localio AR, Barnes BA, *et al* (1991) "The nature of adverse events in hospitalized patients - Results of the Harvard Medical Practice Study II" 324(6) *New England Journal of Medicine*, 377-84; Wilson RM, Runciman WB, Gibberd RW, *et al* (1995) "The Quality in Australian Health Care Study" 163 (9) *Medical Journal of Australia* 458 – 471; Davis P, Lay-Yee R, Briant R, Ali W, Scott A, Schug S (2002) "Adverse events in New Zealand public hospitals I: occurrence and impact" 115 *New Zealand Medical Journal* (1167):U271; Davis P, Lay-Yee R, Briant R, Ali W, Scott A, Schug S (2003) "Adverse events in New Zealand public hospitals II: preventability and clinical context" 116 *New Zealand Medical Journal* (1183):U624; Vincent CA, Neale G, Woloshynowych M (2001) "Adverse Events in British Hospitals: preliminary retrospective record review" 322 *British Medical Journal* 517 – 519; Baker RG, Norton PG, Flintoft V *et al* (2004) "The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada" 170 (11) *Canadian Medical Association Journal*, May 25 - <http://www.cmaj.ca/cgi/content/full/170/11/1678>.
- ii Wilson RM, Runciman WB *et al* (1995) *op cit*.
- iii Review of Professional Indemnity Arrangements for Health Care Professionals (1992) *Compensation and Professional Indemnity in Health Care – A Discussion Paper*, Department of Health, Housing and Community Services, Canberra, February; Review of Professional Indemnity Arrangements for Health Care Professionals (1994) *Compensation and Professional Indemnity in Health Care – An Interim Report*, Australian Government Publishing Service, Canberra, February; Review of Professional Indemnity Arrangements for Health Care Professionals (1995) *Compensation and Professional Indemnity in Health Care – Final Report*, Australian Government Publishing Service, Canberra, November.
- iv Australian Council for Safety and Quality in Health Care (2003) *Safe Staffing – Discussion Paper*, Commonwealth of Australia, Canberra.
- v Australian Council for Safety and Quality in Health Care & Standards Australia (2003) *Open Disclosure Standard: A national standard for open communication in public and private hospitals, following an adverse event in health care*, Commonwealth Department of Health and Ageing, Australia, July.
- vi Australian Council for Safety and Quality in Health Care (2004) *Better Practice Guidelines on Complaints Management for Health Care Services*, Commonwealth of Australia, Canberra, July.
- vii Australian Council for Safety and Quality in Health Care (2004) *Fact Sheet – Incident Management Systems*, Commonwealth of Australia, Canberra, April.
- viii Health Care Complaints Commission (2003) *Investigation Report – Campbelltown and Camden Hospitals – Macarthur Health Service*, December, 187.
- ix Australian Council for Safety and Quality in Health Care (2003) *Safe Staffing – Discussion Paper*, Commonwealth of Australia, Canberra.