The Royal Australasian
College of Physicians

This submission was developed in response to the release of version 2 of the NSQHS Standards. Version 2 placed greater focus on partnerships with consumers as fundamental to ensuring safety and quality of healthcare and consisted of nine specific standards with fewer actions.

The Royal Australasian
College of Physicians

RACP Submission (2015): National Consultation on the draft Version 2 of the NSQHS Standards

Introduction

The safety and quality of health services are fundamental to patient care. Efforts to reduce patient harm and embrace patient-centred approaches have become a focus of health service delivery in every health organisation across Australia. Comprehensive national efforts to improve patient care and standardised approaches to best practice are already underway. To continuously cultivate an environment of excellence in care for our patients, it is pivotal that all health organisations seek to achieve quality and safety improvements at all times and that all health professionals strive to make patient-centred care a reality in everyday clinical practice.

The Royal Australasian College of Physicians (RACP) strongly values the work of the Australian Commission on Quality and Safety in Health Care (the Commission) and broadly supports the National Safety and Quality Health Service (NSQHS) Standards. The Standards' development has resulted in the collaborative pursuit of excellence and progress in the Australian healthcare context at the national, state and local levels. The Standards also provide comprehensive guidance on the design and implementation of the most appropriate hospital quality assurance systems and accreditation. The RACP believes the Standards will continue to be an important driver for clinical excellence in patient care in Australia.

Our submission includes some specific feedback on the Standards' content, structure, feasibility, and areas of improvements, drawn from the range of perspectives of our Fellows. The RACP proposes that Version 2 could be strengthened by also addressing environmental health issues organisation-wide, the issue of opioid prescription and use, as well as the specific vulnerabilities of people with a disability.

Structure and feasibility of the Standards

Broadly, the RACP's view is that Version 2 of the Standards is well set out, much simpler, easier to follow and understand than the previous version with clearly defined measures and outcomes. The changes made in Version 2 markedly underpin our clinicians' endeavours to protect the public from harm and to improve the quality of care for patients. The RACP also welcomes the addition of two new standards — *Standard CC: Comprehensive care'* and *Standard RH: Reducing harm* as well as its particular emphasis on partnerships with consumers. In particular, *Standard CC: Comprehensive care* is crucial to the effective management of chronic illness. In addition, having an effective vision in the introduction section can help provide purpose and a source of inspiration, motiving the readers to purse those objectives.

With regard to its implementation, Version 2 of the Standards is feasible, but the RACP has concerns about the clinical services capability of rural and remote health facilities to put it into practice. Recognising the challenges faced by these health organisations in delivering services in accordance with Version 2 is important. So too is considering how telehealth comes into play in supporting and improving the quality and efficiency of health service delivery in regional, rural and remote areas.

To advance its implementation, both the clinical services capability of rural and remote health facilities and the clinical process standards for telehealth activities need to be outlined in more detail.

Terminology

The RACP considers that some of the terms used in the standards need further refinement. One of our key concerns relates to the term 'episode of care' in the *Comprehensive Care (CC) Standard*. This term seems to indicate that comprehensive care only relates to episodic care. This is not true and contradicts the very spirit of the Standards: coordination of care. Comprehensive care is an approach that cares for the whole patient and all his or her needs along the continuum of care. Today, our health services are still largely built around acute, episodic models of care. This term could undermine reforms geared towards a system that supports comprehensive integrated health care. To realise comprehensive care, our health system needs to move away from its reliance on episodic paradigm of care and shift towards comprehensive, integrated and multifaceted models of care.

To help clarify the terms used in Version 2, the College would recommend the following amendments:

- **GS6 Variation in practice** should be phrased in a way that would not be interpreted as 'reduced variation towards best/ evidence-based'.
- The term 'understands and is responsive' reads better than just 'understand' in **GS8.1**.
- The issue with **GS17.2**, especially with the word 'signage' is that there has not been appropriate engagement with agencies with 'wayfinding' expertise, which encompasses components of architecture, graphics and human verbal interaction. We suggest GS17.2 be changed to either 'provides clear signage and direction using appropriate wayfinding expertise' or 'provides wayfinding and direction considering architecture, graphics and verbal human interaction'.
- The language "has systems" employed in **Comprehensive Care (CC) Standard** does not reflect the action required well, considering that the central issue is the institution of such systems. To reflect those actions better, we would recommend amending to "integrates systems" or 'enacts systems' are better word choices.
- Compared with the term 'consumers', the term 'patients' is more meaningful to clinicians.
- In **BP4.1**, the health organisation should have systems to manage wastage 'at all times', rather than 'in times of shortage'.

Of relevance, one of our geriatric medicine Fellows has provided detailed comments on the terminology used in version 2. These are included as Appendix A.

Additional issues for consideration

i) Climate change

Global climate change is a reality and the far-reaching effects it will have on human health and health service delivery can no longer be underestimated. Hospitals are very energy intensive; they are responsible for considerable environmental health impacts[i]. Evidence indicates that in New South Wales alone, health services contribute to more than 50 per cent of greenhouse gas emissions in the public sector[ii]. Health services' inadvertent contributions to environmental health problems run counter to the health sector's mandate to prevent and cure disease and clinician's oath to "do no harm", undermining public health and contributing to the impact on climate-vulnerable populations.

In view of this, the RACP has taken the perspective that there is particular urgency for the health sector to respond to climate change[1]. We strongly believe the health sector has a critical role to play in promoting greater sustainability and environmental health, grounding a greener, healthier future. Whole-of-system approaches to a more climate-friendly or greener and healthier system is the key. The World Health Organisation (WHO) recommends that the health sector engages in seven key areas to become more climate-friendly: energy efficiency, green building design, alternative energy production, transportation, food sustainability, waste reduction and water conservation[iii].

On this basis, the RACP urges the Commission to incorporate a more global vision of health and sustainability into Version 2 of the Standards, including new targets such as leadership support for climate-friendly hospitals, energy efficiency and waste management. This, in turn, would encourage coordinated actions from health organisations across Australia to create polices that foster climate-friendly hospital as well as reduce the health sector's environmental footprint overall.

ii)   Disability

Disability is an umbrella term covering physical, sensory, developmental, psychiatric, cognitive, age related physical disabilities and/or dementia. Currently, over four million Australians are living with a disability and, of these, 1.4 million have a profound disability[iv]. It is projected that the proportion of the population with disabilities will grow two to three times faster than the general population over the next 70 years[v]. Patients with disabilities are often not homogenous in respect to their needs and priorities, be they children, young people or adults[vi]. Patients with disabilities generally experience higher rates of medical disorders than those without disabilities, and these medical issues are often unrecognised. The approach to manage their conditions differs from patient to patient, depending on their age, gender, health status, cultural expectations and access to support systems.

Australia's disability system has undergone extensive changes in recent years to improve the lives of people with disability, their families and carers, and to address the challenges they face.

The RACP is pleased to see the recognition of the vulnerabilities of patients with cognitive impairment in the Standards. However, many of the draft standards seem to be written to support the needs of patients with delirium or dementia, rather than to a broad spectrum of patients with disabilities, such as developmental and/or physical disabilities. Furthermore, the Standards tend to focus more on mitigating errors, reducing the incidence of injuries or promoting evidence-based practice, instead of addressing the unique challenges faced by people with disability.

Developmentally and physically disabled patients are as vulnerable as patients with cognitive impairment. Their complex needs are increasingly visible within contemporary Australian society. Despite this, their vulnerabilities are further compounded by the absence of disability support services in the hospital setting, disharmony and lack of communication between health and disability sectors, and the fact that health care provision is centred on individual expert health professionals. Their needs and rights need to be acknowledged and taken into consideration. There is a compelling body of evidence suggesting that

---

[1] The RACP has developed a Global Consensus Statement titled, "Act now to reduce the damaging health impacts of climate change http://doctorsforclimateaction.org/consensus-statement/ .

developmentally disabled patients endure higher rates of morbidity, mortality, medical errors, illness-associated suffering, system inefficiencies and costs during their access to healthcare, compared with those without.

The RACP is strongly of the view that refinements of clinical practice to cater for the needs of vulnerable populations are essential. In other words, to make care for developmentally and physically disabled patients truly patient-centred, health assessments conducted by health professionals have to be comprehensive and thorough, from history taking and examination to diagnosis and management. More specifically, health assessments should include the nature of the disability, cognitive and motor skills, home life, proxy consent, support system, usual behaviours, new symptoms or changes, and background health history.

Australia's approach to providing disability support and services is changing. It is therefore imperative that the scope of the Standards complements and aligns with the Government's reform directions in the disability sector. As such, the College recommends the Commission:

- Broadens the scope of vulnerable patient groups covered in the Standards, to provide an overview of disabilities, and articulate both this patient group's unique needs and special requirements in the hospital setting.
- Integrates a "disability accreditation" component into yearly hospital accreditation to ensure the implementation of disability service standards.
- Reiterates the importance of the health and disability sectors working together to achieve best health outcomes for patients with disabilities and to support the establishment of formal working liaison relationships between the disability and health sectors.
- Advocates for the availability of a specialised developmental disability consultancy service in every health setting, considering that there is a lack of expertise in managing acute and chronic illnesses for adults with developmental disability.
- Encourages the development of disability policies that best reflect optimal care for patients with disabilities within the healthcare environment, so that their needs and goals can be effectively identified. This would be further bolstered by the provision of an explanation on how these new disability policies align with other health policies.
- Adds a criterion titled 'self-care and self-esteem' to the standard 'Reducing Harm'. The criterion should outline how health organisations could support patients with disabilities with their daily living tasks such as personal hygiene and toileting and minimise loss of dignity.
- Makes a particular comment about patients with disabilities on the section titled 'end of life care' that there needs to be a clear process in which healthcare providers verify the palliative care status of any patient with developmental disability before confirmation, as studies have identified that patients with developmental disability are often given palliative care status within minutes of their first clinical encounter on the basis of their disability rather than the nature of their acute illness. The inappropriate allocation of palliative care status could consequently result in terrible suffering and prolonged dying.
- Creates a section on challenging behaviours and highlights the fact that these behaviours are a form of communication. There is a need to understand the rationale behind these behaviours, as well as a need to take steps to manage and ameliorate these behavioural problems from a safety perspective, for both patients and staff.
- Considers supporting those already in employment, especially those in casual employment. Patients with disability often lose their positions as a result of frequent and prolonged hospital admissions coupled with a lack of contact with their

employers. This can be alleviated through discussions between the health care teams and employers including discussions on making new working arrangements. However, it is essential to obtain informed consent from patients first.

iii)   Pain Management

Both acute and chronic pain represents a substantial public health burden with devastating impacts on economic, social, and medical costs. Untreated or undertreated pain can compromise patients' everyday functional status and quality of life. For decades, opioids have been the mainstay therapy for pain management and remain to this day among the most effective analgesics available. Despite being the most effective analgesics, they are associated with adverse events such as reduced function, overdose, addiction and even death[vii]. It is therefore widely agreed that good practice in prescribing opioids is an integral part of pain management.

In recent years, the increased consumption of opioids has raised concern. Between April 2013 and March 2014, around 3 million people received at least one PBS-listed opioid analgesic in Australia[viii]. A surge in the use of opioids has been accompanied by increased opioid adverse events. This underlines the challenge of finding a delicate balance between managing pain relief and the risks of opioid use. The RACP believes that it is clinicians' professional and ethical responsibilities to appropriately assess, manage and monitor patients' pain and at the same time screen for relative risk related to abuse, misuse, and addiction. The RACP agrees with the Royal Australian and New Zealand College of Psychiatrists that pain and opioids are a significant concern and are not adequately addressed in the Standards.

Comments specific to individual standards and items

In this section, specific comments on the Standards are offered for consideration.

Standard	Suggested Comment
Standard GS: Governance for safety and quality	There is considerable evidence about the poor health outcomes for people with developmental disability compared to their peers without disability. There is good evidence that the documented high rates of preventable morbidity, mortality and avoidable suffering endured by patients with disability within the health system are due to deficits in care from both the disability and health sectors. Improved inclusion of the disability sector in dealing with the health issues of patients with disabilities, and improved reasonable adjustments to usual processes within the health sector are required to be embedded within the new standards.

Item	Recommended Amendments/ Additions
GS1 Governance and strategic leadership	**GS1.3 (new action)** Where adults or children with developmental disability or mental illness receive care in the organisation, the highest level of governance ensures that the safety and quality goals address the specific health needs of these people
GS 2 Management and executive leadership	**GS2.4 (new action)** Where there are specific safety and quality goals for people with developmental disability or people with mental illness, the health service organisation has targeted strategies to meet these goals
GS4 Policies and procedures	**GS4.3 (new action)** The health service organisation specifically notes and highlights these policies and procedures as they relate to patients with developmental disabilities
GS9 Incident management systems	**GS9.1(f)** includes incident reports related to patients with developmental disability
GS10 Feedback systems	**GS10.1(c)** provides reasonable assistance for patients with disability, to provide feedback about their experiences, and provides scope for disability service providers to be involved in this feedback
GS11 Healthcare records systems	**GS11.2(e)** facilitate the roll-out of the eHealth records for patients with developmental disability and mental illness, in terms of accessibility to their health information.
GS12 Safety and quality training	**GS12.4 (new action)** Where people with developmental disability receive care in the organisation, the health service organisation has strategies to improve the disability principles, disability awareness and competency of the workforce
GS13 Performance management	**GS13.1(d)** incorporate a section on disability awareness into the systems for training
GS14 Credentialing and scope of clinical practice	**GS14.1(e)** have a defined disability credentialing system including logistics of patient care, disability awareness
GS15 Delegating safety and quality roles and responsibilities	**GS15.1(c)** support the workforce to understand the reasonable adjustments for care of vulnerable patients
GS16 Evidence-based care	**GS16.1 (c)** Health professionals need to be made aware of best practice guidelines by regular updates.

GS17 Safe environment for the delivery of care	**GS17.1 (d)** equip Emergency Department with elder-friendly features and design
GS17 Safe environment for the delivery of care	**GS17.5 (new action)** Where patients with disability are admitted, to encourage, facilitate and make the necessary reasonable adjustments for support workers from the disability sector to be involved
PC2 Quality improvement	**PC2.1(d)** ensure reasonable adjustments made to enable meaningful participation by people with developmental disabilities, and disability service providers
PC3 Partnerships in planning, design, delivery, measurement and evaluation	**PC3.2** The health service organisation provides orientation, support and/or education to enable patients, <u>including those with developmental disabilities</u> to fully participate as partners with the organisation
PC3 Partnerships in planning, design, delivery, measurement and evaluation	**PC3.7 (new action)** The health service organisation works in partnership with patient bodies such as the National Disability Insurance Agency (NDIA), and the broader disability support sector
PC 4 Information that is easy to understand and use	**PC4.3 (d)** presented in easy to read English and other formats for people with developmental disabilities
PC6 Working together to share decisions and plan care	**PC6.1** Clinicians work with patients, <u>and where relevant, their carers or advocates</u>, to plan, communicate, set goals and make decisions about their care
PC6 Working together to share decisions and plan care	**PC6.2** Clinicians work in partnership with patients or substitute decision makers to discuss and document preferences and goals for future care when the patient is experiencing a mental illness, experiencing <u>dementia-like</u> cognitive impairment or approaching the end of life (this does not include patients with developmental disability)
CC4 Collaboration and teamwork	**CC4.3 (new action)** The health service organisation service ensure specifically that such processes occur for patients with developmental disability
CC 5 Screening and assessment of risks	**CC5.3 (new criterion)** The health service organisation has systems to routinely ask patients if they have a developmental disability, and to record this information in administrative and clinical information systems

CC5 Screening and assessment of risks	CC5.3→ CC5.4 (d) for patients with developmental disability, documentation on the role of the usual disability support for optimal health in the particular health setting
CC5 Screening and assessment of risks	CC5.4→CC5.5 (b) developmental disability mental illness
CC6Comprehensive care planning	CC6.1(f) support the infrastructure necessary for the time taken to provide this care
RH6 Cognitive impairment	RH6.1(d) liaise with usual service providers to understand the support needs of a person with developmental disabilities and ensure these are implemented within the health care setting
RH6 Cognitive impairment	RH6.2 (new action) To note that the care provided to patients with developmental disability may differ from that of patients with delirium or dementia
RH7 End-of-life care	RH7.2(d) be presented in a manner that can be understood by clinicians, patients, families and carers
RH7 End-of-life care	RH7.3 (New Action) That any end-of-life care for patients with developmental disability is considered with as much care as other patients of the same age without cognitive disability
RH7 End-of-life care	RH7.3→RH7.4 (f) help facilitate end-of-life care at home when this is the expressed preference
RH7 End-of-life care	RH7.5 (New Action) The health service organisation has systems to provide bereavement care to support patients and loved ones in times of grief
RH9 Restraint	RH9.1 (a) Prepare for the healthcare contact by obtaining behaviour care plans and training health care staff
MS4 Medication reconciliation	MS4.3 (New Action) For people with developmental disabilities, written documentation of medication treatment plans are obtained from carer or service provider
MS7 Provision of a medicines list	MS7.1(c) provide patients and where relevant, carers, at discharge with a current medicines list and the reasons for any changes
MS10 High-risk medicines	MS10.1(c) ensure timely dispensing
RR3 Recognising acute deterioration	RR3.1(h) acknowledge that for patients with developmental disability such recognition may be harder to detect and take this into account in protocols
BP7 Documentation	BP7.1 (b) Transfusion history should be displayed prominently in integrated electronic Medical Record (ieMR), including history of massive transfusion, and bleeding risk

Attachments

A. Specific comments from an individual Fellow
B. Royal Australian and New Zealand College of Psychiatrists Submission

i Global green and healthy hospitals http://noharm.org/lib/downloads/building/GGHHA.pdf
ii L Russell. Hospitals should be exemplars of healthy workplaces. The Medical Journal of Australia. 2015; 202 (8): 424-426.
iii L Russell. Hospitals should be exemplars of healthy workplaces. The Medical Journal of Australia. 2015; 202 (8): 424-426.
iv Disability, Ageing and Carers, Australia: Summary of Findings, 2012. Australian Bureau of Statistics.
http://www.abs.gov.au/ausstats/abs@.nsf/products/DAFD731067E636D3CA256F0F0079D6E3?OpenDocument
v National Disability Strategy 2010-2020 https://www.coag.gov.au/sites/default/files/national_disability_strategy_2010-2020.pdf
vi National Disability Strategy 2010-2020 https://www.coag.gov.au/sites/default/files/national_disability_strategy_2010-2020.pdf
vii A Roxburgh. Prescription of opioid analgesics and related harms in Australia. The Medical Journal of Australia. 2011; 195 (5): 280-284.
viii Opioid Analgesics: Overview. Drug utilisation sub-committee. http://www.pbs.gov.au/info/industry/listing/participants/public-release-docs/opioid-analgesics-overview