

Safety and quality

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Abstract

Safe and high quality health care is an objective that everybody supports. With so much written about it and everybody committed to it, why are we still struggling to achieve it? The successful acceptance and adoption of casemix provides some clues as to the answer. This paper examines the factors that assisted casemix and the obstacles to achieving progress with safety and quality. It concludes that both the health industry and community's tolerance of risk in health is too high. The lessons from the casemix story can be applied to advance the safety and quality agenda. A good place to start is a determined campaign focussing on improving safety.

Safety and quality in health – so much written, so much said, so much done and yet how far have we come in Australian hospitals? If I replaced the words “safety and quality” with “casemix” I would have to change the ending to read “and how far we have come!” Why is this so?

Casemix and the quality agenda both appeared almost thirty years ago in Australian hospitals. Both became “flavours of the month” and yet quality still struggles while casemix has become accepted, mainstreamed and embedded. Thirty years ago peer review and clinical audit made a fledgling appearance. Later in that decade formal delineation of clinical privileges commenced. Twenty years ago accreditation appeared and developed momentum. Quality assurance achieved a profile. Brian Collopy and a number of clinical colleges worked with the Australian Council of Healthcare Standards to commence the Clinical Indicators project. A little over ten years ago the quality agenda appeared to take off with great promise. Players started to argue about which path to an organisational quality award – accreditation, Australian Quality Council or International Standards Organisation certification? Writers, gurus and workshop leaders emerged. A journal on clinical quality commenced. Don Berwick and Brent James joined Deming in health libraries. And then it stalled.

Quality had a momentary recharge following the release of the results of the “Quality in Australian Health Care Study” in 1995 (Wilson et al 1995). A taskforce on quality was established. This led to the National Expert Advisory Group on Safety and Quality in 1997. Of interest, safety, as a subset of quality, began to emerge on centre stage. It appears that it is easier to promote a focus on safety than a focus on quality. Perhaps safety is a concept that players can grasp?

A momentum redeveloped in Australia. The 1998 Australian Health Care Agreement included a requirement for quality plans. Additional funding was put into the base by the Commonwealth and labelled as “quality”. While this was more a strategy to enable the Commonwealth to increase its funding offer under a different guise (and in most jurisdictions the funds went into the general operating base budgets for their health systems), the reporting requirement did lead to the development of a number of quality plans. In New South Wales, for example, “A Framework for Managing the Quality of Health Services in New South Wales” was released in early 1999. In 1999, Australia's Health Ministers approved the establishment of the Australian Council for Safety and Quality in Health Care. (ACSQHC)

Similar developments have occurred in the USA and in the UK. In 2000, the US Institute of Medicine released its report, “To Err is Human” (Institute of Medicine 1999). In 2001, the US Committee on Quality of Health Care in America issued a follow up report, “Crossing the quality chasm: a new health system for the 21st century” (Institute of Medicine 2001). In the UK, a National Institute for Clinical Excellence, a National

Patient Safety Agency and the Commission for Health Improvement have been created. The Kennedy Report was released in 2001 following the exposure of problems in paediatric cardiac surgery at the Bristol Royal Infirmary (The Bristol Royal Infirmary Inquiry 2001).

Last year, the Civil Aviation Safety Authority closed down Ansett, then the nation's second largest airline, for a number of days over maintenance documentation anomalies, lack of systematic monitoring, a failure to implement manufacturers' maintenance advices and a plane that flew without an operational escape slide in its emergency door. No one had died or had been injured. Yet we all know that being treated in a hospital is potentially more likely to encounter a "near miss" or an adverse incident than travelling on a scheduled passenger flight. The available data suggests that around 10% of Australian hospital admissions are associated with an adverse event. Fifty per cent of these events are avoidable (Gibberd 2001).

Concerns over deep sleep therapy and patient deaths at the Chelmsford private hospital in Sydney, extending over a number of years, finally resulted in a Royal Commission. Addressing concerns at Bristol took almost a decade. Complaints from relatives revealed a pattern of practice for the GP in Yorkshire, Dr Shipman. Everyone agrees that these are things that should not have happened and are unacceptable. Though soundly, and rightly, condemned they are still regarded by some players as "aberrations".

We know that health care has always involved risks. The health industry, government and the community have accepted this. But events such as operating on the wrong side, an overdose of routine analgesics leading to terminal liver failure, failures to detect or report adverse test results in cancer screening services, administering the wrong blood to patients and failure to see that a CTG tracing is picking up a maternal pulse rather than a seriously ill baby also continue to occur. Risks that we would not tolerate in an airline or in a mine or in a fast food chain or even in a packet of painkillers on a supermarket shelf.

Why is it that Australian hospitals effectively moved to address injuries in the workplace but not injuries in the treatment process? Why is it that the goal of zero injuries at work is now seen as attainable but a modest reduction in avoidable "near misses", morbidity and death is such a challenge?

Why is it that so much energy has been put into successfully making the insides (and progressively the grounds outside) of our Australian hospitals "smoke free"?

Could it be that a combination of using available data, financial incentives, leaders and drivers, penalties and performance comparison works in changing Australia hospitals, and we have not yet got this combination right for safety and quality?

Yet we have many examples of safety and quality at work in Australia's hospitals. Many changes seem to an outsider to have simply "happened". For example, changes in the approach to the management of diabetes, patient controlled analgesia, safety in anaesthesia and the treatment of many childhood cancers. Others have been mandated such as electrical safety and fire safety. Yet other changes have struggled before being adopted. Changes such as palliative care and the transformation of the process flow for a surgical procedure. The proven effectiveness of trauma services. The emerging evidence for early intervention services for young people with psychosis, stroke services, acute chest pain services and "MET" (Medical Emergency Team) services.

Do we fully understand why some changes have rapidly occurred, others have struggled and why other proven interventions have yet to be adopted?

It is interesting that the very real issues of safety and quality in our Australian hospitals appear to be something of a surprise to those who are "outside" the health system. Those of us who are inside seem to know intuitively what services are good, what services are not and those that are somewhat equivocal. What are the indicators of safety and quality that we "insiders" intuitively use?

The "crisis" in medical indemnity premiums and concerns over public liability litigation may turn out to be a very welcome catalyst for concerted action to really institutionalise safety and quality in our hospitals.

It should be disturbing to us all that the Medical Defence Association of South Australia (MDASA) issues a media release in April 2002 headlined, "Australian breakthrough to contain medical indemnity costs" and we read on to find that the "breakthrough" is the launch of an interactive risk management program for MDASA members.

I would suggest that the industry's and the community's tolerance of risk in Australian hospitals is too high. We have had too many people pushing and pursuing quality but not enough "influencers" actually requiring quality. We are worrying too much about getting the quality data "right" instead of using the data to get the quality right. We do not have enough Boards and senior executives worried about their responsibility, both organisational and personal, for safety and quality. We allowed clinical quality to be treated as something separate from other service quality and safety improvement. In short we do not yet have an environment that encourages, supports, rewards and results in continuous quality improvement.

The casemix analogy

In the late 1960s and early 1970s researchers in the US started to examine ways to categorise, measure and cost acute hospital inpatient services. From this research the concepts and tools of Diagnosis Related Groups (DRGs), casemix classification systems, cost weights, clinical costing and casemix funding emerged.

It is to the credit of the researchers, the Commonwealth Department of Health, the "enthusiasts", the Australian Clinical Casemix Committee, State Treasuries, John Paterson and Jeff Kennett that Australia now has Australian DRGs (approaching Version 5), the experience of live field trials and a reasonably robust acute inpatient care cost per case comparative framework.

What are some of the features of this transformation in our understanding of costs, acceptance of performance comparisons and implementation of real change? What lessons does it provide for safety and quality improvement?

Casemix certainly had its share (or perhaps at times, more than its fair share) of advocates, prophets and disciples. A thousand flowers bloomed under the Commonwealth funded casemix development program. For those involved there was a real air of excitement. There was a real sharing of knowledge and experiences.

Data was available, imperfect though it was initially. Most hospitals could produce inpatient activity data, grouped under ICD9-CM. Expenditure data was available – although this was usually at a very high level rather than down to cost centres. Most of the expenditure data was along functional lines rather than service lines – nursing salaries, drugs etc rather than operating theatres or medical wards or A&E. But we were prepared to use cost modelling. We were prepared to use Maryland cost weights till we developed our own. We were prepared to publish and compare. We used this to improve the data rather than waiting for the perfect data to be available.

Clinicians became involved and worked in teams with managers, accountants and researchers. Progress was driven at many levels – individuals, clinical teams, clinical units, professional groups and whole of hospital.

External bodies became interested and involved, including health funds, Treasuries, Audit Offices and the Productivity Commission. Some of this interest coincided with a desire by central agencies to contain the growth in the health budget. Pressure increased to implement what was being learnt from the research and experimentation.

The combination of a clinical costing methodology, a casemix classification system, a comparative performance culture and a direct incentive/penalty context for executives and clinician managers provided a powerful catalyst for changes in clinical practice, admission and discharge processes, settings of care delivery and further experimentation. While some of the gloss has come off the casemix bandwagon, it is now well accepted and understood that casemix is a tool and a means to an end rather than an end in itself.

Thirty years later, unlike quality, it is now mainstreamed as a component of acute hospital care, both public and private, across Australia.

Why hasn't quality followed the path of casemix?

Quality also has its advocates, prophets and disciples. There have been many quality improvement projects and awards. There has been a sharing of knowledge and experience. We now have a Council on Safety and Quality in Health Care. But there are significant differences between the paths of quality and casemix.

Data has not been as readily available. Data on quality is not routinely collected by most hospital information systems. Proxy data such as readmission rates can be easily extracted. Many adverse events are recorded in a medical record but they are not routinely extracted into an easily accessible electronic database. Where systems do exist to capture and store such data they are not always utilised. Interested clinicians and professional groups have developed systems but they have not been connected into the broader hospital information systems or access has been restricted.

A significant database on Australian intensive care patients exists but its data is not widely available. Most major public hospital emergency departments have a relatively sophisticated computer system with quality of care modules and capabilities. Their use for quality improvement is still patchy.

There remains a debate about risk adjustment of available data sets. This debate has prevented publication of comparative data, which in turn has impeded the development of better risk adjustment tools.

Safety and quality lacks the advantage of casemix – what is the safety and quality equivalent of a casemix weight of 1? This lack of a readily understood comparative “denominator” also impedes the presentation of easy to digest data. Hospitals and their quality committees and councils experience real dilemmas in trying to produce meaningful indicators in a format that is readily understood and that permits valid benchmarking over time and against peers. There is no single number or indicator to report on quality, unlike the “cost per case” of roughly \$2,300 that casemix data can produce.

While safety can largely be measured within the hospital during the treatment process, many aspects of quality cannot be measured during the patient’s stay or ambulatory care episode. Hospitals therefore need to have data from other players, both within and outside the health sector, to get a true picture of quality. Complications such as wound infections, DVTs or adverse drug reactions may occur outside the hospital and remain unknown to the service provider and the hospital. This is particularly so if the patient is dissatisfied with the care. Specific outcome data and measures such as return to work, ability to engage in social activities and functional capability require information from others or a follow up data gathering process by the hospital. Satisfaction data obtained during the hospital stay may not be reliable. With casemix, virtually all the data needed to produce the report for the clinician, team, Chief Executive Officer, Board or funder is available to the hospital.

Terminology, as with casemix, has been an issue. However, it now appears that a consensus has emerged that quality has a number of dimensions. The words might still differ but the dimensions now appear to coalesce around:

- safe
- effective
- appropriate
- timely
- efficient
- equitable
- patient centred.

A number of these dimensions are difficult to measure. Appropriateness, for example, requires agreement on what is best practice.

Unlike casemix where clinicians needed to work with managers and accountants, and importantly vice versa, safety and quality in clinical care has been able to segment itself as being part of the clinical domain. The concerns over professional autonomy, confidentiality and exposure to litigation unintentionally allowed this separation to persist.

It is important to recognise that legislated provision of absolute or qualified privilege to quality assurance committees has had some benefits – for example the process of reviewing deaths under anaesthesia and maternal deaths. Where effectively implemented, these activities did lead to improvements in the quality of care. Peak committees in a number of jurisdictions successfully identified risks and strategies to prevent adverse outcomes. Due to the acceptance of these committees by clinicians, these strategies were subsequently incorporated into professional association guidelines and health service operating policies.

However up until recently, safety and quality of clinical care, as distinct from the safety of aspects such as the physical infrastructure, has been regarded as a clinical issue rather than a management issue.

The lengthy debate amongst Commonwealth, State and Territory health authorities about whether a national council on quality should be established was another illustration. The debate included arguments about whether a national body was needed, the effectiveness of a perceived “top down” approach to quality, the existence of “hidden agendas”, the relative contribution of funding by the Commonwealth and the States/Territories and the cost effectiveness of the funding requested.

Interest in quality by funders and external bodies is not at the level that casemix has generated. While again this is understandable, it has meant that an important part of the toolkit has not been in use to promote, provoke and require significant advances in improving the safety and quality of Australian hospital care. The lack of easily understood, meaningful and clinically accepted measures of quality has contributed to this. There may also be a concern that improving quality will cost lurking in the background.

Is casemix the right analogy to use?

In my view the answer is a mix of “yes” and “no”. Yes, because it is a good example in a similar timeframe of how a measurement tool can be developed and adopted by the hospital sector and produce results. There is no doubt that casemix has been a key tool in achieving productivity improvements in the hospital sector in Australia.

No, because improving quality and safety is not as straightforward as casemix development. The drivers and influencers are more complex as they require changes in behaviour by clinicians, funders, consumers, insurers, lawyers, registration boards, coroners, universities, colleges, managers and boards – to name a few.

I am attracted to a commentary in a British Medical Journal editorial in July 2001 – “Bridging the quality chasm” (Kelley and Tucci 2001). Kelley and Tucci from the Henry Ford Health System in Detroit, Michigan, write about the need to understand the motivations of those who work in health care to improve the quality of health care. Health care is not a system that can be changed by “mechanical systems thinking”. Kelley and Tucci see health care as a complex adaptive system. They illustrate the difference by contrasting getting a rock to land where you want with getting a bird to do the same. With a rock, once you know the mass, distance, force of gravity etc you can calculate trajectory and force required. But how do you get a bird to land where you want it? They suggest using our understanding that birds seek food and putting food on the preferred landing site!

Cynics will say that drug companies worked this out years ago. My point is that to make significant and sustained progress on improving safety and quality in Australian hospitals we need to better understand what motivates clinicians to change their behaviour.

Hopefully, in Australia we have some advantages over the picture painted by Kelly and Tucci, but their conclusion remains relevant. They describe US health care as being “fragmented with no common information systems, no national payment standards, and only a handful of national quality standards. ...[providers] are driven by highly individualised value needs, not by an abstract or common desire to improve health care. Before we invite and support experimentation in this challenging environment, we should candidly explore the motivation and incentives of those who provide care in the current environment. Without the knowledge and use of internal rewards to create and sustain key behaviours in providers, we have little chance of widespread, enduring improvement in the processes and systems of health care” (Kelley and Tucci 2001:62).

Donald Berwick, another well known writer on quality in health care from the US has a similar message. Reform from without will not by itself result in sustainable change. Reform must come from within.

What can be done to advance the safety and quality agenda in our hospitals?

I strongly support the need for further research on what motivates and influences clinicians, so that we can more effectively and more rapidly harness the interest, talents and scores already on the quality board to improve safety and quality in our hospitals. However, I believe that we have not done enough to utilise the other tools and drivers available in parallel with the research agenda.

These drivers and tools include:

- key players making safety and quality a centre stage issue;
- giving an initial priority to safety;
- incorporating safety and quality in managerial and clinician performance measurement;
- publishing available data and gathering regular outcome survey data;
- changing the climate so that open disclosure of adverse events becomes the norm;
- incorporating safety and quality in funding agreements;
- moving as rapidly as possible to risk rated liability insurance premiums paid directly by the hospital and not by a central health authority.

The Australian Council on Safety and Quality in Health Care's agenda has recognised the importance of using a number of these drivers.

Will clinical governance help?

The term "clinical governance" emerged in health during the latter half of the 1990s and the concept continues to evolve. At this stage it is generally accepted that the concept embodies the following key elements:

- an acceptance by the governing body and its executive management of their responsibility and accountability for the quality of the clinical care delivered by their organisation;
- a structured, organisation wide approach to monitoring the quality of clinical care and regular reporting of this to the Chief Executive Officer and governing body;
- an effective system of resolving problems identified with the quality of clinical care;
- the fostering of a culture that promotes safety, compliance and effective risk management;
- an acceptance by clinicians of the legitimacy of the governing body's role and that this is a shared responsibility.

Key drivers for the emergence of clinical governance include:

- the legal environment;
- the role of governing bodies;
- the change in attitude towards professional independence;
- the rising cost of insurance.

A series of business failures and corporate frauds during the 1980s, 1990s and regrettably, continuing into the new millennium, focussed the attention of the media, regulators, politicians and the community on the governance role of boards and the responsibilities of directors and executive managers in the corporate sector.

In parallel, the interest of governments in debating the role of government and the degree to which government should be involved in service delivery, lead to the establishment of new governing bodies in health, a change in the mix and competencies of directors, the payment of directors and the introduction of formal performance agreements.

This shift from the previous "voluntary community representative" model of governance to a more business management orientated model was accompanied by legislation setting out the responsibility and accountability of governing bodies and senior managers, including the quality of care provided.

In the corporate sector, the need for effective corporate governance was reinforced by regulators, new legislation and the courts. Similar principles were applied to government businesses and trading entities. While the recent failures of HIH, One Tel and Ansett are clear reminders that the system needs further work, it is clear that the bar has been raised in terms of accountability of boards, directors and senior executives in the commercial sector.

The corporatisation and ownership consolidation of the private hospital sector will hopefully facilitate a transition of commercial corporate governance attitudes and accountabilities to include clinical governance. Public sector hospital governing bodies have not yet fully understood or embraced their clinical governance roles and responsibilities. It is now no longer possible for a governing body or senior manager in health to assert that the quality of the clinical services and the outcomes of care are the responsibility of the clinicians. This responsibility is now shared.

Regulators, funders and insurers need to push this message strongly home to governing bodies in both the public and the private hospital sectors.

Integration of the clinical governance framework with other organisational systems will also be required. For example, integration with human resource systems in relation to recruitment, recertification of competence, maintenance of licencing requirements and employee assistance programs will be required. It is important that appropriate due process, in accordance with the principles of natural justice, is built into the corporate governance framework. This will provide some reassurance to clinicians and also avoid a challenge to subsequent disciplinary action.

Using legislation as a tool to make safety and quality centre stage

The developments in both case law and statute law in Australia and New Zealand are emerging as a key driver. The recognition of a separate and non delegable duty of care of an organisation to its patients and clients awakened managers and governing bodies to the need to monitor the actions of their clinicians. As the number of successful claims increased and began to be reflected in the insurance premium cost, the need for more effective monitoring of critical incidents and adverse events, active claims handling and risk management has become clear.

Statute law has also played a role. The development of comprehensive Occupational Health and Safety legislation in most jurisdictions during the 1970s and 1980s clearly focussed responsibility for the provision of a safe system of work on managers and governing bodies. The potential for personal liability of executives and directors under this legislation also accelerated a greater interest of managers and governing bodies in risk management and the degree to which their organisation had put in place effective systems to improve occupational health and safety.

Other areas of statute law that have had a similar impact include environmental protection and trade practices and consumer protection laws. In Australia, amendments to the Commonwealth Crimes Act that came into effect in December 2001, make organisations, their directors and executives liable for a broader range of breaches of Commonwealth legislation. A successful defence of a prosecution will require the existence of an effective compliance culture within the organisation.

Another factor in the legal environment is the potential impact of health registration bodies if they were to regard the conduct of a registered health professional in their managerial role as forming part of that individual's continued fitness to practice.

Perhaps it is time for some targetted amendments of key health legislation and a few well publicised cases involving directors and senior managers?

Making safety the initial priority

Most people can grasp safety as a readily understood concept. While a comprehensive quality improvement process addressing all the dimensions of quality should remain the goal, why not set an interim goal to make Australian hospitals safer? It is pleasing to see that the ACSQHC has adopted this goal.

The use of critical incident and risk monitoring systems should be mandated in all Australian hospitals. The software exists and groups such as the Australian Patient Safety Foundation, anaesthetists, intensivists and cardiac surgeons have shown that it can be done.

Picking say just three known risks to patient safety to concentrate on over the next 18 months should be sufficient to get the momentum underway.

Using the medical indemnity and public liability insurance “crisis” as a tool

While the contributing factors to the rapid escalation in medical indemnity premiums and the rise in public liability premiums remain contested and debatable, Australia now has a great opportunity to use this “crisis” as a key tool to advance safety and quality in our hospitals.

Governments, both State and Federal, will end up having to underwrite some of this cost. This role provides a bargaining tool to require incident reporting, contribution to a risk and claim database, compulsory adoption of risk management systems and continuing recertification of skills and professional development. It also provides an opportunity to prevent health professionals with a proven track record of unacceptable risk from practising.

Another tool is to move as rapidly as possible to risk rating of insurance premiums and for a significant proportion of the risk rated premium cost to be borne directly by the hospital. A strong financial incentive to act on safety and quality needs to exist.

The debate has highlighted concerns over the damages awarded in cases where negligence has been proven in the management of labour and delivery of a baby. Couldn't these concerns be harnessed to produce a National Health and Medical Research Council, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Australian College of Midwives and Royal Australasian College of Physicians endorsed set of clinical pathways, checklists, agreed risk indicators during labour and agreed indicators for mandatory review by an experienced clinician. While adherence to these will not guarantee either a good outcome or prevention of a statement of claim, they should improve safety and quality and reduce the likelihood of a successful claim.

Publishing available safety and quality data

While accepting that this remains a controversial topic, the experience with the publication of casemix data strongly suggests that the health system responds to data and that making data available is, in itself, an incentive to improve the data.

Marshall and Brook (2002) endorse both the desirability and the inevitability of public reporting of comparative information about the quality of healthcare. (See also Marshall et al 2000 for a review of the evidence for the effectiveness of publication of this data). There is now over a decade of experience with this in the US.

Research suggests that scorecards and the like do not appear to change consumer behaviour significantly, unless the scorecard indicates that the hospital is an outlier – either positive or negative. However, the research does seem to support a position that publication of the data on safety and quality does influence behaviours of health professionals.

There are risks, of course, with the publication of this data. Incentives to select out “riskier” patients and the attribution to an individual clinician of an adverse event resulting from multifactorial influences are two examples.

Health funds and the next Australian Health Care Agreement should require regular publication of safety and quality data.

A significant barrier is the adequacy of the organisation's information and reporting systems. Identification of key indicators for data collection and reports is required. A classification system will be required. Data integrity, confidentiality and security need to be addressed.

Data will need to be gathered across the organisation and across episodes of care. Risk adjusted and benchmarked comparison data are required for meaningful reports. Trend lines and control limits to identify inappropriate variance are necessary. To avoid information overload for executives and governing bodies, exception reports, graphs and diagrams rather than blocks of text and key indicator tables will need to be available.

But these were all issues with casemix and recent history has shown that they were able to be addressed.

Key players making safety and quality a centre stage issue

Advocacy and sustained attention to an issue can bring about significant change. Examples in Australian society include the concerted action to reduce the road toll and the change in community attitudes towards pollution, conservation of water, energy consumption and recycling.

With road trauma, the combined efforts of surgeons and a courageous State government in Victoria created a momentum that changed community attitudes. The campaign also incorporated enforcement, better engineering, earlier and more effective emergency responses, removal of known hazards, political will, advocacy by community opinion leaders and strong media support.

Our Prime Minister, our Premiers, our talk back radio commentators, our clinical leaders, our sporting heroes, our “icons” need to start talking about the need to make our hospitals safer and to further improve the quality of hospital care. This can be done in a positive way, without turning the campaign into a negative and destructive “our health system is in crisis” distraction. The ACSQHC needs to give some thought to how it can harness the media and commentators to advance its agenda, without creating tensions with its funders. Millenson (2002) draws attention to the role of the media in the quality agenda.

Incorporating safety and quality in managerial and clinician performance measurement

An essential criterion to be appointed as a senior clinician, nurse unit manager, clinical unit head or Chief Executive Officer in our Australian hospitals must be a demonstrated ability to improve safety and quality. This ability must continue to be demonstrated and benchmarked after appointment. Safety and quality indicators need to be an integral part of the position key performance indicators.

Creating a climate of open disclosure

The project on creating a climate of open disclosure is underway under the auspices of the Australian Council for Safety and Quality in Health Care is an important step forward. Creating a climate where near misses, critical incidents and adverse events can be openly acknowledged, discussed and addressed is an essential ingredient in moving forward.

Too many cooks?

A mistake that was made in the 1980s and 1990s was to diffuse responsibility and accountability for quality to different players. “Medical” quality was the role of the doctors, “nursing” quality the nurses and so on. The establishment of Quality Co-ordinators, though playing a helpful role in educating staff about quality improvement tools and supporting quality projects, allowed accountability for safety and quality to become blurred in many hospitals. Everyone was responsible but no one was accountable.

We should not allow history to repeat itself this time. While it is important that as many players as possible become involved, there is a risk that we will have too many bodies and again blurr accountability. The ACSQC, colleges and professional associations and bodies such as the Australian Patient Safety Foundation do have a role. Accreditation bodies, Standards Australia, Registration Boards, complaints bodies, Coroners and consumer groups also have roles.

But the primary accountability should be clear – every individual is accountable for the safety and quality of what they do and every governing body and Chief Executive Officer is also accountable for the safety and quality of the services they provide.

A final word

It is time to take the bit between the teeth and strike while the climate is right on the safety and quality agenda. The “crisis” in professional indemnity and public liability premiums is an opportunity that should not be missed. Open disclosure needs to start with an acceptance that our risk tolerance level in Australia hospitals is set too high and that we need to lower it. We can make our hospitals safer, other industries and services have done so. It requires a will to do so, an accountability that requires it and the mix of incentives and penalties to ensure that it happens.

Australian hospitals have changed and continually demonstrate their capacity to change. Safety and quality improvement are achievable. It is time that they came out of the “too hard” basket.

References

- Bristol Royal Infirmary Inquiry (2001). *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*. (www.bristol-inquiry.org.uk/) (26.06.02)
- Gibberd R 2001. 'Why attitudes to quality of care are changing' *Australian Health Review*, vol 24 no 3 pp 5-6.
- Institute of Medicine 1999. *To err is human: Building a safer health system*. Washington, DC, National Academy Press.
- Institute of Medicine 2001, *Crossing the quality chasm: A new health system for the 21st century*. Washington DC, National Academy Press.
- Kelley M & Tucci J 2001. 'Bridging the quality chasm'. *BMJ*, vol 323 (14 July) pp 61-62.
- Marshall M & Brook R 2002. 'Public reporting of comparative information about quality of health care'. *MJA*, vol 176 (4 March) pp 205-6.
- Marshall M, Shekelle P, Leatherman S & Brook RH 2000. 'What do we expect to gain from the public release of performance data? A review of the evidence'. *JAMA*, vol 283 no 14 pp 1866-74.
- Millenson M 2002. 'How the US news media made patient safety a priority', *BMJ* vol 324 (27 April) pp 1044.
- Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD 1995. 'Australian Quality in Health Care Study', *MJA*, vol 163 (6 November) pp 458-71.