

Improving healthcare: Transforming concepts into action with one patient at a time

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Thank you for your refreshing views on healthcare system improvement in your editorial piece entitled 'Improving the system: one action at a time'.¹ The framework for the five elements (patients, processes, people, priorities and partnerships) certainly highlights how we can close the gaps and insufficiencies we have in our Australian healthcare system. There is strong evidence to indicate that we need to do more to address substandard quality and safety outcomes.² The National Health Performance Authority published a report that stated 1621 cases of hospital-associated infections in 2013–14 were acquired by patients while receiving care for an unrelated health condition.³ Although the introduction of the National Standards by the Australian Commission on Safety and Quality in Healthcare in 2013 has seen an improvement in safer health care, we still have a little way to go. I would like to home in on a few elements that particularly stood out to me: patients and partnerships.

Patients must come first! The Francis Inquiry into the UK National Health Service (NHS) Mid Staffordshire Trust revealed a culture that tolerated substandard healthcare that resulted in the death of 400–1200 patients in the face of 'horrific abuse'.⁴ Warning signs were ignored and management were too far removed from patient care, such that they failed to respond to staff concerns, patient complaints and take responsibility for poor patient outcomes.⁵ England is not alone. We only need to look in our own backyards with inquiries into the Bundaberg Base Hospital, King Edward Memorial Hospital and Canberra Hospital to see how poor management, lack of trust among colleagues and fatalistic mindsets can compromise patient safety and care. We know that we need to do better to ensure patient safety. But how do we translate concepts into actions? What can we do now to make a difference? Perhaps it starts with just one patient.

I recently watched a TEDx talk by David Feinberg, Chief Executive Officer (CEO) of University of California Los Angeles (UCLA) Health in the US.⁶ Feinberg was such an inspiring manager, who started his journey to changing the culture of UCLA through his focus on 'the patient'. He identified the gap

between management and patients and rebuilt a culture that thrived on listening to patient feedback and taking accountability for the patient experience. Daily patient rounds were enforced, whereby managers knocked on patients' doors, would sit on the patients' beds and ask them how they were finding the care. Managers took an interest in patient experiences, looked for problems to solve and gave patients a platform where their concerns could be heard. If we could start with one action, I would like to see managers reaching out to patients. Perhaps our hospital CEOs could knock on doors, sit down and ask patients how they could help? This one act of kindness may be the first action that is needed to restore trust in healthcare.

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