Submission to *Improving Maternity Services in Australia – A Discussion Paper from the Australian Government*

AUSTRALIANCOMMISSIONON SAFETYANDQUALITYINHEALTHCARE

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Submission

The Australian Commission on Safety and Quality in Health Care (ACSQHC) describes in this brief submission a key safety concern: maternal referral and transfer. ACSQHC is developing solutions applicable to this safety issue. These solutions are outlined in the submission and ACQSHC would like the opportunity to further assist the team in their development of the National Maternal Services Plan.

> In *Improving Maternity Services in Australia* it is stated that "All over Australia, women have made it clear that safety for themselves and their babies is of paramount importance"

The Australian Commission on Safety and Quality in Health Care

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is pleased to respond to the call from the Department of Health and Ageing for submissions on *Improving Maternity Services in Australia*. The role of the ACSQHC in the safety and quality of health care in Australia is outlined at Appendix 1.

The ACSQHC is currently developing a National Strategic Framework for Safety and Quality which has 3 main foci:

1. Centre health care on the patient

2. Systematise evidence based health practice

3. Build a culture so 'safety is how we do business'

We would also recommend these foci for use in the Development of the National Maternity Services plan. A brief description of these foci and potential work elements is listed at Appendix 2. Additional detail of the rationale are available in our submission to the NHHRC (http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/703C98BF37524DFDCA25729600128BD2/$File/NHHRC-Submission.pdf).

Importance of service infrastructure to safe care delivery

ACSQHC notes that the required "Service Infrastructure" listed by *Improving Maternity Services in Australia* includes the following:

-   Hospital beds and diagnostic and monitoring equipment

-   Reliable communication technology to facilitate specialist advice and support

- Evidence based risk management protocols to support referral
- Access to transport for the safe and timely transfer of women and their babies where referral to another facility is necessary

This section follows a discussion on midwife-led care and although the authors probably didn't intend it, reads as if the listed infrastructure is of concern in relation to potential new alternative models of care delivery. ACSQHC suggests a greater emphasis be made on these four important aspects of the infrastructure required for the delivery of safe care.

Concerns about maternal referral and transfer

The main area of comment for the ACSQHC is on the issue of maternal referral and transfer. The ACQSHC is concerned that currently there is a lack of adequate awareness that the handover of care is always a high risk scenario; a time when safety may be reduced. Clear communication between health professionals and the patient and their family is crucial in obstetrics, particularly as it is a team of providers who cares for the patient in the antenatal and postnatal periods and during labour, and who are involved with the patient in making time-critical decisions. This handover risk is enhanced when physical patient transfer is involved, as when site transfer is added to the handover between care givers, incomplete information transfer may not be noticed or remediated.

The ACSQHC has considerable concern about the *current safety* of transfer protocols and arrangements across Australia. Reports reach the ACSQHC from State safety and quality groups, Health Care Complaints Commissioners and the media.

The common scenario is a patient in labour or bleeding or hypertensive being identified as needing transfer to a higher level of care, sometimes but not always, in association with foetal immaturity. Some transfers are initiated due to temporary staff shortages (typically of anaesthetists or midwives). Then either a delay in transfer and/or a rapid change in the patient's condition results in delivery on-route and/or foetal death or a change in maternal condition (eg severe bleeding or fitting) that can be life threatening during transport.

The patient has often been transferred from a hospital with transfusion facilities and medical staff. While the initial rationale for transfer may have been sound, the eventual outcome for mother and baby is unsatisfactory.

Individual hospitals and transport services may have incident reporting systems but where problems and responsibility cross organisations, reporting is less likely and analysis unlikely to reach all those involved in the chain of care. Adverse outcomes can also easily be interpreted as due to the underlying illness and then no systems analysis occurs. Where reporting exists it may not feed back effectively to change and

improve policy and protocols. Meanwhile policy impairs or prevents front line staff from making their own safety decisions and assessments in a manner that is pragmatic and relates to the specifics of the clinical case. While experience in improving safety in other industries points to the value of protocols, it also highlights the need to allow front line experts to make decisions.

ACSQHC expertise for improving safety in maternal referral and transfer

The ACSQHC has two current priority programs of relevance to the maternal referral and transfer safety issue of concern. These are:

- Identification of the deteriorating patient
- Clinical handover

In addition, the issue of learning from incident monitoring systems and root cause analyses forms part of our information strategy (we will be receiving a substantial report on this early 2009 and following this with stakeholder discussion).

Deteriorating patient

The ACSQHC program regarding the identification of the deteriorating patient has only recently commenced. It includes three initiatives:

- Development of an evidence-based observation chart to identify deterioration and prompt action
- Development of minimum standards for systems for responding to identified deterioration
- Improving identification and management of patients at risk in primary care.

The outputs of these initiatives will be available in 2010.

Clinical Handover

The purpose of the Commission's Clinical Handover work is to identify, develop and improve clinical handover communication.

In February 2007 the Commission's National Clinical Handover Initiative commenced. Part of the Initiative's work includes a pilot program consisting of fourteen clinical handover pilots that are undertaking clinical handover solution development.

Within the National Clinical Handover Initiative, there are three projects of particular significance to this submission: a hospital based project concerned with obstetric handover and two projects concerned with transfer of patients to higher levels of care.

The Mater Health Services in Brisbane has developed a SHARED framework for communicating a crucial situation or a change in patient condition. SHARED stands for situation, history, assessment, risk, expectation, documentation. The tools have been developed and are being tested on the following obstetric "critical times around clinical points of care":

- Referral and admission of a patient from a VMO's private practice

- Transfer of information from midwife/nurse to VMO when a change in a patients condition occurs

- Handover from recovery nurse/midwife post caesarean section

This project completes in January and a full report will be available.

Pilot projects led by Western Australia Country Health Service (WACHS) and Hunter New England Area Health Service (HNEAHS) are developing solutions for inter-hospital transfer.

The WACHS's project developed a clinical handover protocol to ensure optimal transfer of patients from country health services, where emergency or high dependency care is required. Their work has been centred on the use of the ISOBAR tool. ISOBAR stands for Identify, Situation, Observations, Background, Agreed Plan and Read Back/Responsibility. This pilot realised a great deal of success in having their tool embedded into clinician handovers at their pilot sites. The success has been attributed to the simplicity and practical utility of the tools, which assists clinicians to ensure all of their handovers contain the relevant information needed to ensure safe and effective care for patients. It is of note that the "O" in ISOBAR was inserted to reduce the problem of clinicians handing on 'aged' observations. Cases had shown that careful observations were made on patients, yet the handover communication about transport decisions (which may be made over several hours) was not consistently updated with current observations.

HNEAHS is developing tools to improve inter-hospital transfer communication including between rural and metropolitan hospitals. This project is exploring use of a similar tool: ISBAR. ISBAR stands for Introduction, Situation, Background, Assessment and Recommendation. Again in this project, the team is placing an emphasis on detailed knowledge (including pathology) of the patient's condition at the time a transfer request is made to ensure appropriate tasking. This project is scheduled for completion in March 2009.

As a part of the Initiative's work for 2008-09, the OSSIE Guide to Clinical Handover is being developed. The goal of the guide will be to provide on-the-ground clinicians and health managers with practical, easy to implement solutions and tools for improving clinical handover practices. Learnings and tools developed by the pilot program will inform the guide development including incorporation of the ISOBAR concept.

The first edition of the guide will be published in March 2009. This edition will focus on hospital clinical handover and offer an approach to change management, measurement and the use and development of standardised operating processes and data sets. Comment on the first edition will be invited from March – July 2009 and will inform the second edition.

The second edition of the guide will be released in October 2009. In addition to amendments and improvements to the general hospital handover material, the second edition of the guide will include information for other healthcare settings. During 2009, the expert advisory committee will supervise the development of a number of specialty chapters.

Of particular interest to your team will be the chapter on handover in obstetrics care and on inter-hospital transfer of patients when higher level care is required.

In summary, ACSQHC hopes that the work described will be able to assist the Maternity Services Review Team in ensuring safety in maternal referral and transfer.

ACSQHC

The ACSQHC was established in 2006 to lead and coordinate national improvements in safety and quality. Its establishment followed the 2005 review by Paterson.

Health Ministers established the ACSQHC to:

- Lead and coordinate improvements in safety and quality in health care in Australia by identifying issues and policy directions, recommending priorities for action, disseminating knowledge, and advocating for safety and quality.

- Report publicly on the state of safety and quality, including performance against national standards.

- Recommend national data sets for safety and quality, working within current multilateral governmental arrangements for data development, collection and reporting.

- Provide strategic advice to Health Ministers on 'best practice' thinking to drive quality improvement, including implementation strategies.

- Recommend nationally agreed standards for safety and quality improvement.

The development of an Australian Charter of Healthcare Rights has been a fundamental part of ACSQHC's work. The Charter clearly sets out the rights of patients to safe and competent care. These rights underpin the work of the ACSQHC. The focus of ACSQHC work is on priorities for the health system where current and complex problems and community concerns could benefit from national consideration and action.

ACSQHC programs include:

- implementation of the national standard for open disclosure of adverse events.

- prevention of health care associated infection, which includes work on:
    - hand hygiene
    - surveillance of healthcare associated infection
    - building clinician capacity
    - revision of national infection control guidelines
    - antibiotic stewardship.

- development of strategies to reduce patient identification errors.

- creation of an evidence base and tools to reduce the risks associated with clinical handover.

- implementation of a standardised medication chart and other strategies to improve the safety and quality of medicines.

- national review of safety and quality accreditation and recommendations for reform, which includes work on:

  o development and reporting of performance against Australian Health Standards

  o establishing a national quality improvement framework that addresses systems issues such as clinical governance

  o creating a mechanism for mandating an expanded coverage of accreditation of health services

  o piloting innovative accreditation methodologies

  o harmonising safety and quality reporting across the public and private sectors.

- in partnership with AIHW, developing key high level safety and quality indicators across the continuum of care including primary care.

- developing and validating national operating standards for clinical quality registries.

- review and updating of national falls guidelines.

The ACSQHC is not a service provider. It must influence the system and stakeholders to make the recommended changes if the safety and quality of health care in Australia is to improve. The ACSQHC has four key standing committees, which cover the public health sector, the private hospitals and private health insurers, primary care and information strategy. These committees give ACSQHC's work breadth, depth and expertise and enable insight and influence across the whole health system.

The ACSQHC is increasingly engaging with the Healthcare Complaints Commissioners from all states and territories to progress issues of mutual interest. The span of interests of safety and quality stakeholders is broad and includes consumers, private and public hospital sectors, primary care, accreditation organisations, academics, industry such as health insurers, information technology providers, clinical practitioners, professional organisations and education bodies, governments and policy makers. Therefore, the ACSQHC is uniquely placed to influence change as an "honest broker" and assist the DoHA in achieving safety objectives.

ACSQHC – Elements of the National Framework for Safety and Quality

1. Patient centred health care

Patients care involves a series of interactions with services over time. Frequently, they encounter gaps in care, duplication of services (eg blood tests) and difficulty in finding the pathway into a service. Once in a service there may not be provision for integration with, or choice of, other services. A significant limitation on the integration of health care services for a patient is the lack of timely access to all relevant information for all health providers. Benefits will only accrue once there is a critical mass of implementation – of interoperability, electronic health records, communications infrastructure, and patient (not provider) centred policy.

Descriptors under which strategies should be developed include:

- Addressing health literacy in the community.

- Ensuring the community understands their healthcare rights.

- Ensuring the full patient experience is studied and improved, including achieving optimal functional status.

- Establishing data collections that support comprehensive patient care.

- Reviewing funding models to support continuity of care, including financial options for incentives and sanctions.

- Ensuring there is case management for complex care.

- Making available an electronic shared health records that is owned by the patient.

- Implementing radiology image archiving to enable access for any patient, any image, any doctor, any time.

- Providing patients with access to trusted information.

- Ensuring patients are routinely involved in system improvement.

- Training and support for the health care volunteer workforce, including ambulance volunteers and those who are hospital based for instance who have roles monitoring inpatients at risk of falling.

2. Build a culture so 'safety is how we do business'

The current reactive system continues to fail patients and health care workers. Dysfunctional systems cause multiple errors. To improve systems, detailed analysis is necessary. Secrecy, defensiveness and

blame are antagonists to a safety culture and prevent open and comprehensive system analysis.

Descriptors under which strategies should be developed include:

- Supporting and engaging clinicians in organisational safety and quality.

- Reforming of legal processes to facilitate both incident investigation and open disclosure. Reforms also need to address compensation that more equitably and consistently meets the financial needs of injured patients.

- Building safe health facilities and using technology to enhance safety.

- Embedding safety and quality training into the work of health care.

- Defining the consequences for deliberate non-compliance in high risk patient safety areas.

- Creating an environment in which health providers are able to speak up to keep patients safe.

3. Systematisation of evidence based health practice

Currently evidence and treatment protocols are not adequately utilised and many Australian patients do not receive optimum health care. Currently it takes decades for evidence to be incorporated into practice. ACSQHC focus to date has been on: developing an evidence base in areas such as clinical handover, healthcare associated infections and open disclosure and using this evidence for the development of guidelines and tools.

Descriptors under which strategies should be developed include:

- Acquiring evidence about the outcomes of Australian patients (including through data linkage).

- Ensuring clinical guidelines are reliable, accessible, current and incorporated in standard care plans when possible.

- Creating evidence about the effectiveness of solutions and the methods for effective implementation of proven solutions.

- Creating economic information to measure the cost of unsafe and poor quality care.

4. Implement a measurement framework to support Patient Centred Health Care, Systematisation of Evidence Based Practice, and Build a culture so 'safety is how we do business'

Systems measurement is an enabler for the other areas for reform. Performance measures need to be evidence based. For instance, incident

reporting systems, while important for improvement, are not able to measure safety performance.

Performance measurement includes what you do and how well it is done and what you fail to do that should have been done.

An indicative list of safety and quality indicators is at Attachment 2. Measures are least well developed in primary care.

Descriptors under which strategies should be developed include:

- Ensuring data collection provides a return on investment through improved safety and quality by targeting high risk, high volume areas.

- The use of national targets to improve safety and quality.

- Reporting publicly on information where it is likely to offer choice to consumers or spur organisational improvement.

- Developing agreed indicators for: all sectors of the health care system, including primary care and the community sector; and indicators that support continuity of care (eg of treatment, providers and patient records).

- Maximising the safety and quality utility by prioritising the timely return of data to front line staff.