8 February 2010

Consultation on NSQH Standards
Australian Commission on Safety and Quality in Health Care
GPO Box 5480
SYDNEY NSW 2001
(email to: mail@safetyandquality.gov.au)

Dear Sirs

Response By the Australian Day Hospital Association Ltd to the
Australian Commission on Safety and Quality in Healthcare’s release of
Draft National Safety and Quality Healthcare Standards.

Thank you for the invitation to respond to these draft standards.

ADHA congratulates the Commission for this achievement to date. We agree and support the five standards and feel that in the majority of areas Day Hospitals will be able to achieve a high level of compliance.

We are unsure how these standards will map across to the existing ACHS EQuIP and ISO 9001 standards and individual state health department governing bodies or indeed if this is the intent. It is hoped that this is the case and that they are not another set of standalone standards. Because these standards are robust, succinct and have many quality and safety layers we would like to see not only the private accreditation agencies adopt them but extend the standards to State and Territory legislative bodies as well as the Private Health Insurers. The duplication that is currently in place does not deliver the quality and safety outcomes we think should be expected by the public. One set of standards and measurement across all health service providers, all jurisdictions and bodies will deliver clearer safety and quality indicators and give us more objective information about how our health systems are performing so that the standards across the broad health service spectrum are raised.

ADHA’s Response to the Commission’s question set.

1. IS THE LANGUAGE AND FORMAT OF THE HSQH STANDARDS APPROPRIATE?

   The standards are easy to read. The language is slightly different in way of descriptors to what we have been used to, but certainly clear. The format is particularly good, the tables allow for easy implementation and define simply the evidence required to meet each criteria.

   An observation - the language used is very similar to that used by ACHS and in some areas seems to be a duplication of ACHS Equip. eg: SQ5

   *Is there a risk that the industry will end up with duplicated quality policies, measures & audits?*
2. ARE THERE GAPS IN THE NSQH STANDARDS THAT SHOULD BE ADDRESSED?

Not evident - may be tested at the pilot level.

3. ARE THERE UNNECESSARY ITEMS OR DUPLICATION THAT SHOULD BE REMOVED FROM THE STANDARDS?

Not broadly evident. MS:B 2a & 2b could be combined as they are rather similar - will be tested at the pilot level.

4. IS THE LEVEL OF DETAIL PROVIDED ADEQUATE TO IMPLEMENT THE STANDARDS?

Yes, there is good detail at layered levels.

5. IF NOT WHAT ADDITIONAL INFORMATION IS NEEDED?

Will be an outcome of the pilot sites.

6. ARE THERE SETTINGS IN WHICH SOME OF THE ELEMENTS OF INDIVIDUAL STANDARDS DO NOT APPLY?

The standards ADHA think should apply to all healthcare facilities although there are some elements/criteria which may be problematic or not applicable in the Day Hospital setting. We have given brief comment beside each Standard.

1. SQ – excellent and can be applied in full
2. HAI-. HAI:C the patient separation with infection and isolation policy probably does not apply as day hospitals would not admit such a patient.
3. MS - all seems applicable. Need to have a National Day Surgery Medication Chart up and running though.
4. PI - No real problems in implementing except that the Australian Standard Arm Band Specifications has been criticised as “over the top” for day surgery. Do day hospitals need this added expense of a waterproof band as patients do not generally shower in day surgery and the patient would wear the band for a minimal period of time. Approximately 4 hours. Should 4b. PI process measure apply to Day Hospitals?
5. CH- important for day surgeries to have policies procedures in place for discharge, transfer, and shift change. Shift change is a rare occurrence in day surgery.

7. ARE THE PROCESS MEASURES IN INDIVIDUAL STANDARDS APPROPRIATE FOR THE ASSESSMENT OF SAFETY AND QUALITY OF EACH OF THE ELEMENTS?

As per Question 6. The pilot should provide more feedback. 

Shouldn’t the Process Measure for SQ:B 1a be more about evidence of clinical pathway use, analysis of variances and suitable measures introduced in response to variances?

Not all process measures are easily measurable therefore interpretation of results may be difficult. How will this be managed?
8. CAN THE DRAFT STANDARDS BE APPLIED IN YOUR HEALTHCARE SETTING WITHOUT MODIFICATION?

As per Question 6 though compared to the current multiple systems if the intent stays undiluted they would be very workable and resource efficient. The pilot should provide more feedback.

9. SHOULD THE FINAL SET OF NSQH STANDARDS BE THE ONLY SAFETY AND QUALITY REQUIREMENTS FOR ACCREDITATION OR SHOULD JURISDICTIONS AND /OR ACCREDITING AGENCIES HAVE THE CAPACITY UNER THE NEW MODEL TO ADD FURTHER SAFETY AND QUALITY REQUIREMENTS TO ACCREDITATION?

The final set of Standards should definitely be the only standard as stated in the opening paragraphs. The Australian Healthcare System has so many mandatory reporting bodies, so many different reporting standards and reporting requirements that it has become a burden to all sectors giving inaccurate outcomes. Health Care Facilities have lost their drive and enthusiasm for safety and quality because of this constant duplication and overlap. ADHA is opposed to any new requirements being added by any jurisdiction and believe that all bodies have a responsibility to share and embrace this framework.

We would strongly support the Commission set the National Safety and Quality Standards and retain their contract in doing so on a permanent basis so that uniformity and best practice in both safety and quality will reign.

Comment - Is there an intention by the AHIA to embrace & recognize these standards as a symbol of a quality service provided by an individual hospital and therefore provide funding relative to results?

Yours sincerely

PETER STEPHENSON  MBBS, FRACP
ADHA President