The safety of Australian healthcare: 10 years after QAHCS

We need a patient safety initiative that captures the imagination of politicians, professionals and the public

Nearly 10 years have elapsed since the Journal published the ground-breaking Quality in Australian Health Care Study (QAHCS)[1]. With its disturbing findings, the study seared "patient safety" into the public's psyche. The QAHCS methodology focused on the safety aspects of healthcare quality, without providing systematic data on other domains, such as access, efficiency and acceptability, and provided only some insight into effectiveness and appropriateness of care. The role of QAHCS was to estimate the size and nature of the problem of unsafe healthcare.

Now, 10 years on, most patients in our healthcare system do not suffer preventable harm, and receive good care. But it is still possible that up to 16% of hospitalised patients will suffer an adverse event: 50% of these events will be preventable and 10% of these preventable events will lead to permanent disability or death.[1] Studies from the United Kingdom,[2] Canada,[3] Denmark,[4] and France,[5] using similar methodology to the QAHCS, indicate that Australian healthcare is no safer than that provided in these countries. The magnitude of the problem worldwide is reflected in the World Health Organization's recent launch of the Patient Safety Alliance,[6] which aims to improve patient safety in all 192 member nations.

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What has been achieved since the release of the QAHCS? In 2000, 5 years after the study's release, the Australian Council for Safety and Quality in Health Care (ACSQHC) was formed to provide leadership in improving patient safety and quality through advice to all federal, state and territory health ministers. The ACSQHC has championed an extensive work program,[7] including:

- developing an "open disclosure" standard for patients and their families when care processes go wrong;
- developing a national standard for credentialing and defining the scope of practice of medical practitioners;
- involving consumers in improving healthcare safety by producing the booklet *Ten tips for safer health care: what everyone needs to know*;
- establishing a national Centre for Research Excellence in Patient Safety;
- testing strategies to ensure safer medication use at the point of care by involving more than 100 healthcare facilities in the National Medication Safety Breakthrough Collaborative;
- introducing the "Ensuring correct patient, correct site, correct procedure protocol" to reduce "wrong site" or "wrong patient surgery"; and
- launching a "high risk medication alert" on the use of concentrated potassium chloride solutions in hospitals.

Furthermore, each state and territory has developed peak advisory bodies, and many elements of patient safety programs (eg, the reporting and investigation of serious incidents) have been incorporated into hospital practice in all states and territories. Professional bodies such as the Royal Australasian College of Physicians have strengthened activities for maintenance of their members' professional standards,[8] and hospitals and other healthcare facilities have formed committees and created departments to oversee patient safety activities. All this has involved considerable effort and resources. However, much of the investment has been in "top down" activities (in the form of policy or monitoring) rather than "bottom up" activities. This can result in a considerable gap between what patient safety strategies are supposed to have been implemented in the workplace and what strategies are actually in place.

Instances of poor healthcare outcomes for individual patients, or adverse events involving particular hospitals, have rightly been highlighted in the media. The outcries reached deafening crescendos when perceived healthcare "scandals" in three Australian jurisdictions were revealed.[9] This year, the NSW government's Patient Safety and Clinical Quality Program released the "First report on incident management in the NSW public health system 2003–2004";[10] 452 incidents were reported that were regarded as "very high risk, can result in serious patient harm, and must be followed by immediate action …" This followed a similar report by the Victorian government in 2004.[11]

Ten years on can we confidently state that healthcare is safer for patients? Unfortunately, the answer is no. There is insufficient information at a state or national level to determine whether any or all of the efforts over the past 10 years have increased safety in our hospitals. It is regrettable that we have not measured the frequency of adverse events in Australia in a way that allows us to assess how we have fared since 1995; how we compare with other countries; and whether any of the initiatives described above have been effective in reducing patient harm. Given the truism we "manage what we measure", the absence of recent system-wide data on patient safety seriously hinders our ability to manage the problem and make improvements. Its absence makes a mockery of the tenets of continuous quality improvement. We need a thorough understanding of the strengths and weaknesses of data derived from medical record audits, voluntary reporting systems, clinical indicators, and existing large datasets if we are to seriously tackle the size and nature of the problem, and determine whether a particular intervention or program has been successful in improving safety. This information gap is recognised in the 2005 national productivity report on government services.[12]

Despite all the developments in the last 10 years, and in the context of the current Australian Health Ministers' review of the governance arrangements for safety and quality of healthcare,[13] there are still four areas that require more action and greater urgency.

1. *Leadership* — to provide clarity of vision and the will to change. As part of that leadership, we need an explicit and agreed goal, such as "to eliminate preventable patient harm from healthcare within 10 years". A recent challenge from Don Berwick — the 100 000 lives campaign — is to avoid 100 000

preventable deaths in the United States between January 2005 and July 2006 and every year thereafter. The campaign aims to enlist thousands of hospitals across the US in a commitment to implement changes in care that have been proven to prevent avoidable deaths.[14]

2. *Transparency* — fears that open discussion will reduce patient trust in the healthcare system, leading to patients failing to present for care in a timely manner, seem to be unfounded.[15]
3. *Measurement* — to provide information about where to direct our improvement efforts and whether our interventions have been effective. Dependence on voluntary reporting systems will lead to a gross and inconsistent underestimate of the size of the problem.
4. *Improvement tools* — there is a body of evidence on methodology for improvement projects at the local level, from the pioneering contributions of W Edwards Deming and Walter A Shewhart to the more recent Institute for Healthcare Improvement's Breakthrough Collaborative methodology,[16] which, through a collaborative learning model involving multiple organisations, helps health professionals to bring about breakthrough improvements in patient care outcomes.

There has been a lack of appreciation that the use of tested methods increases the likelihood of success of a particular project. Hence, many efforts have not delivered their full potential, or discussion and learning have been prevented because successful efforts have not been publicised. The failure to successfully implement existing knowledge or policy is a worrying characteristic of healthcare systems,[17] and demands greater rigour. Creating this capacity within our organisations is a major challenge to be addressed. The responsibility is on all of us — politicians, health administrators, clinicians and the public. Finally, the governance arrangements for transparency of performance of health service delivery, and the accountability for that performance at an individual, organisational, state and national level, need public negotiation and agreement. Currently, there seems to be an imbalance: much more attention is being paid to the accountability of individual healthcare providers than to improving healthcare safety at an organisational and whole-system level.

Of equal importance is that the ACSQHC appears to have limited relevance to or influence on the daily lives of health professionals. It is sorely in need of an initiative that captures the imagination of politicians, professionals and the public.[18] It could do no better than to emulate the US Institute of Medicine's "Crossing the quality chasm" healthcare quality initiative[19] by selecting a limited number of clinical conditions which have a high healthcare burden and resource use, and which clinicians agree are high priority. The task then is to apply the six aims for healthcare improvement to management of patients with these clinical conditions — their healthcare should be safe, effective, patient centred, timely, efficient, and equitable.[18] Finally, the process must be driven from the bottom up. Alternatively, joining the Berwick challenge to save 100 000 lives by reducing unsafe healthcare could have a galvanising influence.[14]

The magnitude of the challenge of eliminating preventable patient harm is daunting, the progress slow, and the need for our efforts to be successful huge. A significant increase in resolve on the part of all Australians, regardless of their role in healthcare, is needed if we are to meet the challenge of eliminating preventable patient harm over the next 10 years.

Ross McL Wilson
Director, Northern Centre for Healthcare Improvement, Royal North Shore Hospital, St Leonards, NSW; and Member of the Australian Council for Safety and Quality in Health Care
rwilson@doh.health.nsw.gov.au

Martin B Van Der Weyden
Editor, The Medical Journal of Australia, Sydney, NSW

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