Consultation on a resource for community health services applying the National Safety and Quality Health Service (NSQHS) Standards – APNA submission

24 July 2015

The Australian Primary Health Care Nurses Association (APNA) welcomes the opportunity to contribute to the Australian Commission on Safety and Quality in Health Care consultation on a resource for community health services applying the National Safety and Quality Health Service (NSQHS) Standards. We are providing this submission on behalf of our membership, Australian primary health care nurses.

APNA Submission

As an overall comment on the resource, it is important to note that primary health care nurses working in community health service settings are critical to maintaining safety and quality in health care.

With our membership's extensive experience in the field of meeting and maintaining standards, APNA can work with the Commission and accrediting agencies to provide education targeted at the nurse role in clinical governance for infection control, quality and safety.

APNA's specific comments on the questions raised in the consultation paper are listed below:

1) **Overall, is the information provided in the guide useful? If not, what information should be included or deleted?**

Many community health services will be familiar with resources from the Royal Australian College of General Practitioners (RACGP), such as in infection control, and some will have collocated general practice services. The RACGP's resources are not mentioned in the proposed Guide. It may be useful to include them, or to explain the basis on which they are not used.

'Root cause analysis' is described as an example of evidence in some sections and not others. It is preferable for the reference to be consistent – either for the incident and complaints management section to provide guidance to the approach to determining the extent of causal analysis for all incidents, or to articulate the expected threshold for root cause analysis in each area.

Australian Primary Health Care Nurses Association (APNA)
Level 2, 159 Dorcas Street, South Melbourne VIC 3205 | T 1300 303 184 | F 03 9669 7499 | admin@apna.asn.au | www.apna.asn.au
ABN 30 390 041 210 ARBN 111 194 293 Inc. No. A00414155

2) Is the language used in the guide appropriate for community health services? If not, please provide examples of how it could be improved?

The term 'audit' (defined as 'a systematic review of clinical care against a pre-determined set of criteria') is used frequently in the proposed Guide as an example of evidence. Collectively, especially if done rigorously, this implies a substantial, ongoing portfolio of systematic review. It may be useful to collate all references to 'audit' and consider the feasibility of this collectively; and to consider whether some descriptive text about the scale, scope and frequency of the audit would be useful to ensure that the work doesn't become 'reactive' or 'calculative'.[1]

The term 'committee' is used frequently in the proposed Guide. Collectively, especially if committees are meaningful arenas, this suggests a substantial commitment. It may be useful to collate all references to 'committees' and consider whether the scope of some 'committees' substantially overlaps; and provide some descriptive text about efficient and effective ways to structure committees as a whole.

The text and tone of the text with regard to communicating with consumers varies noticeably. For example, at 8.10.1, it says 'Inform consumers and carers about the purpose and process of developing a pressure injury management plan and invite them to be involved in its development'. This 'invitational' tone is in contrast to the section on medication management, which arguably involves the same fundamental approach of engaging people in developing their medication management strategy. It may be useful to compare the text on 'approach' for the consumer and carer sections and ensure that it is consistent and fits the 'meeting of experts' approach that underpins safety.

3) For each of the NSQHS Standards:

   a) Are the requirements for meeting the NSQHS Standards clearly explained? Which actions need further clarification?

   b) Are the suggested strategies appropriate for community health services? If not, what needs to be changed?

   c) Are the examples of evidence appropriate for community health services? If not, what needs to be changed?

   d) Is there unnecessary duplication in the examples of evidence, which should be removed from the guide? If so, please specify.

The proposed Guide presumes two related sets of critical micro-skills – the skill to open conversation about 'touchy issues' (variably involved in 'breaking bad news', addressing horizontal violence, raising same-sex attraction, sometimes called 'crucial conversations'); and the ability to act 'civilly'. The absence of these critical skills in the area on incident and complaints management needs to be addressed. It also needs to be

[1] Hudson, P. Safety Management and Safety Culture – the long, hard and winding road. Leiden University. Leiden, Netherlands: 2001. http://www.caa.lv/upload/userfiles/files/SMS/Read%20first%20quick%20overview/Hudson%20Long%20Hard%20Winding%20Road.pdf Accessed 1 February 2015

addressed in the sections about 'communicating with patients and carers'. Civility is, arguably, central to actions like open disclosure. The Veterans Administration has done work in the civility field which may assist.[2]

In the sections on communicating with patients and carers, it may be useful to be more explicit, in both the suggested approach and the examples of evidence, to be looking for application of models such as 'teach back'.[3]

The proposed Guide refers to activities such as 'providing regular feedback to the workforce on incidents reported' (4.4.1, emphasis added) and 'reports on trends in clinical handover incidents' (6.4.1). It appears to favour aggregate and trend reporting of data and information on incidents and near misses (which often requires time to pass before the report back). This presumes that the incidence/prevalence of events is sufficient to create meaningful trend analysis, for example. It may be useful to review the use of the word 'trend' and consider whether it could be accompanied by phrases such as 'review … incidence and prevalence'.

The Guide could usefully be more explicit about prompt provision of feedback on individual errors and harms where recency and salience can assist to change behaviour. The absence of tailored and timely feedback on individual incidents is a known deterrent to ongoing meaningful participation in incident reporting systems.

The text of the proposed Guide suggests ongoing reliance on print materials (e.g. brochures and fact sheets, at 4.13.2). Consideration could be given to when the proposed Guide would support approaches and look for evidence of print material being complemented with non-print resources (e.g. web-enabled video, push-out messaging/reminders). This sort of approach is evident at 8.9.1; and it may be useful for the proposed Guide to be more consistent in the use of text such as that at 8.9.1.

At 1.1.2, it may be useful to explicitly mention the importance of prioritisation. Not only the impact of a proposal on safety and quality, but its impact relative to other proposals is critical to good governance and management.

At 1.8.3, the approach could usefully include consideration of the description of thresholds for escalation and accountabilities for response. The 'chain of command' needs to be clear when managing rapid escalations of response.

At 1.9.1, it may be useful to include in the approach, and reflect in the examples of evidence, that it is useful to have consistency in the coding of clinical information (compatible with national data dictionaries) and use of terms in free-text.

The section on incident and complaints management omits any mention of 'second victims'. This needs to be rectified as it is critical that the approach to incident management effectively address the needs of second victims. Second victims are the professionals/providers who are involved in a (critical) client incident and become victims in the sense that they are traumatised by the event. Frequently, the second victim feels personally responsible for the harm, with many feeling as though they have failed the person who was

[2] Osatuke K Leiter M Belton L et al. Civility, Respect and Engagement at the Workplace (CREW) – a national organization development program at the Department of Veterans Affairs. Journal of Management Policies and Practices 2-13; 1(2): 25-34.

[3] Tamura-Lis W. Teach-Back for quality education and patient safety. Urologic Nursing 2013; 33(6): 267-71.

harmed.[4] In one study, 14% of staff reported being second victims and 68% of these (9.5% of all staff) reported that they did not receive support from their employer to deal with the issues.[5] Another study reports prevalence of secondary victims as being between 10-50% of staff.[6] Desirable characteristics of staff like a good relationship between the person harmed and the caregiver can make the impact of the event higher (as can the severity of the event itself, past work experiences and having a family member the same age as the client harmed) or another perceived 'connection'.[7]

In section 1.18.4, it is unclear whether the intent (as it is in medication management, for example) to reliably identify all people for whom advance care directives are appropriate and take a systematic approach to their use. It may be useful to consider whether this is the intention and include relevant text if it is.

In section 1.19.3 consideration might be given to adding review of work practices in relation to clinical discussions to the approach, to identify risks associated with 'corridor conversations'.

Section 2 appears not to mention the involvement of consumers in root cause analysis, and this omission might be addressed.

In section 3.5.1., and particularly for older sites and those which have been expanded, it may be useful to audit the consistency of hand wash configuration. In one study of a hospital site, there was substantial variation, diminishing the ability to make hand-cleaning reliable.

At 4.6.1, consideration might be given to looking for evidence of policies on long appointments or on ensuring time is not compromised on initial contact, as this sort of policy assists to ensure that medication history is fully documented, and not compromised due to time constraints.

The section governance and systems for preventing falls (Section 10) is, effectively, silent about falls prevention on the site of the health service. It may be useful to explicitly include reference to the management of this risk.

4) Is the information in the Table 1: Applicability of the NSQHS Standard to community health services appropriate? If not, please provide comment.

The information in Table 1 appears to be appropriate. We have no further comments to make on this.

5) Are the Developmental Items in Appendix 3 appropriate for community health services? If not, please provide comment.

The Developmental Items appear to be appropriate for community health services. We have no further comments to make on this.

[4] Wu AW Boyle DJ Wallace G et al. Disclosure of adverse events in the United States and Canada – an update, and a proposed framework for improvement. Journal of Public Health Research 2013; 2(3): 186-93.
[5] Scott SD Hirchinger LE Cox KR McCoig M Brandt J Hall LW. The natural history of recovery for the healthcare provider 'second victim' after adverse patient events. Qual Saf Health Care 2009; 18:325-50.
[6] Wu Boyle Wallace et al. op cit.
[7] Scott Hirchinger Cox et al. op cit

6) Is the Decision Support Tool in Appendix 5 helpful in determining the levels of evidence required to meet the NSQHS Standards? If not, please provide comment.

It may be unclear to the reader whether the Decision Support Tool or the text of the Guide is more 'authoritative'. Some clarity on this would be helpful.

About APNA

Australian Primary Health Care Nurses Association (APNA) is the peak professional body for nurses working in primary health care. APNA champions the role of primary health care nurses; to advance professional recognition, ensure workforce sustainability, nurture leadership in health, and optimise the role of nurses in patient-centred care.

APNA is bold, vibrant and future-focused. We reflect the views of our membership and the broader profession by bringing together nurses from across Australia to represent, advocate, promote and celebrate the achievements of nurses in primary health care.

Nurses in primary health care contribute to a healthy Australia through innovative, informed and dynamic care.

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