Emergency doctor: We can't cope!

Hospital: ‘overcrowded, overwhelmed’

The Age – 6 October 2011
Emergency Medicine as a policy issue

Labor’s cure for emergency-room shortages

HOSPITALS

PATRICIA KARVELAS
POLITICAL CORRESPONDENT

HOSPITAL emergency departments will get an extra 2000 nurses and 270 specialist doctors over the next decade if Labor is re-elected. Julia Gillard promised yesterday in an attempt to take control of the campaign and fight on Labor’s traditional strengths.

By unveiling the plan, the Prime Minister focused on health for the first time.

But the government came under fire for sowing confusion over the source of funding after it first said the $96 million for the scheme had been allocated in the budget — only to be contradicted by the Prime Minister’s insistence that the money was new.

“The money was, in fact, first allocated in the government’s economic statement in July, as part of an updating of the 2010-11 budget, under the heading of “decisions taken but not yet announced”.

“Yes, it’s building on earlier good work,” Ms Gillard said while campaigning at Launceston General Hospital in the Labor marginal seat of Bass.

Later, when visiting the Devonport GP super clinic, Ms Gillard narrowly missed an embarrassing encounter during a meeting with two patients. After she walked away, Lyn Dean and her husband, John Upton, said in their view Tony Abbott had won the debate in Sunday night.

Nurse Kelly Dee and doctor Tony Joseph in the emergency department at Royal North Shore Hospital in St Leonards, northern Sydney, yesterday.
There are five domains which are considered to encompass the priorities of the ED (Figure 1).

Figure 1: Quality Framework for Emergency Departments
Aim
The Quality Standards for Australian Emergency Departments aim to provide guidance and set expectations for the provision of equitable, safe and high quality emergency care in Australian EDs and hospital-based emergency care providers.

The Standards:
• encourage a proactive focus on quality and safety
• provide defined processes to continuously review and improve quality of care
• illustrate the optimal requirements for running a high quality emergency care service
• offer aspirational criteria for EDs to work towards achieving, thus strengthening the quality improvement culture within EDs.

Source: ACEM Consultation Draft: Quality Standards in Australian Emergency Departments - 7 Oct 2014
## Australian Safety and Quality Framework for Health Care

### Safe, high-quality health is always:

**CONSUMER CENTRED**

This means:
- Providing care that is easy for patients to get when they need it.
- Making sure that healthcare staff respect and respond to patient choices, needs and values.
- Forming partnerships between patients, their family, carers and healthcare providers.

### What it means for me as a consumer or patient:

1. I can get high-quality care when I need it.
2. I have information I can understand. It helps me to make decisions about my health care.
3. I can help to make my care safe.

My health care is well organised. The doctors, nurses and managers all work together. I feel safe and well cared for.

- I know my healthcare rights.
- If something goes wrong, my healthcare team look after me. I receive an apology and a full explanation of what happened.

### Areas for action by people in the health system:

1. **1.1** Develop methods and models to help patients get health services when they need them.
2. **1.2** Increase health literacy.
3. **1.3** Partner with consumers, patients, families and carers to share decision making about their care.
4. **1.4** Provide care that respects and is sensitive to different cultures.
5. **1.5** Involve consumers, patients and carers in planning for safety and quality.
6. **1.6** Improve continuity of care.
7. **1.7** Minimise risks at handover.
8. **1.8** Promote healthcare rights.
9. **1.9** If something goes wrong, openly inform and support the patient.
2. **Driven by Information**

This means:
Using up-to-date knowledge and evidence to guide decisions about care.
Safety and quality data are collected, analysed and fed back for improvement.
Taking action to improve patients’ experiences.

My care is based on the best knowledge and evidence.
The outcome of my treatment and my experiences are used to help improve care.

2.1 Use agreed guidelines to reduce inappropriate variation in the delivery of care.
2.2 Collect and analyse safety and quality data to improve care.
2.3 Learn from patients’ and carers’ experiences.
2.4 Encourage and apply research that will improve safety and quality.

3. **Organised for Safety**

This means making safety a central feature of how healthcare facilities are run, how staff work and how funding is organised.

I know that the healthcare team, managers and governments all take my safety seriously.
The health system is designed to provide safe, high-quality care for me, my family and my carers.

When something goes wrong, actions are taken to prevent it happening to someone else.

3.1 Health staff take action for safety.
3.2 Health professionals take action for safety.
3.3 Managers and clinical leaders take action for safety.
3.4 Governments take action for safety.
3.5 Ensure funding models are designed to support safety and quality.
3.6 Support, implement and evaluate e-health.
3.7 Design and operate facilities, equipment and work processes for safety.
3.8 Take action to prevent or minimise harm from healthcare errors.
# Australian Safety and Quality Goals for Health Care

## Safety of Care: That People Receive Their Health Care Without Experiencing Preventable Harm

### Goal 01

#### Priority Area 1.1 Medication Safety:
Reduce harm to people from medications through safe and effective medication management

#### Priority Area 1.2 Healthcare Associated Infection:
Reduce harm to people from healthcare associated infections through effective infection control and antimicrobial stewardship

#### Priority Area 1.3 Recognising and Responding to Clinical Deterioration:
Reduce harm to people from failures to recognise and respond to clinical deterioration through the implementation of effective recognition and response systems

#### Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1</td>
<td>Older people living in the community experience fewer adverse medicines events</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Older people experience fewer adverse medicines events at admission to and discharge from hospital</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Adults experience fewer venous thromboembolisms associated with hospitalisation</td>
</tr>
<tr>
<td>1.1.4</td>
<td>Children experience fewer dose-related adverse medicines events</td>
</tr>
<tr>
<td>1.1.5</td>
<td>People taking warfarin in the community experience fewer adverse medicines events</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Healthcare providers, consumers and patients use effective, evidence-based hand hygiene practices</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Antimicrobials are prescribed appropriately and people experience fewer infections from resistant pathogens</td>
</tr>
<tr>
<td>1.2.3</td>
<td>Fewer people experience central line associated bloodstream infections, surgical site infections and catheter associated urinary tract infections</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Recognition and response systems are in place in acute healthcare facilities and fewer people experience harm because deterioration in their physical condition is not identified or acted on appropriately</td>
</tr>
</tbody>
</table>

## Appropriateness of Care:

**Goal 02**

**Priority Area**

### 2.1 Acute Coronary Syndrome:
- Provide appropriate, evidence-based care for people with acute coronary syndrome.

### 2.2 Transient Ischemic Attack and Stroke:
- Provide appropriate, evidence-based care for people with a transient ischemic attack or stroke.

**Outcomes**

### 2.1.1 Acute Coronary Syndrome:
- All people with acute coronary syndrome receive care in line with nationally agreed clinical standards, considering the following phases of their journey in the health system:
  - pre-hospital
  - hospital care
  - secondary prevention

### 2.2.1 Transient Ischemic Attack and Stroke:
- All people with a transient ischemic attack or stroke receive care in line with national clinical standards, and have improved quality of life. This is considering the following phases of their journey in the health system:
  - pre-hospital care
  - hospital care
  - community care
How Often Recommended Care is Received, Selected Conditions

- Alcohol dependence: 10.5%
- Hip fracture: 22.8%
- Atrial fibrillation: 24.7%
- Diabetes mellitus: 45.4%
- Asthma: 53.5%
- OVERALL: 54.9%
- Depression: 57.7%
- Congestive heart failure: 63.9%
- Hypertension: 64.7%
- Prenatal care: 73.0%
- Breast cancer: 75.7%

Percentage of eligible encounters at which appropriate care was received* 2009-2010

- Coronary artery disease
- Dyspepsia
- Chronic heart failure
- Hypertension
- Low back pain
- Panic disorder
- Chronic obstructive pulmonary disease
- Diabetes
- Venous thromboembolism
- Osteoporosis
- Depression
- Atrial fibrillation
- Cerebrovascular accident
- Community-acquired pneumonia
- Osteoarthritis
- Preventive care
- Surgical site infection
- Asthma
- Hyperlipidaemia
- Obesity
- Antibiotic use
- Alcohol dependence

Source: J Braithwaite - South Eastern Sydney Local Health District Annual Symposium 17th October 2012

* Bars indicate 95% confidence intervals. Circle size represents the number of eligible encounters for each condition.
PARTNERING WITH CONSUMERS: THAT THERE ARE EFFECTIVE PARTNERSHIPS BETWEEN CONSUMERS AND HEALTHCARE PROVIDERS AND ORGANISATIONS AT ALL LEVELS OF HEALTHCARE PROVISION, PLANNING AND EVALUATION

GOAL 03

PRIORIT AREA

OUTCOMES

3.0.1 Consumers are empowered to manage their own condition, as clinically appropriate and desired

3.0.2 Consumers and healthcare providers understand each other when communicating about care and treatment

3.0.3 Healthcare organisations are health literate organisations

3.0.4 Consumers are involved in a meaningful way in the governance of healthcare organisations
BMJ – 18 May 2013
But partnering with patients must be seen as far more than the latest route to healthcare efficiency. It’s about a fundamental shift in the power structure in healthcare and a renewed focus on the core mission of health systems. We need to accept that expertise in health and illness lies outside as much as inside medical circles and that working alongside patients, their families, local communities, civil society organisations, and experts in other sectors is essential to improving health. Revolution requires joint participation in the design and implementation of new policies, systems, and services, as well as in clinical decision making.
Patient-centred care: Improving quality and safety through partnerships with patients and consumers
What is patient-centred care?

- Health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers
- An innovative approach to the planning, delivery and evaluation of health care which is based on mutually beneficial partnerships between healthcare providers, patients and families

Institute for Family- and Patient-Centered Care
What do patients value in care?

- *Being treated with dignity and respect*
- *Having confidence & trust in providers*
- *Courtesy & availability of staff*
- *Continuity & transitions*
- *Coordination of care*
- *Pain management & physical comfort*
- *Respect for preferences*
- *Emotional support*

Jenkinson et al. (2002) Qual Saf Health Care
PCC linked with improved safety:

- Decreased mortality\(^1\)
- Decreased rates of hospital-acquired infection\(^2\)
- Decreased surgical complications\(^3\)
- Higher quality clinical care/best practice\(^4\)
- Improved patient functional status\(^2\)

“Leadership is about taking responsibility for a group of people and their future direction. Leadership makes sense only within the context of a group – a business, a team, a school, a hospital, a government or a nation – and its collective purpose.”
“Leadership is not about maintaining the status quo – leadership is about creating the conditions for a journey, undertaken by many, and often without a single or known destination.”
Leaders need followers to be effective

- Development of followership bigger challenge than leadership

- Creation of organisations whose professionals are willing to follow their peers needs similar attention
Leadership

Features

- Alignment of interest between leader and the many others
- Trust key element
- Change needs to make sense to group
- Communication that is genuine and connects
- Development of leadership culture within the group
Three ways to lead

<table>
<thead>
<tr>
<th>Overall identity</th>
<th>Sources of power</th>
<th>Selected leadership skills and knowledge required</th>
</tr>
</thead>
</table>
| Institutional leader | ● Clinician executive acting as steward of whole organisation  
                        ● Little direct contact with patient | ● Highly credible to colleagues as clinician and leader; able to communicate vision  
 ● Corporate-level strategic thinking, talent management, succession planning  
 ● Political savvy; strong skills in negotiation and influence |
| Service leader | ● Passionate advocate for own service, feels responsible or its clinical and financial performance  
                       ● Moderate level of direct contact with patients | ● Highly credible to colleagues, primarily as clinician; well connected, can tap into centres of excellence  
 ● Innovative, willing to take risks  
 ● Fluent service-management skills – eg, strategy/people development, budgeting  
 ● Detailed knowledge of evidence-based medicine in own clinical area |
| Frontline leader | ● Great frontline clinician who focus on delivering and improving excellent patient care  
                       ● High level of direct contact with patients | ● Passionate about clinical work, credible to colleagues  
 ● Close to patients and frontline realities; can see opportunities for improvement  
 ● Understanding of systems- and quality-improvement techniques – eg, process mapping, operational improvement  
 ● Self-starter, able to work well in teams |

Attributes of well-functioning clinical teams

- Common purpose and vision
- Open and clear communication; transparent processes
- Participative leadership
- Defined roles and tasks with adequate levels of autonomy, skill
- Mutual respect, collaboration and cooperation
- Agreed methods of negotiation and conflict resolution
- Effective decision making based on objective data and opinion
- Regular meetings of all team members
- Recognition and reward for individual contributions and group successes
Harnessing implementation science to improve care quality and patient safety: a systematic review of targeted literature

JEFFREY BRAITHWAITE1, DANIELLE MARKS1 AND NATALIE TAYLOR1,2

1Centre for Clinical Governance Research, Australian Institute of Health Innovation, University of New South Wales, Sydney, NSW 2052, Australia, and 2Bradford Institute for Health Research, Bradford, UK

Address reprint requests to: Faculty of Medicine, Centre for Clinical Governance Research, Australian Institute of Health Innovation, University of New South Wales, Sydney, NSW 2052, Australia. Tel: +612-9383-2350, Fax: +612-9383-4926. E-mail: j.braithwaite@anu.edu.au

Accepted for publication 16 March 2014

Abstract

Background. Getting greater levels of evidence into practice is a key problem for health systems, compounded by the volume of research produced. Implementation science aims to improve the adoption and spread of research evidence. A linked problem is how to enhance quality of care and patient safety based on evidence when care settings are complex adaptive systems. Our research question was: according to the implementation science literature, which common implementation factors are associated with improving the quality and safety of care for patients?

Methods. We conducted a targeted search of key journals to examine implementation science in the quality and safety domain applying PRISMA procedures. Fifty-seven out of 466 references retrieved were considered relevant following the application of exclusion criteria. Included articles were subjected to content analysis. Three reviewers extracted and documented key characteristics of the papers. Grounded theory was used to distil key features of the literature to derive emergent success factors.

Results. Eight success factors of implementation emerged: preparing for change, capacity for implementation—people, capacity for implementation—setting, types of implementation, resources, leverage, desirable implementation enabling features, and sustainability. Obstacles in implementation are the mirror image of these: for example, when people fail to prepare, have insufficient capacity for implementation or when the setting is resistant to change, then care quality is at risk, and patient safety can be compromised.

Conclusions. This review of key studies in the quality and safety literature discusses the current state-of-play of implementation science applied to these domains.

Keywords: patient safety, appropriate healthcare
Harnessing implementation science

Preparing for Change

Desirable enabling implementation features as a platform for success (e.g., communication, incentives, feedback)

Capacity for implementation: people, setting

Leverage and resources

Types of implementation

Figure 2: Phases of implementation
The National Emergency Access Target (NEAT): can quality go with timeliness?

Abstract

Objective: To report the experience of implementing a 4-hour-rule program.

Design, setting and participants: A 3-year whole-of-hospital clinical service redesign program in a tertiary paediatric hospital in Western Australia, involving all patients presenting to the emergency department (ED) from 1 January 2009 to 31 December 2011.

Main outcome measures: Percentage of patients admitted, discharged or transferred from the ED within 4 hours of arrival at triage, and percentage of patients discharged from inpatient wards before 10 am.

Results: The percentage of patients admitted, discharged or transferred within 4 hours of arrival at the ED increased from 87% in 2009 to 95% in 2011. Safety and quality measures, including the admission rate from the ED, unplanned readmissions at the ED within 48 hours of discharge, patient complaints and inhospital mortality, remained unchanged. The percentage of patients discharged from inpatient wards before 10 am increased from 18% in 2009 to 30% in 2011.

Conclusions: The introduction of a 4-hour-rule program has resulted in improved timeliness of care for patients throughout the hospital, both in the ED and inpatient wards, with no adverse impact on the quality and safety of clinical care.
Literature Review

Emergency Department Targets

- *Strong evidence linking ED overcrowding and access block to poorer patient outcomes in Australia*
- *Similar association in Canada, USA and UK*
- *ED overcrowding and access block contribute to 20 - 30% excess mortality rate*
- *Also contribute to prolonged inpatient length of stay*

Literature Review

“The available evidence suggests that targets face resistance at local level if they are imposed on those who must implement them. Mechanisms that foster participation and a sense of ownership are an important element of a target based strategy”

Source: Ernst, K., Wismar, M et al Chapter 4 “Improving the Effectiveness of Health Targets” In “Health Targets in Europe: Learning from Experience” European Observatory on Health Systems and Policies, Observational Studies Series No 13, 2008
Literature Review

Risks of performance targets

- “Hitting the target but missing the point”, ie quantity not quality
- Alienation of key stakeholders where there is a lack of consultation, planning and communication
- “Gaming” including cherry picking of patients and manipulating data

Literature Review

Disincentives to clinician involvement in sustained quality improvement and practice change.

- Lack of sustained and visible support from senior management and clinical leaders
- Inadequate resources allocated for change implementation
- Insufficient staff time for participation and retraining
- Failure to develop robust measurement and data feedback systems
- Misalignment of incentives structures
- Resistance to change from professional and/or organisational cultures

Source: Scott, I and Phelps, G “Measurement for Improvement: Getting one to follow the other” IMJ 2009, 39, 347-351
Emergency Access and Elective Surgery Targets: Guiding Philosophy of the Expert Panel

“We are fundamentally of the view that strong and public leadership is required at all levels – from Ministers, Commonwealth and State and Territory Health Departments, key stakeholders, Local Hospital Networks and Medicare Locals, Lead Clinicians Groups, hospital managers and clinicians. **If the onus on achieving the benefits that can arise from the process and system redesign falls only to clinicians, they will fail.** Achieving success must be a top priority and responsibility for those in charge of our health system. The risk we face is that without common support and engagement for whole-of-hospital reform, there is little chance for the necessary system change to be achieved”

Guiding Principles

1. *Targets and the changes required to meet them will require commitment right across the health and hospital system*

2. *Hospital executives will need to work in partnership with clinicians to achieve sustainable change*

3. *Clinical engagement and clinical leadership will be essential if the targets are to be met*

4. *Targets must drive clinical redesign with a whole-of-hospital approach*

5. *Clinical redesign must ensure patient safety and enhance quality of care*

Guiding Principles

6. Definitions to be clear and consistent across all jurisdictions

7. The performance of jurisdictions is not comparable

8. Progress towards the targets needs to be linked with continual monitoring of safety and quality performance indicators and audit

9. The impact of targets on demand needs to be monitored and early strategies developed to ensure achievements are sustainable

10. Quality of training is maintained

What makes a difference?

Improving the safety and quality of care: AAQHC Conference

Organisational Factors
- Leadership
- Respect
- Standardised approach
- Celebrating Success

System Factors
- Regulation

Staff Factors
- Education
- Provision of timely data

Consumer Factors
- Patient and family centred approach
- Patient Experience
The Australian Quality Improvement Cycle

Health Sector Programs

Identify issues and risks

National Safety And Quality Goals and Standards

Solutions, actions tools and supports

Data and information

Accreditation – Measurement of systems, actions and data
AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1. Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.
2. The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.
3. Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

What can I expect from the Australian health system?

<table>
<thead>
<tr>
<th>MY RIGHTS</th>
<th>WHAT THIS MEANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>I have a right to health care. I can access services to address my healthcare needs.</td>
</tr>
<tr>
<td>Safety</td>
<td>I have a right to receive safe and high quality health care. I receive safe and high quality health services, provided with professional care, skill and competence.</td>
</tr>
<tr>
<td>Respect</td>
<td>I have a right to be shown respect, dignity and consideration. The care provided shows respect to me and my culture, beliefs, values and personal characteristics.</td>
</tr>
<tr>
<td>Communication</td>
<td>I have a right to be informed about services, treatment, options and costs in a clear and open way. I receive open, timely and appropriate communication about my health care in a way I can understand.</td>
</tr>
<tr>
<td>Participation</td>
<td>I have a right to be included in decisions and choices about my care. I may join in making decisions and choices about my care and about health service planning.</td>
</tr>
<tr>
<td>Privacy</td>
<td>I have a right to privacy and confidentiality of my personal information. My personal privacy is maintained and proper handling of my personal health and other information is assured.</td>
</tr>
<tr>
<td>Comment</td>
<td>I have a right to comment on my care and to have my concerns addressed. I can comment on or complain about my care and have my concerns dealt with properly and promptly.</td>
</tr>
</tbody>
</table>

For further information please visit www.safetyandquality.gov.au