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Consultation on NSQH Standards
Australian Commission on Safety and Quality in Health Care
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HCCA Response to the Consultation Paper on the Draft National Safety and Quality Healthcare (NSQHC) Standards

Background

Health Care Consumers' Association (HCCA) of the ACT was formed over 30 years ago to provide a voice for consumers on local health issues and now provides opportunities for health care consumers in the ACT to participate in all levels of health service planning, policy development and decision making.

Introduction

The Health Care Consumers' Association of the ACT (HCCA) welcomes the opportunity to respond to the Consultation Paper on the NSQHC Standards. *We* were very pleased to work with the Commission to hold a consumer consultation on 1 October 2010 in Canberra.

We consider accreditation to be an important tool in improving the quality of health services. HCCA believes the emphasis should be on achievable outcome measures

We also support the idea that the involvement consumer in the accreditation process has the potential to bring about service wide improvements.

General Comments

We support the objective of the Standards and support the areas addressed within the NSHQ standards. We are supportive of the two core standards. We see that all ten

standards have the potential to increase consumer confidence that minimum safety standards apply across all service settings. We are pleased to see that this iteration of the standards have moved beyond the previous focus on compliance with safety requirements and are moving towards encouraging continuous quality improvement.

Consumers want assurance that the treatment and care we receive is of a high quality. Safety is an important component of quality but not the only aspect that we consider to be essential to high quality care. We would like comprehensive approach to accreditation that looks beyond safety of health services and include quality indicators. There are a number of organisations which accredit health services and include a range of quality indicators. We are interested to see how the NSQHC standards will be used to complement existing accreditation processes.

Further to the need for a comprehensive approach to accreditation, we would like to see the language and definitions to be consistent across all health service accreditation standards. This will make the process more meaningful for health services and the community interested in the results.

Communication with the community about the NSQHC Standards and what they mean for consumers is an important aspect of implementation. Consumers have strongly expressed their interest in pubic reporting of performance against accreditation standards and accessible explanation of what the accreditation standards have measured and what that means for the consumers using that service. Consumers have questions they would like answered including: what happens if services do not meet the standards? What is the sanction if services do not meet the standards? What are the implications for consumers? How will the standards be taken up with the regulators? What are the controls? We would encourage consideration of the development of a single site where information on a health provider's accreditation status can be accessed which would include the standards, a list of accredited health services, information on accreditation outcomes and links to relevant accrediting bodies.

We support the references to the Charter of Health Care Rights in the draft Standard 1(Governance) but would like further consideration of the inclusion of specific references to consumer feedback and complaints management across other standards.

We support the Commission's approach to have the governance standard and consumer engagement as overarching standards provide the context for the implementation of each of the other Standards. We consider it very important to involve consumers in accreditation, including the development and review of standards, evaluation of implementation, and the inclusion of trained consumer representatives as part of review team. We strongly encourage consumer involvement in surveyor training and as surveyors on accreditation teams.

Language and Terminology

When terms such as ***best practice guidelines*** are used we would like to know who determines this. For example, in the Standard 7 (D1a), Standard 8 (A1.1a and A3) and Standard 10 (A1.1b)

Where there are references to evidence of action taken in measures we suggest this be amended to include an assessment of the ***effectiveness of the action*** also. For example, Standard 8 A.2.2a we would be changed to *evidence and effectiveness of action taken as a result of analysis of the frequency and severity of pressure ulcer information*. Similarly in Standard 10 A2.2b would become *Evidence and effectiveness of action taken as a result of the analysis*.

We would like to see the use of the terms ***consumers and carers*** rather than patients. Consumers play a significant role for many consumers dealing with the health system and we encourage the Commission to include carers in the standards.

We commend the Commission on their work to date but would like to emphasise the need for an implementation plan. One way this can be achieved is through the consistency of language in the criteria and measures. We suggest using the word implementing in "are developed and implemented" throughout the standards. For example, Infection Control standard 3B policies and protocols for the prevention of healthcare associated infection are developed ***and implemented***.

Format of the standards

We would like to see consistent approach to the format of the standards so that they all include the standard, explanatory notes, the specific role, criteria and bibliography. To this end we encourage the Commission to include in Standard 2, Partnering for Consumer Engagement, a section outlining Specific Roles and also a Bibliography. In addition to the bibliography we would like to see listed the state and territory consumer organisations listed where they exist; Health Care Consumers Association (ACT), Health Consumers Council (WA), Health Consumer Alliance (SA) and the newly formed consumer body in New South Wales.

Specific comments

Standard 2: Partnering for consumer engagement
Criteria A. Consumer participation in service planning
4. Consumer consultation on the design and content of patient information distribution by the organisation
Consumers can be involved in identifying our information needs but may not be best placed to develop the communication strategy and documents. This is a specialist skill that individual consumers and consumer representatives do not necessarily have. Consumer representatives should not be used as a defacto communication expert on information.

Standard 7: Blood and Blood Product safety
Criteria C Information for Patients
2. An informed consent process for all blood and blood product administration.
We support the need for informed consent for blood and blood products. The difficulty of this criterion is in terms of implementation as consumers are often mailed informed consent documents to be completed at home, often without adequate information or opportunity to ask additional questions or clarify their understanding.

Standard 8: Prevention and management of Pressure ulcers
We strongly support the inclusion in the measure of Criterion A 2.2a for evidence of reporting, monitoring and analysis ***at all levels of the organisation***. This requirement appears only once in the standards and we would encourage the Commission to consider extending this requirement to other criteria.

We see that there is duplication between criterion B (Screening for existing pressure ulcers) and criterion C (Prevention of pressure ulcers) and are of the view that they can be combined.

We consider there to be a need to include measures that require evidence of reduction in rates of pressure ulcers as a result of using risk assessment frameworks. This could be added to measure A 2.2a and possibly an additional measure in Criterion D1.

Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care
A3. Having access at all times to at least one clinician, either on-site or in close proximity, who can practice advanced life support.
This criterion assumes that this is what the consumer wants. We would encourage the Commission to consider changing this criterion to be more inclusive of advanced care directives.

This standard requires a section ***on information for consumers and carers for decision making***. It may be that the reference to advanced care directives is most appropriately placed here.

We encourage the Commission to further consider setting appropriate timeframes for the completion of a review after death or cardiac arrest (Criterion C3). We also would like to see the review involve all staff (clinical and non clinical) as well as families who noted the deterioration.

Thank you for your consideration of this submission.

Darlene Cox
Executive Director