Comment on:
Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems
(October 2012) The National Association for Healthcare Quality

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In spite of significant efforts over the past two decades to improve healthcare quality and safety, it is widely recognized that there is more work needed to eliminate preventable harm in the US healthcare system. While a strong and just safety culture has been recognized as a key element for improvement, a critical deficit that has not yet been fully addressed is the lack of protective infrastructure to safeguard responsible, accurate reporting of quality and patient safety outcomes and concerns...the accelerating implementation of new financial models that tie quality outcomes to payment will raise the stakes associated with quality results. The need will be even greater for a protective infrastructure to safeguard accurate reporting of quality data and patient safety concerns.

So begins the National Association for Healthcare Quality's (NAHQ) ‘Call to Action: safeguarding the integrity of healthcare quality and safety systems’ (NAHQ 2012). The NAHQ, an American organisation dedicated to improving healthcare quality and safety, developed the ‘Call to Action’ in conjunction with a number of other American organisations, including the Joint Commission, the American Medical and Nursing Associations and the American Health Information Management Association. The ‘Call to Action’ is an interesting approach when viewed through an Australian lens. It asserts that, despite many years of education and work to develop ‘just’ and ‘safety’ cultures in healthcare, ‘healthcare has been especially resistant to cultural transformation’ and there is still a culture of intimidation and bullying around reporting adverse events in United States (US) hospitals. In support of this assertion, the paper quotes data published by the Agency for Healthcare Research and Quality (AHRQ) in February 2012, that reports only 44% of surveyed healthcare providers described to error at their organisation as non-punitive (Sorra et al. 2012).

The ‘Call to Action’ recommends the leaders of every healthcare organisation in the country take four key steps to improve protective supports for the reporting of quality and safety concerns and the collection of comprehensive, accurate data: (i) establish accountability; (ii) protect those who report quality and safety findings; (iii) report quality and safety data accurately; and (iv) respond to quality and safety concerns with robust improvement. In addition, the authors recommend a number of contributing roles for national change agents:

- Professional membership associations:
  - provide strong guidance regarding the ethical response to errors and the importance of a strong and just safety culture
  - publish a written code of ethics regarding the identification and reporting of quality and safety concerns
  - create tools such as communication templates for dealing with conflicting interests or intimidation relating to the reporting of quality and safety concerns.

- Accrediting bodies:
  - facilitate education of healthcare organisations regarding the importance of the integrity of error reporting to internal sources and external agencies and promotion of a safety culture.

- Legislative and regulatory bodies:
  - further develop and enforce effective legislative protections for individuals investigating or reporting quality and patient safety concerns.
  - ensure that state regulations provide special protection for individuals with responsibility for reporting data on quality and patient safety performance.
Is this issue confined to US hospitals? It’s hard to tell. Various US studies published over the past year have claimed under-reporting of adverse events at somewhere between 30-90%. Would we find the same results here if we conducted the same drill down record audits on which these studies are based? Or is this a product of deliberate sabotage of the incident reporting system?

There are many reasons for incidents not being reported, for example: not recognising a problem as a reportable incident, lack of time, clumsy reporting systems and simply forgetting. While in Australia we would probably add ‘fear of consequences’ to that list, would it be the primary reason? Or is the US healthcare system and associated funding levers and clinician culture so different that we would not expect to see this as an issue of similar magnitude here?

We are certainly not in a state of safety and quality nirvana. We have a long way to go before we can boast about safe, quality care for every consumer, every time. We are about to receive our ‘Call to Action’ in the form of the new National Safety and Quality Health Service Standards. Many of the recommended actions in this paper we would see as important components of clinical governance systems, which are still works in progress in most health services. The paper’s appendices provide a useful list of resources on the clinicians’ role in creating safe care, which would be a useful addition to any health service clinical governance system.

There is no doubt we should be implementing our own systems with greater focus and urgency, and it is likely that the new National Safety and Quality Health Service Governance Standard will help drive this. We should be aware that fear of consequences is an issue in incident reporting, and continue to develop our just and safety cultures to combat this. We should be grateful that we do not appear to need this particular Call to Action in Australia, but should be alert to the fact that this situation, like everything else in the complex world of healthcare, may change, and requires consistent work and vigilance.

References
NAHQ (2012). Call to Action: safeguarding the integrity of healthcare quality and safety systems. Available at: www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf

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