The August 2011 Council of Australian Governments (COAG) National Health Reform Agreement (NHRA) (Commonwealth of Australia 2011) outlined COAG’s objectives for national health reform, including:

- improving performance reporting through the establishment of the National Health Performance Authority (the Authority)
- improving accountability through the Performance and Accountability Framework (the Framework): the Framework will underpin reporting across three domains; equity, effectiveness and efficiency of service delivery in healthcare.

The Framework has been designed to facilitate the achievement of key national health policy objectives, including:

- the ongoing improvement of the safety and quality of the health system
- ensuring efficiency and sustainability through a rigorous data collection, monitoring and reporting system
- enabling comparisons between all sectors of the Australian health system, including comparisons across the public and private sectors to assist both the public and private sectors in improving performance.

As part of the reform process, Health Ministers endorsed the Model National Accreditation Scheme and the use of 10 National Safety and Quality Health Service Standards (NSQHSS) in November 2010. The accreditation program aims to provide Australian Health Ministers with an alternative model of accreditation, including standards that can be applied across all sectors of the healthcare system. Health services are currently in a transition period, with assessment against the Standards mandatory from 1 January 2013 (Australian Commission on Safety and Quality in Healthcare).

The Standards focus on areas that are essential to improving the safety and quality of care for patients. They provide an explicit statement of the expected level of safety and quality of care to be provided to patients by health services organisations and provide a means for assessing an organisation’s performance.

The Standards present an important opportunity to improve accountability for the provision of safe and effective care through a mandatory compliance approach, which requires every criterion to be met. Demonstrating this compliance will be very challenging as for most health services the documentation of the systems and process of clinical care by clinical staff is fragmented and not standardised. The predominant finding in Serious Adverse Event investigations, or root cause analyses, both within Australia and internationally, is that breakdowns in communication between health professionals, between health professional groups and with patients and their carers are the major causative factor in adverse events.

Health Information Managers (HIMs) also rely on consistent, accurate documentation in clinical records to code patient episodes of care, which in turn underpin funding and hospital activity targets. Clinical records are now being considered as a major source of data for demonstrating compliance with the Standards. These processes are not always well known or understood by clinical staff, who may not recognise the importance of the medical record as both a communication and data collection tool.

The Standards make specific reference to the importance of health records in supporting safe and effective care. Standard One, which covers Governance for Safety and Quality in Health Service Organisations, requires policy, procedures or protocols specifically for collecting and reviewing performance data and for conducting regular clinical audits. Specific action outlined in 1.9.2 requires that the design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards.

An opportunity exists with the introduction of the Standards to strengthen documentation in the health record. By working with Quality and Safety Managers and clinicians, HIMs can explore this approach to improve the standards of documentation and the ability of the health record to be used for clinical auditing. By encouraging the use of standard terms (e.g. based on SNOMED data sets, ICD descriptions and Medicare item numbers), there is great potential to meet the needs of all groups. There is also an opportunity to improve the understanding and use of hospital acquired codes, as currently these are manually collected and audited (e.g. falls and pressure ulcers). Building safety and quality checklists or data elements into routine medical entry, through checklists and structured formats such as specific medical records forms, will also increase the availability of these data.

As the new Standards pose opportunities, they also present challenges. Currently, the source of data for clinical outcome reporting through Executive Committees to the Board are many and varied, including incident reporting systems and data from hospital information systems. Data that are routinely monitored...
include mortality and complications as well as process indicators such as unexpected return to theatre and hospital readmissions. If the data requirements for the National Standards are built into everyday practice and documentation, not only will clinical staff be familiar with the data when externally assessed, but the burden of audit will be reduced. As the quality of the source documentation improves, so too will the quality of coding. The trust that clinicians have in the coded data will then also improve, which should lead to greater use of the coded data set for safety and quality improvement. This in turn will enhance the clinical governance reporting processes in health services. Clearly, HIMs have a key role to play in realising this potential.

Reference

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