

Feedback Form for 'Towards National Indicators of Safety and Quality in Health Care'

Completed feedback forms may be returned to:

- Email to hcsqu-consultation@aihw.gov.au
- Fax to 02 6244 1299 (attention: Jason Thomson)
- Hard copy to: Health Care Safety and Quality Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Your details

Organisation: NHMRC Centre of Research Excellence in Patient Safety

Main area of speciality/interest: Epidemiology Patient Safety

Your role/select more than one category if appropriate):

Academic	Administrative	Medical Practitioner	Nurse	Allied Health
X	X	X	X	
Management	Policy	Safety and Quality	Consumer	Other (please specify)
X	X	X		

Feedback

We appreciate your consideration and feedback relating to the proposed national indicators of safety and quality in health care.

This form details questions relating to the indicator set as a whole (questions 1 - 4), as well as specifically to the individual indicators (question 5).

Please feel free to provide any other feedback you think is appropriate.

1. Proposed indicator set as a whole

Does the proposed indicator set provide an appropriate coverage of the following areas?

	Yes	No
Dimensions of quality		X
Health care settings		X
National Health Priority Areas		X
Burden of disease groups		X
Major areas of health expenditure		
Major disease and injury groups contributing to the major areas of health expenditure		X

2. Please provide any suggestions as to any changes you would recommend. For example, is there an over-emphasis on a particular area, overlaps, etc.

We propose that greater attention be placed on collecting good data from high risk/high cost areas across the health sector.¹ Five strategies for improving measurement are outlined:

1. Invest in Clinical registries

Clinical registries have the capability of collecting epidemiologically sound data which is respected by clinicians and administrators and therefore has unrivalled potential to drive quality improvement. Throughout Europe and the USA, registries are becoming one of the most clinically valued tools for quality improvement.² The Swedish Stroke registry provides an excellent example of how registries can be used to monitor quality of care and improve clinical performance at a national level.³

We propose a greater investment in the development of clinical registries which are strategically placed to generate high quality “quality indicators” in high risk areas.

2. Invest in validating proposed indicators

Many indicators proposed have had little or no validation work which gives little confidence in the quality of the underlying data. While audit checks of the accuracy of coding are performed (albeit variably amongst states and territories), coding is only as good as the quality of documentation. There are vast gaps in documentation in medical records. The impact that this has on these indicators is largely untested. But requires urgent attention.

3. Invest in developing clinical networks

We propose that clinical networks be widely implemented to collate and benchmark quality indicators which can be easily and reliably collected, consistently recorded and objectively measured.¹ These are at various stages of development in the fields of cancer, mental health, rehabilitation, respiratory health, endocrine, cardiovascular, renal disease, maternity and newborn care, neurosciences (including stroke care) and emergency care in Australia.⁴⁻⁸

These networks should be actively involved in the development of high quality epidemiologically sound indicators. Until work is undertaken to validate indicators, benchmark data should not be reported publicly. A work program to validate indicators within Australia must be a priority of these networks.

Clinical networks have been used successfully. The “Get with the Guidelines” program developed by the American Heart Association and the American Stroke Association.⁹⁻¹¹ has successfully improved adherence to guidelines in the management of stroke and cardiovascular disease. It does this by providing tools to support decision making, collect high quality data, and benchmark performance with other clinical networks. It has harnessed support from clinicians by engaging respected clinical leaders in the field to collect good data and adopting a collaborative quality improvement framework.¹²

4. Invest in developing composite indicators

There is promising work to suggest that composite indicators can accurately reflect quality in an institution. Given the huge investment which will be required by institutions to collect the currently proposed set of indicators, this needs further

work. A number of methods have been developed for aggregating indicators into composite indices.¹³ While greater work is needed to explore the suitability of these methods to the national Australian context, their ability to link processes with patient outcomes at the hospital level is appealing. The first step is likely to be to determine which individual indicators may be appropriate for composite approaches and then how these measures may be combined most effectively.

5. Invest in developing a core set of Standards

There are some processes which fundamentally should attain 100% compliance for an institution to be considered safe to function. These processes may not be collected on an ongoing basis but must at a minimum be audited periodically. Accreditation provides the best opportunity to assess that these Standards are being monitored and met. This principle is well established in other sectors, such as finance, where a set of high quality, understandable and enforceable global accounting standards have been established in the public interest and are audited periodically to ensure compliance.¹⁴

1. Evans S, Cameron P, Wilson S *et al.* Measuring Quality in Private Hospitals. Melbourne: Centre for Health Research (available at http://www.achr.com.au/pdfs/MEASURING%20QUALITY%20IN%20PRIVATE%20HOSPITALS_FINALSept08.pdf), 2008.
2. Eynet Sweden. Handbook for Establishing Quality Registries. Sweden: Eynet Sweden, 2005.
3. Asplund K, Hulter Asberg K, Norrving B *et al.* Riks-stroke - a Swedish national quality register for stroke care. *Cerebrovascular Diseases*. 15 Suppl 1:5-7, 2003.
4. Department of Health Western Australia. Clinical Networks in Western Australia: Background Paper. 2005.
5. Government of South Australia. State-wide Clinical Networks: Position Paper. Adelaide: Department of Health, SA, 2006.
6. Department of Human Services. Clinical service network development [Web Page]. 2008; Available at <http://www.dhs.vic.gov.au/ahs/cnsd.htm>. (Accessed 4 June 2008).
7. Queensland Government. Clinical networks [Web Page]. 16 February 2007; (Accessed 4 June 2008).
8. NSW Health. Clinical networks [Web Page]. 3 January 2006; (Accessed 4 June 2008).
9. American Heart Association. Get With The Guidelines [Web Page]. Available at <http://www.americanheart.org/presenter.jhtml?identifier=1165>. (Accessed 4 April 2008).
10. Smaha LA, American Heart Association. The American Heart Association Get with the Guidelines program. *Am Heart J* 2004; 148(5 Suppl):S46-8.
11. LaBresh KA, Ellrodt AG, Gliklich R, Liljestrand J, Peto R. Get with the Guidelines for cardiovascular secondary prevention: pilot results. *Arch Intern Med* 2004; 164(2):203-9.
12. Ellrodt G, Glasener R, Cadorette B *et al.* Multidisciplinary rounds (MDR: an implementation system for sustained improvement in the American Heart

Association's Get with the Guidelines program. Critical Pathways in Cardiology: A Journal of Evidence-Based Medicine 2007; 6(3):106-16.

13. Shwartz M, Ren J, Pekoz E, Wang X, Cohen A, Restuccia JD. Estimating a composite measure of hospital quality from the Hospital Compare Database: Differences when using a Bayesian Hierarchical Latent Variable model versus Denominator Based Weights. Med Care 2008; 46:778-85.
14. International Accounting Standards Committee Foundation. Due process Handbook for the AISB. London, UK: AISCF Publication Department , 2006.

3. Gaps or omissions

Can you identify if there are significant gaps or omissions, either at a whole-of-system level or in your clinical area?

For example, is there a recent local or international piece of indicator work in your area of interest or speciality that you think we should be aware of?

The NHMRC Centre of Research Excellence in Patient Safety is very supportive of the move to introduce measurement into quality. We believe that it should form a key part of Australia's total quality framework. However, for it to have measurable impact on improving outcomes, it is important that measures are chosen very carefully and that there is a clear purpose to which they are being put.

Historically, there is ambiguity as to the benefit provided by the public release of performance data. Few studies have demonstrated significant improvement in quality of care,¹ some have demonstrated only moderate effect²⁻⁴ and others have had a perverse and undesired effect on quality of care (including racial profiling, inability to find a surgeon to operate on higher risk patients, increased preference to treat affluent and more educated patients).⁴⁻⁷

Indicators should be reviewed using the following criteria:

1. Are indicators epidemiologically sound?

- Is it measurable?
- Does it have good face and content validity?
- Is data routinely collected from all eligible patients?
- Is it recorded systematically?
- Is it collected in a standardised manner?
- Is it reproducible?

There is a dearth of information on the quality and standardisation of documentation. Coding is only as good as the quality of the primary data source. There is evidence that important details are either not reliably entered or there is variability in language used which impacts on coding principles.⁸ Additionally, there are differences in coding practice and audit between jurisdictions.

2. Are indicators likely to be impacted on by quality of care?

Is the indicator likely to detect a quality of care issue or is it likely to just cause lots of

noise with little substance? For quality indicators to be useful there needs to be a credible link to quality of care. The contribution of quality of care to death is likely small and will be largely impacted on by comorbidities and discharge policies. When "Deaths in Low Risk groups" was investigated it was found to not represent preventable errors in the majority of paediatric cases, and should not be used to estimate quality of care or preventable deaths in children's hospitals. ⁹

3. Are proposed measures likely to drive perverse behaviour?

Perverse behaviour is often driven by poor quality data. If data are not appropriately risk adjusted then it encourages gaming e.g. surgeons will not operate on high risk patients, poorer/ disadvantaged groups will be further marginalised. ¹⁰

If indicators do not pass this litmus test then they will not have clinical credibility. Without clinical credibility they will not drive change.

1. Williams SC, Schmaltz SP, Morton DJ, Koss RG, Loeb JM. Quality of care in U.S. Hospitals as reflected by standardized measures, 2002-2004. *N Engl J Med* 2005; 353(3):255-64.
2. Fung C, Lim Y, Mattke S, Damberg C, Shekelle P. Systematic review: the evidence that publishing patient care performance data improves quality of care. *Ann Int Med* 2008; 148:111-23.
3. Lindenauer PK, Remus D, Roman S *et al*. Public reporting and pay for performance in hospital quality improvement. *N Engl J Med* 2007; 356(5):486-96.
4. Rosenthal MB, Frank RG. What is the empirical basis for paying for quality in health care? *Medical Care Research & Review* 2006; 63(2):135-57.
5. Werner RM, Asch DA, Polsky D. Racial profiling: the unintended consequences of coronary artery bypass graft report cards. *Circulation* 2005; 111(10):1257-63.
6. Freeman T. Using performance indicators to improve health care quality in the public sector: a review of the literature. *Health Serv Manage Res* 2002; 15:126-37.
7. Petersen L, Woodard L, Urech T, Daw C, Sookanan S. Does pay-for-performance improve the quality of health care? *Ann Intern Med* 2006; 145:265-72.
8. Milburn JA, Driver CP, Youngson GG, King PM, MacAulay E, Krukowski ZH. The accuracy of clinical data: a comparison between central and local data collection. *Surgeon Journal of the Royal Colleges of Surgeons of Edinburgh & Ireland* 2007; 5(5):275-8.
9. Sedman A, Harris JM 2nd, Schulz K *et al*. Relevance of the agency for healthcare research and quality patient safety indicators for children's hospitals. *Pediatrics* 2005; 115(1):135-45.
10. Werner R, Goldman L, Dudley R. Comparison of Change in Quality of Care Between Safety-Net and NonSafety-Net Hospitals. *JAMA* 2008; 299(18):2180-7.

5. Indicator Feedback

In addition to the specific questions relating to each indicator, your comments relating to the specific indicators are welcomed. You may provide feedback on as many or as few of the individual indicators as you feel appropriate.

Indicator 1: Birth trauma- injury to neonate

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	x			

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Not reliably documented/inconsistently recorded/ Definition of what is present at birth vs. complication of birth often unclear. No independent evaluation of the validity of this indicator. ¹ There is no denominator and numerator is subject to reporting bias.

2. Are indicators likely to be impacted on by quality of care?

No validity has been undertaken. While many injuries might occur inutero or be unavoidable, this indicator may detect quality of care issues (poor technique etc)

3. Are proposed measures likely to drive perverse behaviour?

Unlikely

4. Comment:

Validation studies and denominator required before this should progress to a national indicator

1. Miller MR, Elixhauser A, Zhan C. Patient safety events during pediatric hospitalizations. *Pediatrics* 2003; 111(6 Pt 1):1358-66.

Indicator 6: Failure to diagnose

- d. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

- e. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	x
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

- f. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Interval cancer rates for breast ¹ and cervical ² cancer can be collected using existing data sources (registries). Small numbers makes benchmarking problematic at an institutional level. Interval-cancer rates can be compared with background or underlying rates to better assess the effectiveness of screening. Further, comparing the rate of interval cancers with the underlying rate allows comparison between different screening programs in populations with different incidences of breast cancer. They have been used to detect quality of care issues but are restricted by small numbers.

2. Are indicators likely to be impacted on by quality of care?

Might detect quality of care in relation to failure to diagnose.

3. Are proposed measures likely to drive perverse behaviour?

Unlikely

1. Rickard MT, Taylor RJ, Fazli MA, El Hassan N. Interval breast cancers in an Australian mammographic screening program. *Med J Aust* 1998; 169(4):184-7.
2. Taplin SH, Rutter CM, Finder C, Mandelson MT, Houn F, White E. Screening mammography: clinical image quality and the risk of interval breast cancer. *AJR Am J Roentgenol* 2002; 178(4):797-803

Indicator 7: Potentially preventable hospitalisations

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	x
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Only vaccine-preventable conditions might be epidemiologically sound as data are readily available for many conditions to enable this to occur. Objective measure (serology) confirms diagnosis. Denominator difficult to ascertain (population-based). Public health measure. It should not be called "Potentially preventable hospitalisations as it does not accurately reflect the one indicator which should be captured here. We don't know what proportion of chronic condition admissions is potentially preventable or which subgroups?

The advantage of vaccine-preventable conditions is that they occur at one point in time, are conclusively diagnosed and can be effectively treated.

2. Are indicators likely to be impacted on by quality of care?

No. However, might detect impact of reduction in immunisation rates which has public health implication

3. Are proposed measures likely to drive perverse behaviour?

Unlikely

Indicator 8: Assessment for risk of venous thromboembolism

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	x			

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>Not reliably documented/inconsistently recorded/ Definition what constitutes a risk assessment unclear. Insufficient evidence as to the value of VTE prophylaxis to promote treatment of most medical conditions. Debate is too immature to translate into widespread implementation. Could restrict to high risk areas and to treatment rather than assessment – subsumes need for assessment</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>Yes. Risk assessment should be undertaken on high risk groups. If this is not done, it is a quality of care issue.</p> <p>3. Are measures likely to drive perverse behaviour?</p> <p>Potentially. Without definitions and criteria this will not be done well.</p> <p>4. Comment:</p> <p>Consistent documentation and validation studies are required before this should progress to a national indicator. This should be discussed following release of Standards for VTE prophylaxis in 2009. Adherence should be audited periodically-NOT ONGOING. As a quality improvement project, a point prevalence study could be undertaken on specifically defined medical patients where denominator would be patients at risk on that day (in similar way to that done for pressure ulcers). Need to investigate whether Indicators 8 and 9 are both needed.</p>

Indicator 9: Appropriate prophylaxis for venous thromboembolism

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
X				

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	

Provide information to the providers of the services that would directly inform their quality improvement activities

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

See Indicator #8. Need to be more specific about what is appropriate. This requires consensus Standards which are currently lacking (but due for release 2009).

In the absence of clear definitions of what are appropriate and objective measures, this will rely on clinical judgement which will introduce bias. Therefore, this is not a good measure to collect nationally or to benchmark at present.

Indicator 10: Appropriate use of antibiotics in general practice for upper respiratory tract infections

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	x			

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the

definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Not reliably documented/ definition of URTI open to interpretation in the absence of gold standard for identifying cases in most instances. Difficult to ascertain cases. Might be captured by BEACH on an audit basis.

2. Are indicators likely to be impacted on by quality of care?

Yes. Inappropriate prescribing is likely cause.

3. Are proposed measures likely to drive perverse behaviour?

Potentially. Withholding Abs for patients might lead to harm if bacterial infection present.

4. Comment:

Good evidence that antibiotics do not improve outcomes in initial treatment of URTI.
¹ Validation studies required before this should progress to a national indicator.
 Would require a checklist approach to inclusion e.g. are tonsils enlarged, pus on tonsils. An EMR would be necessary.

1. Arroll B, Kenealy T, Falloon K. Are antibiotics indicated as an initial treatment for patients with acute upper respiratory tract infections? A review. N Z Med J 2008; 121(1284):64-70.

Indicator 11: Survival from out-of-hospital cardiac arrest following ambulance service intervention

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			X	

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	X
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Questionable comparable data in some States: would need further validation before benchmarking is possible.

2. Are indicators likely to be impacted on by quality of care?

In the US there is little evidence that variation in outcome is due to quality of in-hospital care.¹ While factors such as hospital size, ED volume, cardiac catheterisations performed annually, AMIs treated, ICU beds, physician and nurse numbers were analysed, the only hospital characteristic correlated with survival was the number of beds per nurse. Might assess variation in time to defibrillation, and effectiveness of chest compression and assisted ventilation.

3. Are proposed measures likely to drive perverse behaviour?

Potentially. Would need to adjust data to include factors known to impact on survival following out-of-hospital cardiac: younger age, male gender, non-white race, witnessed arrest in a public location, bystander cardiopulmonary resuscitation (CPR), a modest number of defibrillations, and initial cardiac rhythm of ventricular tachycardia.²

4. Comment:

Greater attention is required to integrating ambulance care record with hospital discharge status.

1. Nichol G, Thomas E, Callaway CW *et al.* Regional variation in out-of-hospital cardiac arrest incidence and outcome. JAMA 2008; 300(12):1423-31.

2. Liu JM, Yang Q, Pirralo RG, Klein JP, Aufderheide TP. Hospital variability of out-of-hospital cardiac arrest survival. Prehosp Emerg Care 2008; 12(3):339-46.

Indicator 12: Pain management in the Emergency Department

- a. Should this indicator be included in the national safety and quality indicators set?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	x			

b. Should the purpose of this indicator be to^(a):

Inform the general public about the safety and quality of the health system overall	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

This indicator is good to drive improvements at local level but would serve little purpose at a national level.

Would need to have clear and unambiguous definitions and objective data to ensure data are valid and reliable. In its current format there are no clear definitions of numerators or denominators. There are patients who present with chronic pain which is very difficult to control. Numerous minor procedures (venepuncture etc) are performed in the ED for which pain is difficult to control.¹² These factors would need to be adjusted for in analysis. There is no doubt that this is an area needing more work, but it is important to visit the work that has been done by NICS to see what recommendations they would make.

Neither of the provided numerator options is desirable. How robust is existing data about the relationship between patient satisfaction with pain management and quality of care? Option 2 (drug intervention) may not be the most appropriate management for patients with chronic pain or drug and alcohol dependency

1. Johnson SH. The social, professional, and legal framework for the problem of pain management in emergency medicine. *Journal of Law, Medicine & Ethics* 2005; 33(4):741-60.
2. MacLean S, Obispo J, Young KD. The gap between pediatric emergency department procedural pain management treatments available and actual practice. *Pediatr Emerg Care* 2007; 23(2):87-93.

Indicator 13: Thrombolysis for Acute Myocardial Infarction

a. Should this indicator be included in the national safety and quality indicators set?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	X			

b. Should the purpose of this indicator be to^(a):

Inform the general public about the safety and quality of the health system overall	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>Outcome (thrombolysis) reliably measured. Likely collecting all cases.</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>Potentially not. It might be quite appropriate to withhold thrombolytic if patient is having PPCI. Given advances in interventional cardiology this needs to be considered. Randomized, controlled trials of thrombolytic therapy and primary coronary intervention (PPCI) in ST-elevation myocardial infarction have consistently shown the superiority of the interventional approach. ¹ Using other data sources there are conflicting results as to whether thrombolysis has a place in the acute management of AMIs over that of PPCI. ²</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>Potentially. It may lead to patients being given it within 1 hour to meet indicator which would make them ineligible for PPCI (increased bleeding risk).</p> <p>4. Comment:</p> <p>This indicator requires further work. At the very least, those undergoing PPCI should be excluded.</p> <p>1. Keeley EC, Boura JA, Grines CL. Primary angioplasty versus intravenous thrombolytic therapy for acute myocardial infarction: a quantitative review of 23 randomised trials. <i>Lancet</i> 2003; 361(9351):13-20.</p> <p>2. Steg P, Bonnefoy E, Chabaud S <i>et al.</i> Impact of time to treatment on mortality after prehospital fibrinolysis or primary angioplasty: data from the CAPTIM randomized clinical trial. <i>Circulation</i> 2003; 108:2851-6.</p>

Indicator 14: Thrombolysis for Stroke

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Outcome (thrombolysis) reliably measured. Likely collecting all cases. Registry established which will collect this indicator.

2. Are indicators likely to be impacted on by quality of care?

Yes. There are some concerns which would necessitate careful monitoring of the indicator. Need to consider whether all institutions are capable of giving thrombolysis and have capacity to diagnose thrombotic vs. haemolytic stroke. Could potentially increase harm by penalising institutions who do not have capacity to thrombolyse pts

3. Are proposed measures likely to drive perverse behaviour?

Potentially. It may lead to patients being given it to treat a haemorrhaging stroke causing further harm.

4. Comment:

If the indicator is looking at improving the *timeliness* of treatment (e.g. did patient get appropriately triaged, CT done etc within window period) then it should focus on time to CT/thrombolysis from arrival in ED. This is because hospitals cannot control the time it took for the patient to seek medical assistance in a hospital.

If the indicator is looking at *appropriateness*, (e.g. assuming tests etc were done and

patient was sitting waiting for treatment, did it occur) as this seems to be doing, then it makes sense to use this indicator.

Indicator 15: Stoke patients treated in a stroke unit

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	x
<i>Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement</i>	x
<i>Report on the safety and quality of aspects of specific health care services</i>	x
<i>Provide information to the providers of the services that would directly inform their quality improvement activities</i>	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Stroke Units need to be defined (registered and meet specific criteria). There is as yet no widely accepted definition of what a stroke unit is and the facilities they should provide.¹ Need to explore whether diagnosis of stroke on admission is accurately captured (vs. differential diagnoses)

2. Are indicators likely to be impacted on by quality of care?

There is good evidence that being managed in a dedicated stroke unit improves outcome (decreased deaths and institutional care) when compared to general wards and a mobile stroke team.²

3. Are proposed measures likely to drive perverse behaviour?

Potentially. Those patients admitted following stroke with very poor prognosis and who would benefit only from palliative care should not be included in the numerator.

1. Rudd AG, Hoffman A, Irwin P, Pearson M, Lowe D, Intercollegiate Working Party for Stroke. Stroke units: research and reality. Results from the national sentinel audit of stroke.[See comment]. Quality & Safety in Health Care 2005; 14(1):7-12.

2. Stroke Unit Trialists' Collaboration. Organised inpatient (stroke unit) care for stroke.[Update of Cochrane database syst rev. 2002;(1):cd000197; pmid: 11869570]. Cochrane Database of Systematic Reviews 2007; (4):CD000197.

Indicator 16: Management of Acute Myocardial Infarction

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			X	

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	X
Report on the safety and quality of aspects of specific health care services	X
Provide information to the providers of the services that would directly inform their quality improvement activities	X

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

ACE inhibitors, beta-blockers, aspirin and statins are all clearly measurable provided pharmacies document this. Would need to review capacity of pharmacies to systematically collect this data. Most discharges would be expected to capture drugs except those given on impress supply. Provided generics and trade names included, this data can be collected.

2. Are indicators likely to be impacted on by quality of care?

Yes. Good evidence that most patients should be prescribed these meds. Not prescribing is usually a quality of care issue. These indicators have had some success in improving processes of care. ¹⁻³

3. Are proposed measures likely to drive perverse behaviour?

Potentially. Where meds are inappropriate (known exceptions) this would need to be documented. Need to be aware of exceptional reporting issues identified in the UK and monitor this carefully. ⁴

4. Comment:

This should not be reported nationally but used by Clinical Networks to drive quality improvement.

1. Williams SC, Schmaltz SP, Morton DJ, Koss RG, Loeb JM. Quality of care in U.S. Hospitals as reflected by standardized measures, 2002-2004. *N Engl J Med* 2005; 353(3):255-64.
2. Scott IA, Darwin IC, Harvey KH *et al.* Multisite, quality-improvement collaboration to optimise cardiac care in Queensland public hospitals. *Med J Aust* 2004; 180(8):392-7.
3. Scott IA, Denaro CP, Flores JL *et al.* Quality of care of patients hospitalized with congestive heart failure. *Internal Medicine Journal* 2003; 33(4):140-51.
4. Doran T, Fullwood C, Gravelle H *et al.* Pay-for-performance programs in family practices in the United Kingdom. *N Engl J Med* 2006; 355(4):375-84.

Indicator 17: Management of Chronic Heart Failure

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	x
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

See indicator 16

Indicator 18: Mental health inpatients having seclusion

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	X			

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	X
Provide information to the providers of the services that would directly inform their quality improvement activities	X

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Seclusion is clearly defined under Mental Health Act. It is not currently recorded systematically or reliably.

2. Are indicators likely to be impacted on by quality of care?

Good evidence that seclusion is implicated in many adverse events. Reducing seclusion may = better care. Many patients have multiple episodes of seclusion which is an identified problem ¹ This indicator will not collect total number of seclusions, which would be a better indicator. **Need to change the definition: should look at number of episodes of seclusion per patient per bed days.**

3. Are proposed measures likely to drive perverse behaviour?

Unknown.

1. Knight MM. Quality improvement initiatives to minimize seclusion and restraint. J Healthc Qual 2005; 27(2):20-5.

Indicator 19: Health Care Associated Infections (HCAI) acquired in hospital

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
		X		

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	X
Provide information to the providers of the services that would directly inform their quality improvement activities	X

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Many SSI not captures as they are identified post discharge and these are difficult to capture using existing systems and in the absence of a Universal Identifier. Outcome should be microbiologically confirmed samples. Ventilator associated nosocomial pneumonia difficult to confirm due to difficulties in diagnostic criteria and surveillance protocols therefore avoided in numerator. Data using ICD has been shown not to be good. Therefore, should use purposefully collected data sources such as CHRISP VICNISS etc not admin data.

2. Are indicators impacted on by quality of care?

Yes. Good link between deep SSI and infection control breach in all but emergency procedures.

3. Are proposed measures likely to drive perverse behaviour?

Potentially. Need to apply risk adjustment to data to avoid biasing those undertaking complicated emergency surgery. THE NISS in the US guidelines for reporting SSIs is being used for procedures in some states and territories. ASA score, status of operation (emergency, elective), length of surgery all impact on likelihood of infection.

4. Comment:

Confine to SSIs

1. Uckay I, Ahmed QA, Sax H, Pittet D. Ventilator-associated pneumonia as a quality indicator for patient safety?. Clin Infect Dis 2008; 46(4):557-63.

Indicator 20: Staphylococcus aureus (including MRSA) bacteraemia in acute care hospitals

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			X	

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	X
<i>Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement</i>	X
<i>Report on the safety and quality of aspects of specific health care services</i>	X
<i>Provide information to the providers of the services that would directly inform their quality improvement activities</i>	X

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Currently there are numerous definitions for bloodstream infections. Infection captured within 48 hours of admission is not recorded in existing VICNISS database as they could be community-acquired. Data extracted from ICD coding has poor validity when compared with other means of data collection such as registries. Needs more work to get a good definition which is collected in standardised manner. No denominator has been recorded in AIHW Discussion Paper. This should be restricted to MRSA bacteraemias following CVC insertion as per VICNISS definition.

2. Are indicators likely to be impacted on by quality of care?

If bacteraemias are detected within window period of CVC being inserted then this will likely impact on infection control practices.

3. Are proposed measures likely to drive perverse behaviour?

Risk adjustment : There are many cases of s.aureus bacteraemia that occur in the community, subsequently present and are admitted to hospital. Obviously the occurrence of these cases will not reflect hospital care. It is not clear reading this indicator whether these community cases are to be included. Also, it will be very important to ensure that hospitals receiving patients from other institutions or the community are not penalised by having this included in the numerator. Detection bias post discharge.

Indicator 21: Adverse drug events

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
x				

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
<i>Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement</i>	
<i>Report on the safety and quality of aspects of specific health care services</i>	
<i>Provide information to the providers of the services that would directly inform their quality improvement activities</i>	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Definition not clear. Description mentions requiring hospital treatment but numerator includes "occurred in hospital" which is inconsistent. Data has poor validity. Not collected in standardised and systematic manner. Adverse drug events detected by medical record differ from those identified through pharmacy systems and incident reports which highlight the (poor) quality of the data. When CPOE is rolled out, might be considered. However this needs to be done with care before implementation and not as we implement. No accurate method for ascertaining a denominator.

2. Are indicators likely to be impacted on by quality of care?

Unclear. In some instances could be due to poor prescribing, dispensing or administration but some ADE are non-preventable.

3. Are proposed measures likely to drive perverse behaviour?

Might foster poor documentation/reporting of ADEs

Indicator 22: Pressure ulcers in care settings

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
		x		

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>Diagnosis and recording of pressure ulcer currently poor in medical record, particularly Stage 1 and 2 ulcers. Unlikely that ICD data will be any good at present. Validation work required</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>Many ulcers are community acquired. Development of pressure ulcers in hospital is highly preventable with adequate resources (mattresses etc)</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>Need to exclude out-of-hospital acquired pressure ulcers. Important area and effort should be made to collect it through audit (PUPPS)</p>

Indicator 23: Falls resulting in patient harm (in a health or aged care setting)

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>

			x	
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b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>If this indicator only collected # data then it would likely be well captured using ICD codes. However, this would need some validation.</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>Many falls are preventable and there is good evidence that nursing intervention can reduce incidence and impact of falls.</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>Potential to increase restraint use.</p> <p>4. Comment:</p> <p>A better indicator might be in-hospital fractures which might be captured through OT databases and ICD codes. Falls associated with fracture are a relatively low event rate and therefore may not be a useful indicator for driving improvement. - more a 'sentinel event'. However considerably more work needs to be done before a robust indicator is defined.</p>

Indicator 24: Intentional self-harm in hospitals

a. Should this indicator be included in the national safety and quality indicators set?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	x			

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>Self harm is poorly defined. Difficult to collect reliably using existing data as documentation poor. Suicide in an in-hospital facility can be reliably collected.</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>Questionable link between self harm and quality of care. Suicide should be reported</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>Potential to increase physical/drug restraint use.</p> <p>4. Comment:</p> <p>Suicide in an in-patient facility is a sentinel event which should be reported nationally.</p>
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Indicator 25: Complications of anaesthesia

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	x			

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	

Provide information to the providers of the services that would directly inform their quality improvement activities

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?
 Definition needs to be explicit. Complications not consistently documented/collected. For many cases the proposed numerator/denominator are ill-defined and will result in inaccurate calculations.

2. Are indicators likely to be impacted by quality of care?
 Unknown

3. Are proposed measures likely to drive perverse behaviour?
 Refusal to operate on high risk patients if outcomes do not adjust for case mix.

4. Comment:
 A good screening indicator is "unplanned admission to the ICU after surgery and anaesthesia". It has been shown to correlate with adverse events.¹ However, this should also not be reported nationally. It should be reported to clinical networks where it can be used to drive quality improvement.

1. Haller G, Myles PS, Wolfe R, Weeks AM, Stoelwinder J, McNeil J. Validity of unplanned admission to an intensive care unit as a measure of patient safety in surgical patients. *Anesthesiology* 2005; 103(6):1121-9

Indicator 26: Accidental puncture/laceration (technical difficulty with procedure)

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
x				

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	

Provide information to the providers of the services that would directly inform their quality improvement activities

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

More work is required to investigate the validity of the data and to understand the clinical setting better e.g. how surgeon code lacerations. What are implications for different coding processes? This will impact on the value of the data. US data suggests that it has limited sensitivity. ¹

2. Are indicators likely to be impacted on by quality of care?

Unknown. Sometimes a gallbladder is nicked as it is being removed but this has not impact whatsoever on patient outcome. Yet this could be coded as an adverse event.

3. Are proposed measures likely to drive perverse behaviour?

¹ Rivard PE, Rani E, Loveland S et al Applying Patient Safety Indicators (PSIs) Across Health Care Systems: Achieving Data Comparability Agency for Healthcare Research and Quality (AHRQ) Advances in Patient Safety: From Research to Implementation Volume 2. Concepts and Methodology

Indicator 27: Obstetric trauma - third and fourth degree perineal tears acquired during childbirth

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Data are being collected on 3rd and 4th degree tears at a national level as part of the Perinatal Data Collection.

2. Are indicators likely to be impacted on by quality of care?

There is some evidence that tears are impacted by quality of care. Main determinants of tear are: primiparous, head position of baby which can rotate during delivery, self-massage in antenatal period, guarding perineum during birth, delivery position (standing and squatting = increased risk), type of episiotomy (although conflicting evidence), instrumentation, person delivering baby.¹

3. Are proposed measures likely to drive perverse behaviour?

Might increase c-section rates.

1. Byrd LM, Hobbiss J, Tasker M. Is it possible to predict or prevent third degree tears? Colorectal Disease 2005; 7(4):311-8.

Indicator 28: Postoperative respiratory failure

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
x				

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>Imprecise definition and not well documented. Therefore data will not be reliably collected. There is no evidence that existing data (ICD) can accurately collect this data.</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>Link to quality of care unfounded. A study in paediatric patients demonstrated that this indicator identified a very large numbers of cases but had low capture of quality of care issues and most had low preventability.¹ In adults the definition includes Discharges with ICD-10 codes for acute respiratory failure in any secondary diagnosis field. Therefore indicator is likely inappropriate but needs to be assessed in an Australian population.</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>Potential to have untoward effect e.g. do not resuscitate. This should not be included.</p> <p>1. Scanlon M, Harris J2, Levy F, Sedman A. Evaluation of the agency for healthcare research and quality pediatric quality indicators. Pediatrics 2008; 122(1):182-3.</p>

Indicator 29: Postoperative haemorrhage

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
x				

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
<i>Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement</i>	
<i>Report on the safety and quality of aspects of specific health care services</i>	x
<i>Provide information to the providers of the services that would directly inform their quality improvement activities</i>	x

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

As with Indicator #28 this indicator has good face validity, however data limitations restrict its use at a national level. More work is required before this indicator should be reported nationally. No validation work has been undertaken. While coding for what is in the medical record might be accurate, documentation is likely very poor. Definition of postoperative haemorrhage or haematoma is open to interpretation and therefore will not be reliably collected. There is no evidence that existing data (ICD) can accurately collect this data.

2. Are indicators likely to be impacted on by quality of care?

Link to quality of care unfounded.

3. Are proposed measures likely to drive perverse behaviour?

Risk adjustment capability is limited. Procedures such as ERCP endoscopy should not be included in the denominator as risk of haemorrhage is reduced when compared to open procedures. Also, number of endoscopies performed is higher than open procedures therefore denominator will be higher.

4. Comments

Surgeons are sceptical about interpretation of indicators in the absence of clinical review ¹ and appropriate risk adjustment. Where surgical mortality audit and practice review has been undertaken using data which adequately accounts for variations in casemix e.g. POSSUM ² it has driven practice change.

1. Pierce RG, Bozic KJ, Bradford DS. Pay for performance in orthopaedic surgery. *Clinical Orthopaedics & Related Research* 2007; 457:87-95.
2. Copeland G, Jones D, Walters M. POSSUM: A scoring system for surgical audit. *Br. J. Surg* 1991; 78:355-60.

Indicator 30: Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT)

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	x			

- b. Should the purpose of this indicator be to^(a):

Inform the general public about the safety and quality of the health system overall

Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	X
Provide information to the providers of the services that would directly inform their quality improvement activities	X

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>Many present post discharge and are not captured. This needs to be recorded as a limitation when reporting outcomes. PE and DVT are likely accurately reported in medical record but could validate with VQ scan data.</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>Yes. Assess VTE prophylaxis.</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>Not envisaged.</p>

Indicator 31: Unplanned return to operating theatre in same admission

- a. Should this indicator be included in the national safety and quality indicators set?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	X			

- b. Should the purpose of this indicator be to^(a):

Inform the general public about the safety and quality of the health system overall	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	X
Provide information to the providers of the services that would directly inform their quality improvement activities	X

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Should report this as a Standard of Care collected as part of the accreditation process. Collection methods variable across hospitals making benchmarking problematic.

2. Are indicators likely to be impacted on by quality of care?

Yes

3. Are proposed measures likely to drive perverse behaviour?

Unknown.

Indicator 32: Unplanned re-admission to an Intensive Care Unit

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	x			

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Should report this as a Standard of Care. Collection methods variable across hospitals making benchmarking problematic. Whether an institution implements

effectively should be periodically assessed as part of the accreditation process

2. Are indicators likely to be impacted on by quality of care?

Yes

3. Are proposed measures likely to drive perverse behaviour?

Unknown.

Indicator 33: Unplanned hospital readmissions

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	x			

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
<i>Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement</i>	
<i>Report on the safety and quality of aspects of specific health care services</i>	x
<i>Provide information to the providers of the services that would directly inform their quality improvement activities</i>	X

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Should report this as a Standard of Care. Collection methods variable across hospitals making benchmarking problematic. Current limitations including lack of a unique identifier make this very difficult to capture accurately at present. Whether an institution implements effectively should be periodically assessed as part of the accreditation process

2. Are indicators likely to be impacted on by quality of care?

Yes

3. Are proposed measures likely to drive perverse behaviour?

Unknown.

Indicator 34: Failure to prevent a clinically important deterioration (Failure to rescue)

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
x				

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>No. Many 'failures to rescue' are actually NOT FOR RESUSCITATIONS which are poorly recorded. Many patients/patients with advanced conditions do not want to be rescued</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>The sensitivity of this indicator has recently been evaluated in the US. ¹ It found that many factors influenced whether a case was included in the measure, such as existing health problems, the presence of complex comorbidities, and variation in clinical documentation and coding practices. Half of the identified cases were related to coding issues.</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>1. Talsma A, Bahl V, Campbell DA. Exploratory analyses of the "failure to rescue" measure: evaluation through medical record review. J Nurs Care Qual 2008; 23(3):202-10.</p>
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Indicator 35: Risk-adjusted In-hospital Mortality

a. Should this indicator be included in the national safety and quality indicators set?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	X			

b. Should the purpose of this indicator be to^(a):

Inform the general public about the safety and quality of the health system overall	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	X
Provide information to the providers of the services that would directly inform their quality improvement activities	X

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Death data are reliably collected. However, discharge practices will impact on the ability to detect in-hospital mortality and for this reason 30 day mortality should also be collected.

2. Are indicators likely to be impacted on by quality of care?

Link to quality of care not founded. Intuitively, without 'drilling down' to clinical dept/specialty level it would be difficult to identify quality of care issues (e.g. rogue surgeon Patel). Might be useful for specific procedure codes, but this needs validation. This would require additional peer review. Would be most useful to have this data presented to clinical networks for discussion.

3. Are proposed measures likely to drive perverse behaviour?

Potentially if data are not properly risk adjusted. ICD data does not collect comorbidities in a standardised manner and this will impact on survival. Possible consequences to monitor for include refusal to operate on high-risk patients (NY Cardiac Surgery). Discharge policy might be altered to reduce 'in-hospital' mortality rate if this information is publicly reported and hospitals identified.

Indicator 36: Death in low mortality DRGs

a. Should this indicator be included in the national safety and quality indicators set?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	X			

b. Should the purpose of this indicator be to^(a):

Inform the general public about the safety and quality of the health system overall	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>Intuitively, this indicator would identify patients not expected to die, however no published studies were identified investigating the validity of this indicator. Likely to pick up vulnerable groups (elderly with many comorbidities) who have operation out of necessity (appendicectomy) and would not be expected to have a good prognosis.</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>No evidence that this detects poor quality of care. While it might be useful as a screening tool (perhaps to reflect whether proper assessment was undertaken prior to OT) it should not be reported nationally until work has been undertaken to identify what it is detecting e.g. it will likely have a lot of 'noise' (poor sensitivity in detecting poor performance).</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>Unknown.</p>
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Indicator 37: Independent peer review of surgical deaths

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
		X		

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
<i>Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement</i>	
<i>Report on the safety and quality of aspects of specific health care services</i>	
<i>Provide information to the providers of the services that would directly inform their quality improvement activities</i>	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>This should be routinely collected when hospitals are accredited. External review of surgical mortality (WAASM etc) is likely beneficial however would benefit from greater cross jurisdictional activity and shared learnings with feedback on action taken. See surgeons website http://www.surgeons.org/Content/NavigationMenu/Research/Audit/default.htm</p> <p>It should not be a national 'indicator'. It is a Standard of Care.</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>Probably. Reasonable evidence that audit can change individual's practice.</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>Potential to refuse to operate on high risk patients.</p>

Indicator 38: Presence of appropriate incident monitoring arrangements including sentinel events monitoring

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>

b. Should the purpose of this indicator be to^(a):

Inform the general public about the safety and quality of the health system overall	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>4. Are indicators epidemiologically sound?</p> <p>This should be routinely collected when hospitals are accredited. It should not be a national 'indicator'. It is a Standard of Care.</p> <p>5. Are indicators likely to be impacted on by quality of care?</p> <p>Yes</p> <p>6. Are proposed measures likely to drive perverse behaviour?</p> <p>Potential to not report events. Evidence that this is currently the case.</p>

Indicator 39: Knee and hip replacement revision within 5 years

a. Should this indicator be included in the national safety and quality indicators set?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
			x	

b. Should the purpose of this indicator be to^(a):

Inform the general public about the safety and quality of the health system overall	x
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p>1. Are indicators epidemiologically sound?</p> <p>Data currently being collected by AOA JRR. Data collected from 98% of eligible population with link to revision rates.</p> <p>2. Are indicators likely to be impacted on by quality of care?</p> <p>It should be noted that this indicator will pick up poorly performing prostheses but not necessarily poorly performing surgeons where joints are not revised.</p> <p>3. Are proposed measures likely to drive perverse behaviour?</p> <p>No</p>
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Indicator 40: Cancer survival

- a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

- b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	x
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

- c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Cancer registries collect details on all patients diagnosed with cancer. It is an incidence database which links to Death Index. Data are mostly complete and accurate. Therefore data epidemiologically sound.

2. Are indicators likely to be impacted on by quality of care?

At a public health level this is good data but most registries do not collect clinical data to enable quality of care issues to be investigated. To improve quality of care, investment is needed in the development of clinical cancer registries in areas where variation in outcome is identified. Without clinical data cancer survival rates are of limited assistance in improving quality of care.

3. Are proposed measures likely to drive perverse behaviour?

Cancers should be risk adjusted according to Stage at diagnosis.

Indicator 41: Continuity of care - discharge planning

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
		x		

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
<i>Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement</i>	
<i>Report on the safety and quality of aspects of specific health care services</i>	x
<i>Provide information to the providers of the services that would directly inform their quality improvement activities</i>	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Work is being undertaken by NeHTA to introduce standardised EMR discharge summaries. The requirements for what constitutes discharge summary needs to be made explicit.

2. Are indicators likely to be impacted on by quality of care?

Timely discharge summaries are more important for some conditions than others. Elective surgery is probably not as time critical as other discharges. Needs to be reviewed.

3. Are proposed measures likely to drive perverse behaviour?

Could mean that limited resources (interns) are being used to write discharge summaries for little benefit and this could direct resources away from areas of greater need (patients).

Comments

It is important that the quality of the discharge summary is not compromised by a requirement that it be sent from the hospital within 1 day of discharge.

Indicator 42: Post-discharge community care for mental health patients

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	x			

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

4. Are indicators epidemiologically sound?

Unclear definition as to what constitutes 'follow up' therefore data likely unreliably collected across institutions.

5. Are indicators likely to be impacted on by quality of care?

It is often not appropriate for patients to get follow up in the community within 7 days. It depends on clinician judgment and acceptance of the patient by the community mental health team. This is an area which needs more work before it is introduced nationally. It may divert already scarce resources unnecessarily and increase harm. More work is required to assess the benefit of the follow up and to understand better the purpose to which the indicator will be put.

6. Are proposed measures likely to drive perverse behaviour?

Potential. Poor quality service to all mental health clients.

Indicator 46: People with asthma who have a written asthma action plan

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
	x			

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Asthmatics poorly defined. Therefore denominator is not epidemiologically sound.

2. Are indicators likely to be impacted on by quality of care?

Unclear evidence of the effect of asthma action plans. Current evidence is inconclusive as to the value of Asthma Action Plan¹ particularly on stable asthmatics. All patients discharged from hospital should receive documentation about the reason for their admission, their treatment during admission, what to do when they leave hospital and who and how to make further contact if necessary. This should be a STANDARD of Care assessed within Accreditation.

3. Are proposed measures likely to drive perverse behaviour?

Unlikely

1. Lefevre F, Piper M, Weiss K, Mark D, Clark N, Aronson N. Do written action plans improve patient outcomes in asthma? An evidence-based analysis. *Fam Pract* 2002; 51(10):842-8.

Indicator 50: End stage kidney disease in people with diabetes

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	x
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Data on ESRD collected by ANZDATA. High quality data. Diabetes data at a population level less well known so outcomes would have to have caveat around quality of the denominator data.

2. Are indicators likely to be impacted on by quality of care?

Potentially. It may be a marker of poor quality of diabetic care although might also reflect individual behaviour choices not under the control of the medical system . Would need to be interpreted with caution.

3. Are proposed measures likely to drive perverse behaviour?

No

Indicator 51: Lower-extremity amputation in people with diabetes

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	x
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	x
Provide information to the providers of the services that would directly inform their quality improvement activities	x

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

ICD codes for procedures such as amputation likely to be good. As with #50, difficulty in detecting diabetics creates problems in getting good denominator data

2. Are indicators likely to be impacted on by quality of care?

There is evidence to suggest lower limb amputation can be reduced with appropriate preventive care - it could be argued that this would fall within the 'avoidable' hospitalisation indicator area but is also a high priority condition that Australia

needs to be targeting

3. Are proposed measures likely to drive perverse behaviour?

No

Indicator 57: Accreditation of health care services

a. Should this indicator be included in the national safety and quality indicators set?

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
			x	

b. Should the purpose of this indicator be to^(a):

<i>Inform the general public about the safety and quality of the health system overall</i>	x
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	x
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

1. Are indicators epidemiologically sound?

Accreditation is clearly and reliably defined and collected. Number of hospitals seeking accreditation and those registered as healthcare institutions clearly defined. Therefore epidemiologically sound.

Are indicators likely to be impacted on by quality of care?

Some evidence that accredited hospitals provide higher quality of care compared to non-accredited facilities.

2. Are proposed measures likely to drive perverse behaviour?

No

Indicator 58: Patient experience

a. Should this indicator be included in the national safety and quality indicators set?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	x			

b. Should the purpose of this indicator be to^(a):

Inform the general public about the safety and quality of the health system overall	
Inform discussion and decision-making about overall priorities and system-level strategies for safety and quality improvement	
Report on the safety and quality of aspects of specific health care services	
Provide information to the providers of the services that would directly inform their quality improvement activities	

(a) More than one category can be selected

c. Additional comments. For example: whether the indicator/s we have proposed are the most appropriate or whether you can suggest an alternative; whether the definition, numerator and denominator are appropriate and will provide the information required; whether the most appropriate data source is being proposed for use; etc)

<p style="text-align: center;">1. Are indicators epidemiologically sound?</p> <p>No standardised tool currently being implemented. Good research is being done in this area ¹ but it is still very under-developed.</p> <p style="text-align: center;">2. Are indicators likely to be impacted on by quality of care?</p> <p>Limited evidence.</p> <p style="text-align: center;">3. Are proposed measures likely to drive perverse behaviour?</p> <p>Potential to redirect resources inappropriately.</p> <p>¹ Picker Institute http://www.pickereurope.org/page.php?id=21</p>
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