AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Reports

Towards quality improvement at scale in the New Zealand primary care setting: Findings from consumer and health service engagement
Wells S
Wellington: Health Quality & Safety Commission New Zealand; 2019. p. 45.

URL	https://www.hqsc.govt.nz/our-programmes/primary-care/news-and-events/news/3739/ https://www.hqsc.govt.nz/our-programmes/primary-care/publications-and-resources/publication/3740/
Notes	The Health Quality & Safety Commission New Zealand has released this report of the findings of a consumer, health service and stakeholder engagement that sought to garner views on primary care in New Zealand. According to the Commission's website, 'the document captures and summarises sector feedback according to key themes, which are to: • develop definitions of quality and quality improvement from tangata whenua, to reflect Aotearoa New Zealand perspectives • investigate the application of the 'collective impact' model, develop a shared vision for quality improvement and a national cross-agency unified charter and strategy • expand our knowledge management role

	- continue to build workforce capability - consider primary care collaboratives as a vehicle for addressing health outcomes, building intersectoral relationships, teamwork (across consumers and the health and social service workforce) and quality improvement capability building. Overall, the document findings support the need for central agencies and the Commission to work much more collectively and create a national charter or framework for quality improvement with clear strategic initiatives.'

Journal articles

Review of medication errors that are new or likely to occur more frequently with electronic medication management systems
Van de Vreede M, McGrath A, de Clifford J
Australian Health Review. 2019;43(3):276-83.

DOI	https://doi.org/10.1071/AH17119
Notes	Technologies are often applied to address issues, but can also contribute to existing issues and raise new ones. This paper reports on a study that sought s to identify and quantify medication errors reportedly related to electronic medication management systems (eMMS) and those considered likely to occur more frequently with eMMS. The study involved eight hospitals in Victoria and reviewed nearly 6,000 medication-related incidents. Of these, 93 (47 prescribing errors, 46 administration errors) were identified as new or potentially related to eMMS. However, harm was minimal as only one ISR 2 (moderate) and no ISR 1 (severe or death) errors were reported. The most commonly reported error types were 'human factors' and 'unfamiliarity or training' (70%) and 'cross-encounter or hybrid system errors' (22%).

For information on the Commission's work on medication safety, including the safe implementation of electronic medication management systems, see https://www.safetyandquality.gov.au/our-work/medication-safety/

Improving quality in hospital end-of-life care: honest communication, compassion and empathy
Rawlings D, Devery K, Poole N
BMJ Open Quality. 2019;8(2):e000669.

DOI	https://doi.org/10.1136/bmjoq-2019-000669
Notes	Paper describing the development of e-learning modules derived from the *National Consensus Statement on Essential Elements for Safe and High-Quality End-of-Life Care*. The modules were developed by a palliative care educator with the support of a peer review group and were piloted with 35 health professionals. Pre-post module evaluation data were collected and during a 10-month period from 2016 to 2017 a total of 5181 individuals registered for the project accessing one or more of the six modules.

For information on the Commission's work on end of life care, including the *National Consensus Statement on Essential Elements for Safe and High-Quality End-of-Life Care* and access to the three end-of-life education modules to assist acute care clinicians in meeting the challenges of providing end-of-life care, see https://www.safetyandquality.gov.au/our-work/end-of-life-care-in-acute-hospitals/

Towards a strategy for clinical quality registries in Australia
Ahern S, Evans S, Hopper I, Zalcberg J
Australian Health Review. 2019;43(3):284-7.

DOI	https://doi.org/10.1071/AH17201
Notes	Paper noting the proven utility and potential for clinical quality registries. The papers notes the work of the Australian Commission on Safety and Quality in Health Care in this area, but also calls for the Commission to have a leadership role. The author's call for a national strategy that ensures improved governance, more secure funding and ensures data provision and quality to registries. As was noted in last week's issue of *On the Radar*, a Draft National Clinical Quality Registry Strategy has been developed and is currently in a consultation phase. For information about the Draft National Clinical Quality Registry Strategy consultation, see https://consultations.health.gov.au/health-economics-and-research-division/national-cqr-strategy/

For information on the Commission's work on clinical quality registries, see
https://www.safetyandquality.gov.au/our-work/information-strategy/clinical-quality-registries/

Disclosure of adverse events: a data linkage study reporting patient experiences among Australian adults aged ≥45 years
Walton M, Harrison R, Smith-Merry J, Kelly P, Manias E, Jorm C, et al
Australian Health Review. 2019;43(3):268-75.

DOI	https://doi.org/10.1071/AH17179
Notes	The need for open disclosure in the event of error, including adverse events, is generally understood. Following the development of the *Australian Open Disclosure Framework*, many Australian health systems implemented disclosure policies. This paper reports on a study that received survey responses from 7661 patients in New South Wales hospitals to identify 474 patients who had reported an adverse event. The authors report that of these 'a significant **majority reported an informal or bedside disclosure** (91%; 430/474). Only 79 patients (17%) participated in a formal open disclosure meeting. Most informal disclosures were provided by nurses, with only 25% provided by medical practitioners.' The authors observe that: • most patients receive informal disclosures rather than a process that aligns with the current policy guidance • patients' experiences are variable, and lack of, or poor quality disclosures are all too common • open disclosure may be enhanced by informing patients of their right to full disclosure in advance of or upon admission to hospital • recognition of and support for informal or bedside disclosure for appropriate types of incidents. • guidelines for bedside disclosure should be drafted to assist medical practitioners and other health professionals facilitate and improve their communications about adverse events.

For information on the Commission's work on open disclosure, including the *Australian Open Disclosure Framework*, see https://www.safetyandquality.gov.au/our-work/open-disclosure/

Dangers of diagnostic overshadowing
Iezzoni LI
New England Journal of Medicine. 2019;380(22):2092-3.

DOI	http://doi.org/10.1056/NEJMp1903078
Notes	This Perspective piece recounts the experience of patient with an existing disability whose condition 'overshadowed' new or emerging conditions such that the diagnosis and treatment of the new conditions by the clinicians involved were significantly delayed. Assumptions about the patient and their conditions may have contributed to '"diagnostic overshadowing" — the erroneous attribution of all new symptoms to an underlying health condition, especially in patients with disability.'

For information on the Commission's work on patient and consumer centred care, see
https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Artificial Intelligence in Health Care: Will the Value Match the Hype?
Emanuel EJ, Wachter RM
JAMA. 2019 [epub].

DOI	https://doi.org/10.1001/jama.2019.4914
Notes	Recent issues of *On the Radar* have include a number of items on artificial intelligence and 'its many related applications (ie, big data, deep analytics, machine learning)'. This short Viewpoint piece reflects some of those other pieces in pondering the impact of these on health care. Here the focus is on the 'effector arm' and how 'A narrow focus on data and analytics will distract the health system from what is needed to achieve health care transformation: meaningful behavior change.' The authors argue that sustained improvements in health and health care are the consequence of human actions and behaviours, both by patients/consumers and by clinicians.

Australian Health Review
Volume 43, Number 3 (2019)

URL	https://www.publish.csiro.au/ah/issue/9365
Notes	A new issue of *Australian Health Review* has been published. Articles in this issue of *Australian Health Review* include: • **Healthcare in a carbon-constrained world** (Kate E Charlesworth and Maggie Jamieson) • General practitioners' views on the **influence of cost on the prescribing of asthma preventer medicines**: a qualitative study (Jacqueline Tudball, Helen K Reddel, Tracey-Lea Laba, Stephen Jan, Anthony Flynn, Michele Goldman, Kirsty Lembke, Elizabeth Roughead, Guy B Marks and Nick Zwar) • Community views on factors affecting **medicines resource allocation**: cross-sectional survey of 3080 adults in Australia (Lesley Chim, Glenn Salkeld, Patrick J Kelly, Wendy Lipworth, Dyfrig A Hughes and Martin R Stockler) • Cost analysis of an **integrated aged care program for residential aged care facilities** (Rod Ling, Andrew Searles, Jacqueline Hewitt, Robyn Considine, Catherine Turner, Susan Thomas, Kelly Thomas, Keith Drinkwater, Isabel Higgins, Karen Best, Jane Conway and Carolyn Hullick) • **Disclosure of adverse events**: a data linkage study reporting patient experiences among Australian adults aged ≥45 years (Merrilyn Walton, Reema Harrison, Jennifer Smith-Merry, P Kelly, E Manias, C Jorm and R Iedema) • Review of **medication errors** that are new or likely to occur more frequently with **electronic medication management systems** (Melita Van de Vreede, Anne McGrath and Jan de Clifford)

	- Towards a strategy for **clinical quality registries** in Australia (Susannah Ahern, Sue Evans, Ingrid Hopper and John Zalcberg) - Systematic review of the evidence related to mandated **nurse staffing ratios in acute hospitals** (Richard Olley, Ian Edwards, Mark Avery and H Cooper) - Factors affecting the **performance of public out-patient services** (Ugenthiri Naiker, Gerry FitzGerald, Joel M. Dulhunty and Michael Rosemann) - Going digital: a checklist in preparing for **hospital-wide electronic medical record implementation and digital transformation** (Ian A. Scott, Clair Sullivan and Andrew Staib) - Improving the **efficacy of healthcare services for Aboriginal Australians** (Kylie Gwynne, Thomas Jeffries Jr and Michelle Lincoln) - Improving access to important **recovery information for heart patients with low health literacy**: reflections on practice-based initiatives (Lucio Naccarella, Catuscia Biuso, Amanda Jennings and Harry Patsamanis) - **Bullying and sexual harassment of junior doctors** in New South Wales, Australia: rate and reporting outcomes (Anthony Llewellyn, Aspasia Karageorge, Louise Nash, Wenlong Li and Dennis Neuen) - Building capacity for change: evaluation of an **organisation-wide leadership development program** (Tim Schultz, Jodie Shoobridge, Gill Harvey, Libby Carter and Alison Kitson) - Combining participatory action research and appreciative inquiry to design, deliver and evaluate an **interdisciplinary continuing education program for a regional health workforce** (Julie-Anne Martyn, Jackie Scott, Jasper H. van der Westhuyzen, Dale Spanhake, Sally Zanella, April Martin and Ruth Newby) - Widening **participation of Māori and Pasifika students in health careers**: evaluation of two health science academies (Lesley Middleton, Ausaga Faasalele Tanuvasa, Megan Pledger, Nicola Grace, Kirsten Smiler, Tua Taueetia Loto-Su'a and Jacqueline Cumming)

Health Affairs
Volume: 38, Number: 6 (June 2019)

URL	https://www.healthaffairs.org/toc/hlthaff/38/6
Notes	A new issue of *Health Affairs* has been published with the theme '**Community Care For High-Need Patients**'. Articles in this issue of *Health Affairs* include: - Beyond Twelve Steps, **Peer-Supported Mental Health Care** (M C Marill) - **Home And Community-Based Workforce For Patients With Serious Illness** Requires Support To Meet Growing Needs (Joanne Spetz, Robyn I Stone, Susan A Chapman, and Natasha Bryant) - Policy Changes Key To Promoting Sustainability And Growth Of The **Specialty Palliative Care Workforce** (Arif H Kamal, Steven P Wolf, Jesse Troy, Victoria Leff, Constance Dahlin, Joseph D Rotella, George Handzo, Phillip E Rodgers, and Evan R Myers) - **Care For** America's **Elderly And Disabled People** Relies On Immigrant Labor (Leah Zallman, Karen E Finnegan, David U Himmelstein, Sharon Touw, and Steffie Woolhandler) - Beyond Functional Support: The **Range Of Health-Related Tasks Performed In The Home By Paid Caregivers** In New York (Jennifer M Reckrey, Emma K Tsui, R Sean Morrison, Emma T Geduldig, Robyn I Stone, Katherine A Ornstein, and Alex D Federman)

- A Path To **High-Quality Team-Based Care** For People With Serious Illness (Courtney H Van Houtven, S Nicole Hastings, and Cathleen Colón-Emeric)
- **Care Management For Older Adults**: The Roles Of Nurses, Social Workers, And Physicians (Karen Donelan, Yuchiao Chang, Julie Berrett-Abebe, Joanne Spetz, David I Auerbach, Linda Norman, and Peter I. Buerhaus)
- A Large-Scale Advanced Illness Intervention Informs **Medicare's New Serious Illness Payment Model** (Brad Stuart, E Mahler, and P Koomson)
- Including **Family Caregivers In Seriously Ill Veterans' Care**: A Mixed-Methods Study (Nina R Sperber, Nathan A Boucher, Roxana Delgado, Megan E Shepherd-Banigan, Kevin McKenna, Madison Moore, Rachael Barrett, Margaret Kabat, and Courtney H Van Houtven)
- **Spousal Caregivers** Are Caregiving Alone **In The Last Years Of Life** (Katherine A Ornstein, Jennifer L Wolff, Evan Bollens-Lund, Omari-Khalid Rahman, and Amy S. Kelley)
- Historical Mismatch Between **Home-Based Care Policies And Laws Governing Home Care Workers** (Lisa I Iezzoni, N Gallopyn, and K Scales)
- **Home Health Care Providers Struggle With State Laws And Medicare Rules** As Demand Rises (Susan Jaffe)
- **Home Health Care For Children With Medical Complexity**: Workforce Gaps, Policy, And Future Directions (Carolyn C Foster, Rishi K Agrawal, and Matthew M Davis)
- The **Financial Burden Of Paid Home Care On Older Adults**: Oldest And Sickest Are Least Likely To Have Enough Income (Richard W Johnson and Claire Xiaozhi Wang)
- Work-Related **Opportunity Costs Of Providing Unpaid Family Care** In 2013 And 2050 (Stipica Mudrazija)
- **ACO Serious Illness Care**: Survey And Case Studies Depict Current Challenges And Future Opportunities (William K Bleser, Robert S Saunders, Lia Winfield, Mark Japinga, Nathan Smith, Brystana G Kaufman, Hannah L Crook, David B Muhlestein, and Mark McClellan)
- 'Eyes In The Home': ACOs Use **Home Visits To Improve Care Management, Identify Needs, And Reduce Hospital Use** (Taressa K Fraze, Laura B Beidler, Adam D M Briggs, and Carrie H. Colla)
- Impact Of Physicians, Nurse Practitioners, And Physician Assistants On **Utilization And Costs For Complex Patients** (Perri A Morgan, Valerie A Smith, Theodore S Z Berkowitz, David Edelman, Courtney H Van Houtven, Sandra L Woolson, C C Hendrix, C M Everett, B S White, and G L Jackson)
- Users Of **Veteran-Directed Care And Other Purchased Care** Have Similar Hospital Use And Costs Over Time (Yingzhe Yuan, Kali S Thomas, Austin B Frakt, Steven D Pizer, and Melissa M Garrido)
- **Remaining At Home With Severe Disability** (Michael Ogg)

BMJ Quality and Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • **Missed nursing care in newborn units**: a cross-sectional direct observational study (David Gathara, George Serem, Georgina A V Murphy, Alfred Obengo, Edna Tallam, Debra Jackson, Sharon Brownie, Mike English) • **Management of low back pain** in Australian emergency departments (Giovanni E Ferreira, Gustavo C Machado, Christina Abdel Shaheed, Chung-Wei Christine Lin, Chris Needs, James Edwards, Rochelle Facer, Eileen Rogan, Bethan Richards, Christopher G Maher) • When **order sets** do not align with clinician workflow: assessing **practice patterns in the electronic health record** (Ron C Li, Jason K Wang, Christopher Sharp, Jonathan H Chen) • Exposure to **incivility hinders clinical performance** in a simulated operative crisis (Daniel Katz, Kimberly Blasius, Robert Isaak, Jonathan Lipps, Michael Kushelev, Andrew Goldberg, Jarrett Fastman, B Marsh, S DeMaria)

Online resources

Pressure Injury Toolkit for Spinal Cord Injury and Spina Bifida
https://www.aci.health.nsw.gov.au/networks/spinal-cord-injury/pi-toolkit
The New South Wales Agency for Clinical Innovation (ACI) has developed this toolkit to support clinical decision-making and the use of an interdisciplinary, consumer focused approach to pressure injury assessment and management. It is intended for use by all health professionals working in collaboration with children and adults with spinal cord injury and spina bifida, including general practitioners and other medical practitioners, nurses, occupational therapists, rehabilitation engineers, physiotherapists, social workers, dietitians, psychologists, case managers and peer support workers, in hospital and community settings.

[UK] NICE Guidelines and Quality Standards
https://www.nice.org.uk/guidance
The UK's National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest reviews or updates are:
• Quality Standard QS183 **Physical activity**: *encouraging activity in the community*
  https://www.nice.org.uk/guidance/qs183

[USA] Learning Health Systems
https://www.ahrq.gov/learning-health-systems/index.html
The US Agency for Healthcare Research and Quality (AHRQ) has developed this resource to help health system executives better understand what it takes to create a learning health system. A learning health system (LHS) combines internal data and experience with external evidence to make care higher quality, safer, more efficient care for patients. The key traits of LHS' are detailed in a series of four real-world case studies and other resources.

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