AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Journal articles

Association Between State-Mandated Protocolized Sepsis Care and In-hospital Mortality Among Adults With Sepsis
Kahn JM, Davis BS, Yabes JG, Chang C-CH, Chong DH, Hershey TB, et al
Journal of the American Medical Association. 2019;322(3):240-50.

DOI	https://doi.org/10.1001/jama.2019.9021
Notes	Sepsis is common and potentially serious. This paper investigates the impact of the introduction in 2013 of state regulations in the state of New York that mandated the use of protocols for sepsis recognition and treatment. This was a retrospective cohort study of adult patients hospitalised with sepsis in New York State and in 4 control states (Florida, Maryland, Massachusetts, and New Jersey) using all-payer hospital discharge data for the period (1 January 2011 to 30 September 2015) and a comparative interrupted time series analytic approach. The **mandated protocolised sepsis care** in New York State was **associated** with a **significantly greater decline in risk-adjusted mortality** in New York compared with a group of control states that did not implement mandated protocolised sepsis care. By the 10th quarter after implementation of the regulations, the adjusted absolute mortality was 3.2% lower than expected in New York State relative to the control states.

Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis
Panagioti M, Khan K, Keers RN, Abuzour A, Phipps D, Kontopantelis E, et al
BMJ. 2019;366:l4185.

Preventable harm: getting the measure right
Papanicolas I, Figueroa JF
BMJ. 2019;366:l4611.

DOI	Panagioti et al https://doi.org/10.1136/bmj.l4185 Papanicolas and Figueroa https://doi.org/10.1136/bmj.l4611
Notes	Panagioti et al report on their systematic review and meta-analysis that focused on 70 studies involving 337,025 patients in order to quantify the prevalence, severity and nature of preventable patient harm. They report that the **prevalence of overall harm**, preventable and non-preventable, is **12%** across medical care settings, with about **half of this harm deemed preventable**. In the related editorial, Papanicolas and Figueroa call for standardisation of terminology and better measurement. They suggest that there is a need for: • a **culture** that strongly encourages the diligent **reporting** of near misses, all of which are learning opportunities for staff and systems • improving the **ability to detect harm** across all settings • **increase patient and public engagement** in identifying causes of preventable harm.

We need to talk: Provider conversations with peers and patients about a medical error
Dhawale T, Zech J, Greene SM, Roblin DW, Brigham KB, Gallagher TH, et al
Journal of Patient Safety and Risk Management. 2019 [epub].

DOI	https://doi.org/10.1177/2516043519863578
Notes	Conversations and disclosure following a medical error are important and necessary. This paper reports on a study that had responses from 303 healthcare providers about conversations with peers and patients after medical error. Analysis revealed four major themes in such conversations: information sharing; emotion handling; preventing recurrences; and responsibility. While the majority of provider responses included information sharing, fewer than one-third described the event as an error. Significantly, fewer providers addressed emotion with their peer than with the patient (10% vs. 54%). Providers were more likely to bring up prevention of recurrences with their peer than with the patient (43% vs. 19%). Approximately one-quarter of providers addressed responsibility with the peer and patient (25% vs. 26%, although fewer than 10% acknowledged personal responsibility for the error in either context. It is perhaps not surprising that the conversations with peers are somewhat different to those with patients. The authors suggest that additional (communication) training or support could be of use.

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

The Mental Health Trigger Tool: Development and Testing of a Specialized Trigger Tool for Mental Health Settings
Sajith SG, Fung D, Chua HC
Journal of Patient Safety. 2019 [epub].

DOI	http://doi.org/10.1097/PTS.0000000000000606
Notes	In recent years a number of trigger tools have been developed to detect issues from electronic health record information. This paper reports on the development of a 25-item trigger tool for use in mental health. The tool is designed to detect both traditionally defined adverse events and other mental health–related patient safety incidents.

BMJ Quality & Safety
July 2019 - Volume 28 - 8

URL	https://qualitysafety.bmj.com/content/28/8
Notes	A new issue of *BMJ Quality & Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality & Safety* include: • Editorial: **More ward nursing staff improves inpatient outcomes**, but how much is enough? (Jack Needleman, Paul G Shekelle) • **Assessment of non-technical skills**: why aren't we there yet? (Adam P Johnson, Rajesh Aggarwal) • **Nurse staffing, nursing assistants and hospital mortality**: retrospective longitudinal cohort study (Peter Griffiths, Antonello Maruotti, Alejandra Recio Saucedo, Oliver C Redfern, Jane E Ball, Jim Briggs, Chiara Dall'Ora, Paul E Schmidt, Gary B Smith) • A qualitative positive deviance study to **explore exceptionally safe care on medical wards** for older people (Ruth Baxter, Natalie Taylor, Ian Kellar, Rebecca Lawton) • Characterising **ICU–ward handoffs** at three academic medical centres: process and perceptions (Lekshmi Santhosh, Patrick G Lyons, Juan C Rojas, Thomas M Ciesielski, Shire Beach, Jeanne M Farnan, Vineet Arora) • Use of a **maternal newborn audit and feedback** system in Ontario: a collective case study (Jessica Reszel, Sandra I Dunn, Ann E Sprague, Ian D Graham, Jeremy M Grimshaw, Wendy E Peterson, Holly Ockenden, Jodi Wilding, Ashley Quosdorf, Elizabeth K Darling, Deshayne B Fell, JoAnn Harrold, Andrea Lanes, Graeme N Smith, M Taljaard, D Weiss, M C Walker) • Development and performance evaluation of the Medicines Optimisation Assessment Tool (MOAT): a prognostic model to target **hospital pharmacists' input to prevent medication-related problems** (Cathy Geeson, Li Wei, Bryony Dean Franklin) • **Can patients contribute to safer care in meetings with healthcare professionals?** A cross-sectional survey of patient perceptions and beliefs (Carin Ericsson, Janna Skagerström, Kristina Schildmeijer, Kristofer Årestedt, Anders Broström, Amir Pakpour, Per Nilsen) • **Safety-I, Safety-II and burnout**: how complexity science can help clinician wellness (Andrew Smaggus) • Observer-based tools for **non-technical skills assessment** in simulated and real clinical environments in healthcare: a systematic review (Helen Higham, Paul R Greig, John Rutherford, Laura Vincent, Duncan Young, C Vincent)

American Journal of Medical Quality
Volume: 34, Number: 4 (July/August 2019)

URL	https://journals.sagepub.com/toc/ajmb/34/4
Notes	A new issue of the *American Journal of Medical Quality* has been published. Articles in this issue of the *American Journal of Medical Quality* include: • Editorial: The **Oncology Care Model**: Oncology's First Foray Away From Volume and Toward Value-Based Care (Andrew Song, Valerie P Csik, Amy Leader, and Vittorio Maio) • Developing and Testing a Chart Abstraction Tool for **ICU Quality Measurement** (Jarone Lee, J. Matthew Austin, Jungyeon Kim, Paola D. Miralles, Haytham M. A. Kaafarani, Peter J. Pronovost, Vipra Ghimire, Sean M. Berenholtz, Karen Donelan, and Elizabeth Martinez) • Making **Triage Decisions for the Acute Community Care Program**: Paramedics Caring for Urgent Health Problems in Patients' Homes (Lisa I. Iezzoni, Dhruva Kothari, Carlos A. Camargo, Jr, Amy J. Wint, W. Scott Cluett, III, Yorghos Tripodis, and Joseph Palmisano) • **Primary Care 2.0**: Design of a Transformational Team-Based Practice Model to Meet the Quadruple Aim (Cati G. Brown-Johnson, Garrett K. Chan, Marcy Winget, Jonathan G. Shaw, Kendra Patton, Rumana Hussain, J. Nwando Olayiwola, Sang-ick Chang, and Megan Mahoney) • **Preoperative Evaluation Clinic Redesign**: An Initiative to Improve Access, Efficiency, and Staff Satisfaction (Joan M. Irizarry-Alvarado, Matthew Lundy, Barbara McKinney, Frank A. Ray, Virginia E. Reynolds, and Sher-Lu Pai) • Leveraging Structural Changes in an Electronic Health Record Tool to **Standardize Written Handoff** (Jillian Zavodnick, Rebecca Jaffe, Marc Altshuler, Scott Cowan, Alexis Wickersham, and Gretchen Diemer) • Characterization of the **Recommendations in the Choosing Wisely Initiative** (Kelsey Corrigan, Leonid Aksenov, Alexandra Paul, Banafsheh Sharif-Askary, Sarvesh Agarwal, and Arif Kamal) • A Comparative Analysis of **Academic and Nonacademic Hospitals** on **Outcome Measures and Patient Satisfaction** (Alissa S. Chen, Lee Revere, Alissa Ratanatawan, Christopher L. Beck, and Julio A. Allo) • A Quality Improvement Intervention to Improve the Efficiency of **Arteriovenous Access Placement for Pre-Dialysis Inpatients** (Yasmin Brahmbhatt, Peter Burke, Brianna Shinn, Brandon Menachem, Babak Abai, Dawn Salvatore, and Rachel Sorokin) • A Discharge Time-Out: A Case Study on **Physician–Nurse Discharge Communication** and the Challenge of Sustainability in **Resident-Led Quality Improvement** (Katie E. Raffel, Neha Gupta, Christopher Vercammen-Grandjean, Jessica Hohman, S Ranji, E Pierluissi, and M Mourad) • Creating a Culture of **Continuous Improvement in Outpatient Laboratories**: Effects on Wait Times, Employee Engagement, and Efficiency (Joseph Featherall, Alexander Chaitoff, Anthony Simonetti, James Bena, Daniel Kubiak, M Rothberg, K Roumina, N Hurle, W Henricks, and L Yerian) • **Reducing Telemetry Use** Is Safe: A Retrospective Analysis of Rapid Response Team and Code Events After a Successful Intervention to Reduce Telemetry Use (Lijia Xie, Trit Garg, David Svec, Jason Hom, Rajani Kaimal, Neera Ahuja, James Barnes, and Lisa Shieh)

	• Adherence to **Inpatient Venous Thromboembolism Prophylaxis**: A Single Institution's Concurrent Review (Tyler M Bauer, Adam P Johnson, Katerina Dukleska, Johanna Beck, M S Dworkin, K Patel, S W Cowan, and G J Merli) • Recommendations for the Use of Audit and Feedback to **De-Implement Low-Value Care** (Melanie D Whittington, P Michael Ho, and C D Helfrich) • The **Domino Effect of Medical Errors** (Samer Ellahham) • Providing **Linguistically Competent Care** for Refugee Patients in Clarkston, Georgia: An Interprofessional Quality Improvement Team Initiative (Rebecca Engels, Cricket Gullickson, BA, Reem Hamoda, J. Joyce Kim, and Julia Schiff) • Improving **Warfarin Safety** for Hospitalized Patients (Margaret A Day, Molly S Malone, Vasanthi Mandhadi, Abu Saleh M Mosa, and R J Koopman) • **Electronic Health Record and Physician Burnout** (Don Hayes, Jr) • Assessing and Standardizing **Informed Consent for Total Thyroidectomies** (Stephanie J Wong, Charles N Babb, Vishnu Kadiyala, and Matthew C Miller) • The **ACMQ 2019 Quality Institute**: Blueprint for Change (Don Casey)

Patient Experience Journal
Volume 6, Issue 2 (2019) Special Issue: The Role of Technology and Innovation in Patient Experience

URL	https://pxjournal.org/journal/vol6/iss2/
Notes	A new issue of the *Patient Experience Journal (PXJ)* has been published. This is special issue on **The Role of Technology and Innovation in Patient Experience**. Articles in this special issue of the *Patient Experience Journal (PXJ)* include: • Editorial: **Reframing innovation and technology for healthcare**: A commitment to the human experience (Jason A Wolf) • **Transformations in health information technology and the impact on patient experience** (Cynthia J Sieck and Tim R Huerta) • **Technology, innovation and transforming healthcare faster, smarter and together**: A conversation with Dr. Rasu Shrestha (Jason A Wolf) • The digital revolution will see you now: **transforming patient experience in the digital era** (Emily Kagan Trenchard, Laura Semlies, and Sven Gierlinger) • **Co-producing healthcare** in a volume vs. value-based healthcare system: perspective of a parent of a patient and a health professions' educator (Rosemary M Caron) • A **patient portal** push toward acceptance and utilization of the technology (Deborah Kornacker; Kathy Fitzgerald; and Stacie Elder) • Assessing capacity to engage in healthcare to **improve the patient experience through health information technology** (Cynthia J Sieck, Daniel M Walker, Megan Gregory, Naleef Fareed, and Jennifer L Hefner) • Socio-demographic predictors associated with **capacity to engage in health care** (Ran Sun, Linden Wu, Scott Barnett, Patsy Deyo, and Ellen Swartwout) • How do healthcare staff respond to **patient experience feedback online**? A typology of responses published on Care Opinion (Lauren Paige Ramsey, Laura Sheard, Rebecca Lawton, and Jane O'Hara) • Beneath the surface of talking about physicians: A **statistical model of language for patient experience** comments (Taylor Turpen; Lea Matthews and Senem Guney) • A **next-day, brief e-survey** overcomes the excessive variability seen in CAHPS-style emergency department surveys so that **individual physician**

	performance can be assessed on a regular basis (Tom Scaletta, Eva Hare, and Christopher Sung Lee) • Involving patients and families in a **social robot study** (Lillian Hung, Annette Berndt, Christine Wallsworth, Neil Horne, Mario Gregorio, Jim Mann, Cindy Liu, Evan Woldum, Andy Au-Yeung, and Habib Chaudhury) • Engagement of patients with scleroderma to revise an **internet self-management program** (Janet L Poole, Sharon L Newbill, Jennifer Serrano, Dana Rosson, Josephine Battyany, Laura Dyas, Luke Evnin, Dennis W Raisch, Cynthia Maxwell, Mary Alore, Saville Kellner, Pedro Cuencas, Richard M Silver, and Dinesh Khanna) • A novel **mobile biobehavioral regulation system for personalized trauma recovery support** (Holly Matto, Padmanabhan Seshaiyer, Anna Newcomb, Shira Rothberg, and Adriana Lopez-Piper) • "Anyone can co-design?": A case study synthesis of six **experience-based co-design (EBCD) projects for healthcare systems improvement** in New South Wales, Australia (Tara L Dimopoulos-Bick, Claire O'Connor, Jane Montgomery, Tracey Szanto, Marion Fisher, Violeta Sutherland, Helen Baines, Phillip Orcher, John Stubbs, Lynne Maher, Raj Verma, and Victoria J Palmer)

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: • **Influence of doctor-patient conversations on behaviours of patients** presenting to primary care with new or persistent symptoms: a video observation study (Dorothee Amelung, Katriina L Whitaker, Debby Lennard, Margaret Ogden, Jessica Sheringham, Yin Zhou, Fiona M Walter, Hardeep Singh, Charles Vincent, Georgia Black)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-articles
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Pediatric clinician perspectives on **communicating diagnostic uncertainty** (Ashley N D Meyer, Traber D Giardina, Arushi Khanna, Viraj Bhise, Geeta R Singhal, Richard L Street, Jr., Hardeep Singh) • Creating a pathway for **public hospital accreditation** in Rwanda: progress, challenges and lessons learned (Agnes Binagwaho, Kirstin Woody Scott, Theophile Dushime, Parfait Uwaliraye, Edward Kamuhangire, Dennis Akishuri, Denise Wanyana, Arielle Eagan, Laetitia Kakana, Joy Atwine) • Evaluating the impact of a hospital **scale-up phase of a quality improvement intervention** in Ghana on mortality for children under five (Kavita Singh, Ilene Speizer, Pierre M Barker, Josephine Nana Afrakoma Agyeman-Duah, Justina Agula, Jonas Kofi Akpakli, Salomey Akparibo, Ireneous N Dasoberi, Ernest Kanyoke, Johanna Hermina Steenwijk, Elma Yabang, Nana A Y Twum-Danso, Sodzi Sodzi-Tettey) • Impact of **TeamSTEPPS on patient safety culture** in a Swiss maternity ward (Anthony Staines, Estelle Lécureux, Pascal Rubin, Christian Baralon, Alexandre Farin)

Online resources

[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:

- NICE Guideline NG42 ***Motor neurone disease****: assessment and management* https://www.nice.org.uk/guidance/ng42
- NICE Guideline NG115 ***Chronic obstructive pulmonary disease*** *in over 16s: diagnosis and management* https://www.nice.org.uk/guidance/ng115
- NICE Guideline NG127 ***Suspected neurological conditions****: recognition and referral* https://www.nice.org.uk/guidance/ng127
- Quality Standard QS35 ***Hypertension in pregnancy*** https://www.nice.org.uk/guidance/qs35
- Quality Standard QS101 ***Learning disability****: behaviour that challenges* https://www.nice.org.uk/guidance/qs101
- Quality Standard QS187 ***Learning disability****: care and support of people growing older* https://www.nice.org.uk/guidance/qs187

[USA] Teamwork Toolkit
https://www.hsq.dukehealth.org/teamwork-toolkit/
The Duke Center for Healthcare Safety and Quality has developed this toolkit to help facilities create a culture that embeds teamwork into daily practice routines. Topics covered include team leadership, learning and continuous improvement, clarifying roles, structured communication, and support for raising concerns.
