AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Reports

How doctors in leadership roles establish and maintain a positive patient-centred culture
Research Report for the General Medical Council
Shale S.
London: General Medical Council; 2019. p. 60.

URL	https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/how-doctors-in-senior-leadership-roles-establish-and-maintain-a-positive-patient-centred-culture
Notes	The General Medical Council in the UK has produced this report arguing that **positively engaged leaders from diverse backgrounds are key to transforming organisational cultures**. It observes that such individuals may be unprepared and unsupported for the challenges of leadership during the early stages of their management careers. Further, there needs to be support to help for, as is noted, 'Leading in healthcare isn't easy. Leaders are developed, not born, and doctors who choose to take on these roles deserve to have all the necessary support and resources to help them succeed.'

	The research identified some particular challenges, including balancing competing priorities and demands, focusing on people and culture rather than tasks, and recognising and tackling problematic subcultures. Five 'notable clinical subcultures', that could be harmful if allowed to develop, were identified as part of the research: • Diva subcultures – powerful and successful professionals are not held to account for inappropriate behaviour. • Factional subcultures – arise when disagreement becomes endemic, and the team starts to organise itself around continuing conflict. • Patronage subcultures – arise around influential leaders who have social capital in the form of specialist knowledge, professional connections, high status, respect and access to resources. • Embattled subcultures – where resource has been inadequate, and unequal to demand, practitioners eventually become overwhelmed. • Insular subcultures – some units become isolated from the cultural mainstream of a larger organisation, resulting in professional practice or standards of care that deviate from what is expected. The report highlighted how damaging subcultures were a challenge to an organisation's senior leaders, and once they became established significant time and resources were required to turn them around.

Investigation into failures in communication or follow-up of unexpected significant radiological findings. Final report
Healthcare Safety Investigation Branch
Farnborough: Healthcare Safety Investigation Branch; 2019. p. 68.

URL	https://www.hsib.org.uk/investigations-cases/communication-and-follow-unexpected-significant-radiological-findings/final-report/
Notes	This report from the UK's Healthcare Safety Investigation Branch (HSIB) is their final report from an investigation in lapses following unexpected significant radiological findings. The report includes four recommendations: • The Royal College of Radiologists, working with the Society and College of Radiographers and other relevant specialties through the Academy of Royal Medical Colleges, develops: 1. principles upon which findings should be reported as 'unexpected significant', 'critical' and 'urgent' 2. a simplified national framework for the coding of alerts on radiology reports 3. a list of conditions for which an alert should always be triggered, where appropriate and feasible to do so. • NHS England and NHS Improvement's patient safety team act to implement the key findings regarding risk controls such as a monitored acknowledgement system for critical, urgent and unexpected significant findings. • NHSX develops a method of digitally notifying patients of results. This should be used to inform patients of unexpected significant radiological findings after an agreed timeframe. • The Care Quality Commission amends all appropriate core service frameworks to include risk controls identified in this report, to mitigate the risk of significant abnormal findings not being followed up.

Healthcare in Focus: People's use and experiences of mental health care in NSW
Bureau of Health Information
Chatswood: BHI; 2019. p. 84.

URL	http://bhi.nsw.gov.au/BHI_reports/healthcare_in_focus/mental_health_care
Notes	The Bureau of Health Information (BHI) in New South Wales has published this report in their Healthcare in Focus series. This report looks at the performance of the NSW health system through a specific lens – the use and experiences of health services by people with lived experience of mental health issues. The report examines care in the community; emergency departments (EDs); and public hospitals, including specialised mental health inpatient units.

Aboriginal people's experiences of hospital care
Bureau of Health Information
Chatswood: BHI; 2019. p. 12.

URL	http://bhi.nsw.gov.au/BHI_reports/snapshot_reports/Aboriginal-peoples-experiences-of-hospital-care
Notes	The Bureau of Health Information (BHI) also recently released this 'snapshot' report on Aboriginal people's experiences of hospital care in New South Wales public hospitals. The report is based on the reported experiences of more than 1,000 Aboriginal people treated in emergency departments or as admitted patients.

Journal articles

The impact of hospital harm on length of stay, costs of care and length of person-centred episodes of care: a retrospective cohort study
Tessier L, Guilcher SJT, Bai YQ, Ng R, Wodchis WP
Canadian Medical Association Journal. 2019;191(32):E879.

DOI	https://doi.org/10.1503/cmaj.181621
Notes	Paper reporting on a Canadian study looking at the longitudinal effects of adverse events that occur in hospital, specifically in the period after discharge. The study sought to quantify the impact of adverse events on hospital length of stay, length of person-centred episodes of care (PCEs) and costs of PCEs, as well as their impact on the total health system. Using data on 610,979 **acute hospital admissions** of adults in the Canadian province of Ontario admission between 1 April 2015 and 31 March 2016, the study found 36 004 (**5.9%**) **involved an occurrence of** harm. The authors report that the 'impact of harm on the incremental length of hospital stay ranged from 0.4 to 24.2 days …; the incremental length of the PCE ranged from 0.3 to 30.2 days …; and the incremental costs of the PCE ranged from $800 to $51 067.' They also report that the total hospital days attributable to hospital harm amounted to 407 696, and the total attributable cost to the Ontario health system amounted to $1 088 330 376.. Such results led them to conclude the 'experiencing harm in hospital significantly affects both in-hospital and post-discharge use of health services and costs of care, and constitutes an enormous expense to Ontario's publicly funded health system.'

Risk Assessment, Genetic Counseling, and Genetic Testing for BRCA-Related Cancer: US Preventive Services Task Force Recommendation Statement
U. S. Preventive Services Task Force
JAMA. 2019;322(7):652-65.

Risk Assessment, Genetic Counseling, and Genetic Testing for BRCA-Related Cancer in Women Updated Evidence Report and Systematic Review for the US Preventive Services Task Force
Nelson HD, Pappas M, Cantor A, Haney E, Holmes R.
JAMA. 2019;322(7):666-85.

Broadening Criteria for BRCA1/2 Evaluation: Placing the USPSTF Recommendation in Context
Domchek S, Robson M
JAMA. 2019;322(7):619-21.

US Preventive Services Task Force Breast Cancer Recommendation Statement on Risk Assessment, Genetic Counseling, and Genetic Testing for BRCA-Related Cancer
Newman L
JAMA Surgery. 2019 [epub].

Hereditary Cancer Evaluation in 2019—a Rapidly Evolving Landscape
Yung RL, Korde LA
JAMA Oncology. 2019 [epub].

USPSTF Recommendations for BRCA1 and BRCA2 Testing in the Context of a Transformative National Cancer Control Plan
Rajagopal PS, Nielsen S, Olopade OI
JAMA Network Open. 2019;2(8):e1910142-e.

Should I Be Tested for BRCA Mutations?
Jin J
JAMA. 2019;322(7):702.

DOI	US Preventive Services Task Force https://doi.org/10.1001/jama.2019.10987 Nelson et al https://doi.org/10.1001/jama.2019.8430 Domchek and Robson https://doi.org/10.1001/jama.2019.9688 Newman https://doi.org/10.1001/jamasurg.2019.3184 Yung and Korde https://doi.org/10.1001/jamaoncol.2019.3431 Rajagopal et al https://doi.org/10.1001/jamanetworkopen.2019.10142 Jin https://doi.org/10.1001/jama.2019.11251
Notes	Breast cancer is among the most prevalent of cancers and BRCA gene mutations have been associated with susceptibility to breast cancer (and ovarian, fallopian tube and peritoneal cancers). The US Preventive Services Task Force has reviewed the evidence on risk assessment, genetic counselling, and genetic testing for potentially harmful BRCA1/2 mutations and their statement, the evidence report and systematic review that inform the recommendation. (Nelson et al) and a number of editorials across JAMA publications, including Domchek and Robson (*JAMA*), Newman (*JAMA Surgery*), Yung and Korde (*JAMA Oncology*) and Rajagopal et al (*JAMA Network Open*) have all been published, along with a 'Patient Page' (Jin). The USPSTF recommends that: • Primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with BRCA1/2 gene mutations with an appropriate brief familial risk assessment tool.

	• Women with a positive result on the risk assessment tool should receive genetic counselling and, if indicated after counselling, genetic testing. (B recommendation) • The USPSTF recommends against routine risk assessment, genetic counselling, or genetic testing for women whose personal or family history or ancestry is not associated with potentially harmful BRCA1/2 gene mutations. (D recommendation)

Risk Assessment, Genetic Counseling, and Genetic Testing for *BRCA*-Related Cancer

BRCA1/2 gene mutations, which are passed down among families, are linked to an increased risk of breast and ovarian cancer in women. Some women may benefit from genetic testing for harmful *BRCA1/2* mutations based on their personal and/or family history of breast or ovarian cancer.

Population

Women without cancer symptoms with unknown *BRCA1/2* mutation status

USPSTF recommendation

The USPSTF recommends risk assessment for women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with harmful *BRCA1/2* mutations with an appropriate risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.

The USPSTF recommends against risk assessment, genetic counseling, or genetic testing for women without risk factors for harmful *BRCA1/2* mutations.

Evaluation of interventions to improve inpatient hospital documentation within electronic health records: a systematic review
Wiebe N, Otero Varela L, Niven DJ, Ronksley PE, Iragorri N, Quan H
Journal of the American Medical Informatics Association. 2019.

DOI	https://doi.org/10.1093/jamia/ocz081
Notes	Paper reporting on a systematic review that sought to assess the effectiveness of interventions seeking to improve electronic health record (EHR) documentation within an inpatient setting. Based on 24 studies, the authors found that 'Interventions implemented to enhance EHR documentation are highly variable and require standardization. Emphasis should be placed on this novel area of research to improve communication between healthcare providers and facilitate data sharing between centers and countries.'

Evaluation of Economic and Clinical Outcomes Under Centers for Medicare & Medicaid Services Mandatory Bundled Payments for Joint Replacements
Haas DA, Zhang X, Kaplan RS, Song Z
JAMA Internal Medicine. 2019;179(7):924-31.

R*educed Spending With Mandatory Bundled Payments for Joint Replacements*
Jayakumar P, Bozic KJ
JAMA Internal Medicine. 2019;179(7):932-3.

DOI	Haas et al https://doi.org/10.1001/jamainternmed.2019.0480 Jayakumar and Bozic https://doi.org/10.1001/jamainternmed.2019.0486
Notes	How to fund or reimburse the delivery of health care is a vexed issue. Bundled payments have been posited as one option. These papers indicate that in the USA bundled payments for joint replacement have reduced spending. The research paper (Hass et al) and related commentary (Jayakumar and Bozic) looked at the Centers for Medicare & Medicaid Services (CMS) Comprehensive Care for Joint Replacement (CJR) model that provides a wide-scale, mandatory, episode-based bundled payment program for lower extremity joint replacement. They found that in the first two years of operation 'the Comprehensive Care for Joint Replacement model was associated with reduced Medicare Part A spending driven by postacute savings, without changes in volume, quality, or patient selection.'

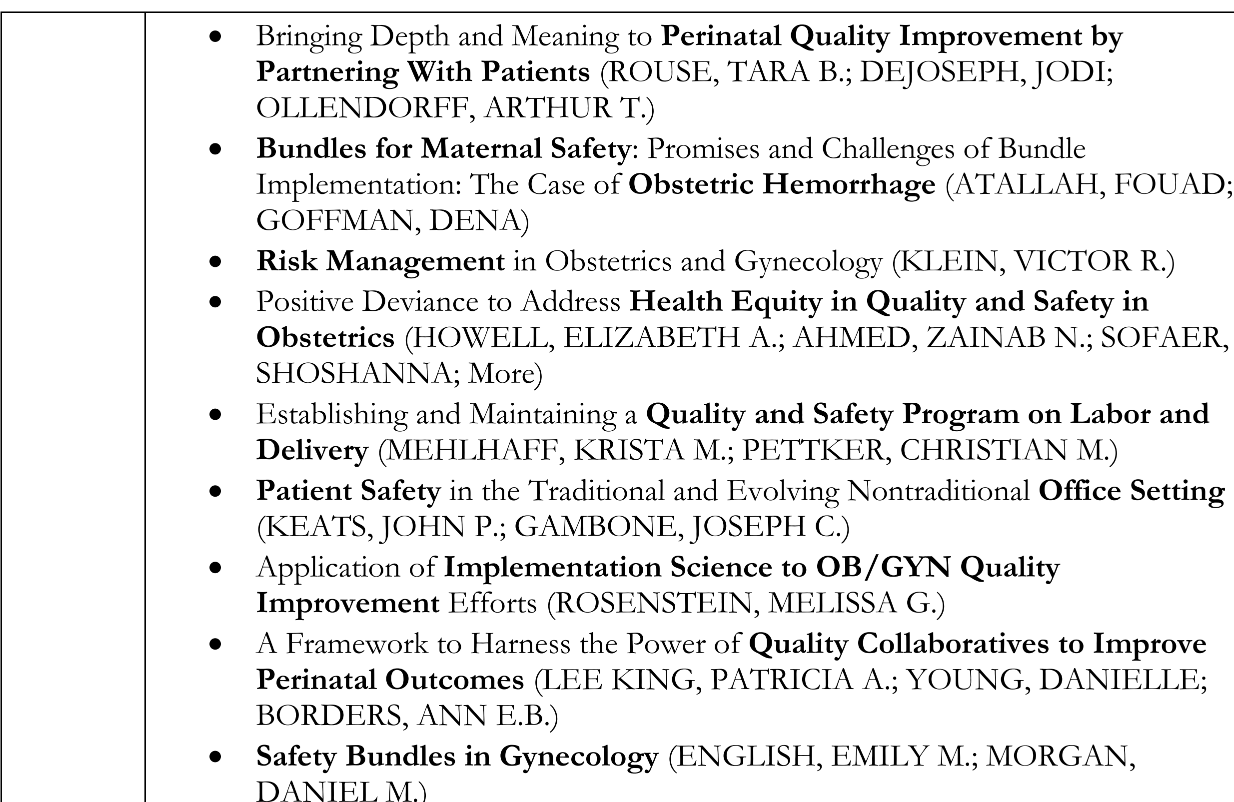
BMJ Quality & Safety
September 2019 - Volume 28 - 9

URL	https://qualitysafety.bmj.com/content/28/9
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: **Are increases in emergency use and hospitalisation always a bad thing?** Reflections on unintended consequences and apparent backfires (Kaveh G Shojania) • Editorial: To catch a killer: **electronic sepsis alert tools** reaching a fever pitch? (Halley Ruppel, Vincent Liu) • Effects and costs of implementing **predictive risk stratification in primary care**: a randomised stepped wedge trial (Helen Snooks, Kerry Bailey-Jones, Deborah Burge-Jones, Jeremy Dale, Jan Davies, Bridie Angela Evans, Angela Farr, Deborah Fitzsimmons, Martin Heaven, Helen Howson, Hayley Hutchings, Gareth John, Mark Kingston, Leo Lewis, Ceri Phillips, Alison Porter, B Sewell, D Warm, A Watkins, S Whitman, V Williams, I Russell) • **Hospital nurse staffing and staff–patient interactions**: an observational study (Jackie Bridges, Peter Griffiths, Emily Oliver, Ruth M Pickering) • Variation in use and outcomes related to **midline catheters**: results from a multicentre pilot study (Vineet Chopra, Scott Kaatz, Lakshmi Swaminathan, Tanya Boldenow, Ashley Snyder, Rachel Burris, Steve J Bernstein, S Flanders) • Use of performance reports among trauma medical directors and programme managers in the American College of Surgeons' **Trauma Quality Improvement** Program: a qualitative analysis (Lesley Gotlib Conn, Christopher Hoeft, Melanie Neal, Avery Nathens) • Can universal patient-held health booklets promote **continuity of care and patient-centred care** in low-resource countries? The case of Mongolia (Hussein Ibrahim, Uyanga Munkhbayar, Aira Toivgoo, Claire Humphries, Chimedsuren Ochir, Indermohan S Narula, R Lilford, S Manaseki-Holland)

	• What US hospitals are currently doing to prevent **common device-associated infections**: results from a national survey (Sanjay Saint, Michael Todd Greene, Karen E Fowler, David Ratz, P K Patel, J Meddings, S L Krein) • 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, Benjamin Marsh, S DeMaria) • **Sepsis and antimicrobial stewardship**: two sides of the same coin (Fidelma Fitzpatrick, C Tarrant, V Hamilton, F M Kiernan, D Jenkins, E M Krockow) • Electronic health record-based clinical decision support alert for **severe sepsis**: a randomised evaluation (Norman Lance Downing, Joshua Rolnick, Sarah F Poole, Evan Hall, Alexander J Wessels, Paul Heidenreich, Lisa Shieh) • Quality and safety in the literature: September 2019 (Nathan Houchens, Jennifer Meddings, Ashwin Gupta)

Clinical Obstetrics and Gynecology
September 2019 - Volume 62 - Issue 3

URL	https://journals.lww.com/clinicalobgyn/toc/2019/09000
Notes	A new issue of *Clinical Obstetrics and Gynecology* has been published with the themes of **Burnout** and **Resilience** and **Quality and Safety Programs**. Articles in this issue of *Clinical Obstetrics and Gynecology* include: • Foreword: **Burnout and Resilience in Obstetrics and Gynecology** (FOWLER, JEFFREY M.; GABBE, STEVEN G.) • **Burnout in Obstetricians and Gynecologists** (SMITH, ROGER P.) • **Burnout in OB/GYN Students and Residents** (RIGBY, FIDELMA B.; BYNUM, BLYTHE; SANTEN, SALLY A.; More) • Interventions to **Reduce Burnout and Improve Resilience**: Impact on a **Health System's Outcomes** (MOFFATT-BRUCE, SUSAN D.; NGUYEN, MICHELLE C.; STEINBERG, BETH; More) • The Impact of **Burnout on the Obstetrics and Gynecology Workforce** (VETTER, MONICA HAGAN; SALANI, RITU; WILLIAMS, THOMAS E. JR; More) • **Physician Work-Life Integration**: Challenges and Strategies for Improvement (KARAKASH, SCARLETT; SOLONE, MICHELLE; CHAVEZ, JORDAN; More) • **Burnout Woman-Style**: The Female Face of Burnout in Obstetrics and Gynecology (FRONEK, HELANE; BRUBAKER, LINDA) • Moving From **Physician Burnout to Resilience** (SOTILE, WAYNE M.; FALLON, REBECCA S.; SIMONDS, GARY R.) • Organizational Strategies to Create a **Burnout-resistant Environment** (BINKLEY, PHILIP F.; LEVINE, EDWARD) • Foreword: **Quality and Safety Programs in Obstetrics and Gynecology** (MAIN, ELLIOTT K.) • **Failure to Rescue, Communication, and Safety Culture (**LYNDON, AUDREY) • **Checklists, Huddles, and Debriefs**: Critical Tools to Improve **Team Performance in Obstetrics** (TREJO, FATIMA ESTRADA; IGEL, CATHERINE M.; CHUANG, MELEEN; More)



	• Bringing Depth and Meaning to **Perinatal Quality Improvement by Partnering With Patients** (ROUSE, TARA B.; DEJOSEPH, JODI; OLLENDORFF, ARTHUR T.) • **Bundles for Maternal Safety**: Promises and Challenges of Bundle Implementation: The Case of **Obstetric Hemorrhage** (ATALLAH, FOUAD; GOFFMAN, DENA) • **Risk Management** in Obstetrics and Gynecology (KLEIN, VICTOR R.) • Positive Deviance to Address **Health Equity in Quality and Safety in Obstetrics** (HOWELL, ELIZABETH A.; AHMED, ZAINAB N.; SOFAER, SHOSHANNA; More) • Establishing and Maintaining a **Quality and Safety Program on Labor and Delivery** (MEHLHAFF, KRISTA M.; PETTKER, CHRISTIAN M.) • **Patient Safety** in the Traditional and Evolving Nontraditional **Office Setting** (KEATS, JOHN P.; GAMBONE, JOSEPH C.) • Application of **Implementation Science to OB/GYN Quality Improvement** Efforts (ROSENSTEIN, MELISSA G.) • A Framework to Harness the Power of **Quality Collaboratives to Improve Perinatal Outcomes** (LEE KING, PATRICIA A.; YOUNG, DANIELLE; BORDERS, ANN E.B.) • **Safety Bundles in Gynecology** (ENGLISH, EMILY M.; MORGAN, DANIEL M.)

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: • Validation of new ICD-10-based patient safety indicators for identification of **in-hospital complications in surgical patients**: a study of diagnostic accuracy (Daniel I McIsaac, Gavin M Hamilton, Karim Abdulla, Luke T Lavallée, Husien Moloo, Chris Pysyk, Jocelyn Tufts, W A Ghali, A J Forster) • Nursing roles for **in-hospital cardiac arrest response**: higher versus lower performing hospitals (Timothy C Guetterman, Joan E Kellenberg, Sarah L Krein, Molly Harrod, Jessica L Lehrich, Theodore J Iwashyna, Steven L Kronick, Saket Girotra, Paul S Chan, Brahmajee K Nallamothu) • **Mental well-being, job satisfaction and self-rated workability in general practitioners and hospitalisations for ambulatory care sensitive conditions among listed patients**: a cohort study combining survey data on GPs and register data on patients (Karen Busk Nørøxe, Anette Fischer Pedersen, Anders Helles Carlsen, Flemming Bro, Peter Vedsted)

Online resources

Too Much of a good thing
https://croakey.org/launching-a-new-series-too-much-of-a-good-thing/
This new blog series is a collaboration between Wiser Healthcare and Croakey. The series will seek to investigate how to reduce overdiagnosis and overtreatment in Australia and globally. The first post examines why overdiagnosis matters, including because of concerns about quality and safety of healthcare, lost opportunity, inequity and squandering precious resources.

Asking the Question of Origin
https://www.heartfoundation.org.au/for-professionals/aboriginal-health-resources/training-centre
Online learning module from the Heart Foundation that educates health professionals and health service staff on how to identify Aboriginal and Torres Strait Islander patients. The module aims to:

- increase participants' understanding of the importance, responsibilities and reasons for identifying Aboriginal and Torres Strait Islander peoples in general practice and/or hospital settings
- improve participants' knowledge, skills and confidence to identify Aboriginal and Torres Strait Islander people and record identification data in line with standard practice.

The module is supported by a range of printed resources.

[UK] Professionalism and Cultural Transformation (PACT) toolkit
https://www.nhsemployers.org/case-studies-and-resources/2019/08/professionalism-and-cultural-transformation-pact-toolkit
NHS Employers has released this toolkit aiming to educate and empower staff to improve professionalism within their workplace, helping organisations move towards making the NHS the best place to work. The toolkit is based on work undertaken by Hull University Teaching Hospitals NHS Trust and is designed to help staff embed the PACT programme in their organisation. It contains practical information, advice and solutions to equip staff to deal with unprofessional attitudes and behaviours in the workplace.

[UK] Progressive neurological conditions toolkit
https://www.england.nhs.uk/rightcare/products/pathways/progressive-neurological-conditions-toolkit/
NHS England has released this RightCare toolkit to aid health facilities with understanding the priorities in care for people living with various progressive neurological conditions. People with progressive neurological conditions are experiencing delays in diagnosis and treatment, fragmented and uncoordinated services, limited availability of neurospecialist rehab and reablement and a lack of psycho–social support. The toolkit covers the following neurological conditions; multiple sclerosis (MS), motor neurone disease (MND), Parkinson's and the atypical Parkinsonism's of multiple system atrophy (MSA), progressive supranuclear palsy (PSP) and corticobasal degeneration (CBD).

[UK] Preventing falls in people with learning disabilities: making reasonable adjustments
https://www.gov.uk/government/publications/preventing-falls-in-people-with-learning-disabilities/preventing-falls-in-people-with-learning-disabilities-making-reasonable-adjustments
Public Health England has produced this guidance information to help staff in public health, health services and social care to prevent falls in people with learning disabilities. It is also intended to help falls prevention services to provide support that is accessible to people with learning disabilities. The guide can be used by family carers, friends and paid support staff to help them think about what risks may contribute to falls and how to reduce such risks.

[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 QS188 *Coexisting* ***severe mental illness*** *and* ***substance misuse*** https://www.nice.org.uk/guidance/qs188
- Clinical Guideline CG132 ***Caesarean section*** https://www.nice.org.uk/guidance/cg132

[UK] BTS/SIGN British Guideline on the Management of Asthma
https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/
The British Thoracic Society (BTS) and Scottish Intercollegiate Guidelines Network (SIGN) have released updated guidance on the management of asthma. The guidance has a focus on the prevention of asthma attacks. Health professionals advised to assess all patients for future asthma attack risk to help tailor future care and treatment. Patients whose asthma is not under control after using standards 'controller therapies' should be referred for specialist care.

[USA] Patient Safety Primers
https://psnet.ahrq.gov/primers/
The Patient Safety Primers from the (US) Agency for Healthcare Research and Quality (AHRQ) discuss key concepts in patient safety. Each primer defines a topic, offers background information on its epidemiology and context, and provides links to relevant materials.

- **Clinical Decision Support Systems** – Clinical decision support systems are designed to provide information or recommendations to help clinicians make safe and evidence-based decisions. This primer discusses the growing use and sophistication of clinical decision support systems, enabled by widespread implementation of electronic health records and advances in clinical informatics. https://psnet.ahrq.gov/primers/primer/51

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