AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Reprocessing of reusable medical devices in health service organisations
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/as1807-reprocessing-reusable-medical-devices-health-service-organisations
The Australian Commission on Safety and Quality in Health Care released an amended advisory on 12 December 2019 that describes the minimum requirements for health service organisation compliance with Action 3.14 following the introduction and subsequent revision by Standards Australia of *AS/NZS 4187:2014 Reprocessing of reusable medical devices in health service organisations*.

Journal articles

Measuring Quality
Khorana MM, Khorana AA
Journal of the American Medical Association. 2019;322(21):2077-2078.

The illusion of perfection
Smulowitz P
BMJ Quality & Safety. 2019 [epub]

DOI	Khorana and Khorana https://doi.org/10.1001/jama.2019.18730 Smulowitz http://dx.doi.org/10.1136/bmjqs-2019-010501
Notes	A pair of narrative pieces that offer reflections on the purpose and nature of healthcare delivery and remind us how it is not simply a mechanical, industrial or scientific process. Health is a profoundly human, individual activity with implications for everyone: patient, families, carers, clinicians. Getting healthcare "right" requires care, understanding and empathy for everyone.

Never events in UK general practice: A survey of the views of general practitioners on their frequency and acceptability as a safety improvement approach
Stocks SJ, Alam R, Bowie P, Campbell S, de Wet C, Esmail A, et al
Journal of Patient Safety. 2019;15(4):334-342.

DOI	https://doi.org/10.1097/PTS.0000000000000380
Notes	The full extent of errors, adverse event, never events, etc. in primary care remains something of a mystery. This paper reports on a survey of British GPs on their views on the most severe category, "never events". As the name suggests these are things that should never happen. Never events that occur in hospitals are recorded in many countries, but their occurrence in primary care is not well understood. A preliminary list of never events (NEs) for UK general practice has been developed and this study sought to estimate (1) the frequency of 10 NEs occurring within GPs' own practices and (2) the extent to which the NE approach is perceived as acceptable for use. The study analysed responses from 556 GPs in 412 practices. The authors report that 'most participants (70%–88%, depending on the NE) agreed that the described incident should be designated as a NE. Three NEs were estimated to have occurred in less than 4% of practices in the last year; however, two NEs were estimated to have occurred in 45% to 61% of the practices. General practitioners reporting that a NE had occurred in their practice in the last year were significantly less likely to agree with the designation as a NE compared with GPs not reporting a NE (odds ratio, 0.42; 95% CI = 0.36–0.49).' The preliminary list of never events specifically for UK general practice are: 1. Prescribing aspirin for a patient 12 years or younger 2. Methotrexate prescribed daily rather than weekly 3. Adrenaline is NOT available when needed 4. Prescribed teratogenic drug when pregnant 5. Prescribed hormone replacement therapy (HRT) and has intact uterus 6. Cancer referral not sent 7. Ambulance transport is not arranged 8. Needle stick injury due to sharps disposal failure 9. Prescribing when adverse reaction recorded 10. Abnormal investigation result is not reviewed.

Primary Care Physicians' Role In Coordinating Medical And Health-Related Social Needs In Eleven Countries
Doty MM, Tikkanen R, Shah A, Schneider EC
Health Affairs. 2019 [epub].

DOI	https://doi.org/10.1377/hlthaff.2019.01088
Notes	The Commonwealth Fund in the USA coordinates a survey of aspects of health care in a number of high-income on a regular basis. The 2019 survey 'primary care physicians in eleven high-income countries about their ability to coordinate patients' medical care with specialists, across settings of care, and with social service providers'. The authors observe that ', improving care coordination is not only central to achieving high-performing primary care but is also an indispensable strategy for reducing fragmentation, eliminating inefficiencies, and reducing costs of care.' The results – and analysis – focus on the USA but also provide information about health care in the other countries. The USA often fares poorly in these comparisons with much higher costs not leading to better outcomes. Australia tends to have something of a mixed set of results. For example, lower costs than many of the comparator nations, fair to good outcomes but some issues, for example high out of pocket costs. In this year's results, as shown in this article, Australia does not fare terribly well with results that are more similar to those of the USA and Canada rather than Europe and the UK, including in communication with acute care and social care and the use of technology in communicating with their patients and across sectors. It is instructive that Australia is rarely cited as an example of how to do things well, which is something of a contrast with some of the previous Commonwealth Fund surveys and publications.

For information on the Commission's work on patient-clinician communication, see https://www.safetyandquality.gov.au/our-work/communicating-safety/patient-clinician-communication

For guidance, tools and resources to support the core skills for communicating for safety, see the Communicating for Safety resource portal https://www.c4sportal.safetyandquality.gov.au/

Awareness of diagnosis and follow up care after discharge from the emergency department
Leamy K, Thompson J, Mitra B
Australasian Emergency Care. 2019;22(4):221-226.

DOI	https://doi.org/10.1016/j.auec.2019.08.004
Notes	This Australian study looked at whether providing emergency department (ED) patients with additional information – specifically, a simplified discharge card – improved their understanding. While most patients receive a discharge summary after an ED visit, the authors of this paper sought to see if a simplified discharge information card could improve patients' awareness of their discharge diagnosis and requirements for follow-up. This was a prospective pre-post design interventional study with 112 patients in the pre-intervention group and 117 in the post-intervention group. The authors report that the patient-focused communication (the discharge information card) improved awareness of discharge diagnoses and follow-up requirements.

Shared decision making: why the slow progress? An essay by Neal Maskrey
Maskrey N
BMJ. 2019;367:l6762.

DOI	https://doi.org/10.1136/bmj.l6762
Notes	In this essay, the author considers why the adoption of shared decision making has been 'remarkably slow'. How the medical profession deals with and communicates about uncertainty has been considered as one possible issue. However, this piece considers it more a consequence of doctors' communication skills, including a lack of research, training and assessment. A change to the consultation model and greater responsibility for communication is suggested.

For information on the Commission's work on shared decision making, see https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making

Institutionalizing quality within national health systems: key ingredients for success
Kandasami S, Syed SB, Edward A, Sodzi-Tettey S, Garcia-Elorrio E, Mensah Abrampah N, et al.
Journal for Quality in Health Care. 2019.

DOI	https://doi.org/10.1093/intqhc/mzz116
Notes	This perspectives piece makes the case for 'an overarching national policy or strategy on quality' to 'provide direction for quality initiatives across all levels of the health system'. The authors believe that such a strategy can 'can strengthen service delivery along with strong leadership, resources, and infrastructure as essential building blocks for the health system'. They proceed to identify further elements to drive quality, including active learning, strong partnerships and coordination across multiple levels, engagement at all health system levels and strong political commitment.

Prevalence and nature of medication errors and preventable adverse drug events in paediatric and neonatal intensive care settings: A systematic review
Alghamdi AA, Keers RN, Sutherland A, Ashcroft DM
Drug Safety. 2019;42(12):1423-1436.

DOI	https://doi.org/10.1007/s40264-019-00856-9
Notes	This paper reports on a systematic review that examined empirical studies examining the prevalence and nature of medication errors and preventable adverse drug events in paediatric and neonatal intensive care units published between January 2000 and March 2019. Using 35 studies, the authors report: • In paediatric intensive care units (PICUs), the median rate of medication errors was 14.6 per 100 medication orders and between 6.4 and 9.1 per 1000 patient-days. • In neonatal intensive care units (NICUs), medication error rates ranged from 4 to 35.1 per 1000 patient-days and from 5.5 to 77.9 per 100 medication orders. • In both settings, prescribing and medication administration errors were found to be the most common medication errors, with dosing errors the most frequently reported error subtype. • Preventable adverse drug event rates were reported in three PICU studies as 2.3 per 100 patients and 21–29 per 1000 patient-days. • In NICUs, preventable adverse drug event rates from three studies were 0.86 per 1000 doses and 0.47–14.38 per 1000 patient-days. • Anti-infective agents were commonly involved with medication errors/preventable adverse drug events in both settings.

For information on the Commission's work on medication safety, see https://www.safetyandquality.gov.au/medication-safety

BMJ Quality & Safety
January 2020 - Volume 29 - 1

URL	https://qualitysafety.bmj.com/content/29/1
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: **Nurses matter**: more evidence (Linda H Aiken, Douglas M Sloane) • Editorial: The harms of promoting '**Zero Harm**' (Eric J Thomas) • Editorial: Realising the potential of **health information technology to enhance medication safety** (Aziz Sheikh) • Association of **registered nurse and nursing support staffing with inpatient hospital mortality** (Jack Needleman, Jianfang Liu, Jinjing Shang, Elaine L Larson, Patricia W Stone) • **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) • Exploring the sustainability of **quality improvement interventions in healthcare organisations**: a multiple methods study of the 10-year impact of the 'Productive Ward: Releasing Time to Care' programme in English acute hospitals (Glenn Robert, Sophie Sarre, Jill Maben, Peter Griffiths, R Chable) • **Community pharmacy medication review, death and re-admission after hospital discharge**: a propensity score-matched cohort study (Lauren Lapointe-Shaw, Chaim M Bell, Peter C Austin, Lusine Abrahamyan, Noah M Ivers, Ping Li, Petros Pechlivanoglou, Donald A Redelmeier, Lisa Dolovich) • Assessing the **safety of electronic health records**: a national longitudinal study of medication-related decision support (A Jay Holmgren, Zoe Co, Lisa Newmark, Melissa Danforth, David Classen, David Bates) • **Managing risk in hazardous conditions**: improvisation is not enough (Rene Amalberti, Charles Vincent) • Use and reporting of experience-based **codesign studies in the healthcare setting**: a systematic review (Theresa Green, Ann Bonner, Laisa Teleni, Natalie Bradford, Louise Purtell, Clint Douglas, Patsy Yates, Margaret MacAndrew, Hai Yen Dao, Raymond Javan Chan) • Interventions for improving **teamwork in intrapartem care**: a systematic review of randomised controlled trials (Michael Wu, Jennifer Tang, Nicole Etherington, Mark Walker, Sylvain Boet)

Journal of Patient Safety & Risk Management
Volume 24, Issue 6, December 2019

URL	https://journals.sagepub.com/toc/cric/24/6
Notes	A new issue of the *Journal of Patient Safety & Risk Management* has been published. Articles in this issue of the *Journal of Patient Safety & Risk Management* include: • Editorial: **Patient safety pearls** (Albert W Wu, Tommaso Bellandi, Peter Buckle, Robert Francis, Elliott R Haut, Allen Kachalia, Alpana Mair, John Øvretveit, Chris Power, Peter J. Pronovost, Hugo Sax, David W Shapiro, Eric J Thomas, David Newman-Toker, Charles Vincent)

	• Editorial: Competing **patient safety concerns about surgical scrub caps** – Infection control vs. breakdowns in communication (Katrina C Duncan, Elliott R Haut) • Editorial: Addressing need and formulating ideas to mitigate **prescribing errors in pediatric settings** (Shweta Shah, Michelle Chui) • The **Surgical Risk Preoperative Assessment System**: Determining which predictor variables can be automatically obtained from the electronic health record (Robert A Meguid, Michael R Bronsert, Karl E Hammermeister, David P Kao, Anne Lambert-Kerzner, Jacob A Sinex, J M Myers, W G Henderson) • Types and prevalence of **adverse events among obstetric clients** hospitalized in a secondary healthcare facility in Ghana (Elom-Hilary Otchi, Reuben K Esena, Emmanuel K Srofenyoh, Kissinger Marfo, Evans Kofi Agbeno, Kwaku Asah-Opoku, Sebastian Ken-Amoah, Emmanuel Ogbada Ameh, Titus Beyuo, Frederick Oduro) • **Adverse events associated with medical devices** in patients at different clinics and hospitals in Colombia (Jorge E Machado-Alba, Edwar A Cardona-Trejos, Yudy Lorena Delgado-Pascuaza, Daniel R Torres-Bahamon, A Portilla) • Building an **organizational culture of patient safety** (Kok Hian Tan, Nguk Lan Pang, Chuin Siau, Zann Foo, Kok Yong Fong)

Australian Journal of Primary Health
Volume 25 Number 6

URL	https://www.publish.csiro.au/py/issue/9447
Notes	A new issue of the *Australian Journal of Primary Health* has been published. Articles in this issue of *Australian Journal of Primary Health* include: • Barriers and enablers to delivering preventative and early intervention **footcare to people with diabetes**: a scoping review of healthcare professionals' perceptions (Leanne Mullan, Andrea Driscoll, K Wynter and B Rasmussen) • Association of **health literacy and diabetes self-management**: a systematic review (Padam K Dahal and Hassan Hosseinzadeh) • Developing **professional education** for **primary healthcare providers** about **nutrition** (Catherine J Lucas, Anne T McMahon and Karen E Charlton) • Feasibility of the PHYZ X 2U program: a mobile and cloud-based outreach service to improve **chronic disease outcomes in underserviced rural communities** (Serene S Paul, Tania Gardner, Angela Hubbard, Justin Johnson, Colleen G Canning, Andrew Leaver, J Raymond and S M Dennis) • Development and psychometric testing of a patient-reported inventory to measure **patient-centred care in dietetic practice** (Ishtar Sladdin, Wendy Chaboyer, Lauren Ball and Brigid M Gillespie) • **Childhood infection, antibiotic exposure and subsequent metabolic risk** in adolescent and young adult Aboriginal Australians: practical implications (Sandra Campbell, Ella Tracey, Ruth Fagan, Kingsley Pearson, Fintan Thompson, Robyn McDermott and Malcolm McDonald) • The **advance care planning nurse facilitator**: describing the role and identifying factors associated with successful implementation (Jeremy Rogers, Charlotte Goldsmith, Craig Sinclair and Kirsten Auret) • Predicting **general practitioner utilisation** at a small area level across Western Australia (Greg Lyle and Delia Hendrie)

The Milbank Quarterly
December 2019 (Volume 97)

URL	https://www.milbank.org/quarterly/issues/december-2019/
Notes	A new issue of *The Milbank Quarterly* has been published. Articles in this issue of *The Milbank Quarterly* include: • **New Zealand's Wellbeing Budget** Invests in Population Health (Michael Mintrom) • What Does a **Wellbeing Budget** Mean for Health and Health Care? (Ashley Bloomfield) • Putting **Health at the Heart of National Policymaking**: Learning from New Zealand (Sandro Galea, Salma M Abdalla) • Focusing on **State-Level Primary Care Initiatives**: From a Small State With a Great Need (Kara Odom Walker) • **A Catastrophe for Public Health and Law** (Sara Rosenbaum) • Deaths of Despair: Lessons from the **Vietnam Draft Lottery** (Dalton Conley, Tim Johnson) • **Shareholders, Stakeholders, and US Health Care** (John E. McDonough) • New Drugs, New Ideas: Payment Policy Innovations for **High-Cost Pharmaceuticals** (Brian J Miller, Gail R Wilensky) • **Adolescence: An Opportunity for Population Health** (J M Sharfstein) • Navigating the Shifting Terrain of **US Health Care Reform**—Medicare for All, Single Payer, and the Public Option (Jonathan Oberlander) • Toward a **Corporate Culture of Health**: Results of a National Survey (Michael Anne Kyle, Lumumba Seegars, John M Benson, Robert J Blendon, Robert S Huckman, Sara J Singer) • **Childhood Vaccination Mandates**: Scope, Sanctions, Severity, Selectivity, and Salience (Katie Attwell, Mark C Navin) • **Private Health Insurance in France**: Between Europeanization and Collectivization (Cyril Benoît, Gaël Coron) • Innovation and Its Discontents: Pathways and Barriers in the Diffusion of **Assertive Community Treatment** (David A Rochefort)

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: • **Institutionalizing quality within national health systems**: key ingredients for success (Stephanie Kandasami, Shamsuzzoha Babar Syed, Anbrasi Edward, Sodzi Sodzi-Tettey, E Garcia-Elorrio, N Mensah Abrampah, P M Hansen) • **Bending the quality curve** (Jeffrey Braithwaite, Robyn Clay-Williams, Natalie Taylor, Hsuen P Ting, Teresa Winata, Gaston Arnolda, Rosa Sunol, Oliver GrÖne, Cordula Wagner, Niek S Klazinga, Liam Donaldson, S Bruce Dowton) • Did a quality improvement intervention improve **quality of maternal health care**? Implementation evaluation from a cluster-randomized controlled study (Elysia Larson, Godfrey M Mbaruku, Jessica Cohen, Margaret E Kruk)

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: • Impact of structured **interdisciplinary bedside rounding** on patient outcomes at a large academic health centre (Padageshwar R Sunkara, Tareq Islam, Abhishek Bose, Gary E Rosenthal, Parag Chevli, Hanumantha Jogu, Luqman Arafath TK, Chi-Cheng Huang, Dipendra Chaudhary, Daniel Beekman, Abhishek Dutta, Suma Menon, Jaime L Speiser) • Editorial: Seeing the wood and the trees: the impact of the healthcare system on **variation in primary care referrals** (Thomas Round, Gary Abel) • The relationship between **off-hours admissions for primary percutaneous coronary intervention, door-to-balloon time and mortality for patients with ST-elevation myocardial infarction** in England: a registry-based prospective national cohort study (Sahan Jayawardana, Sebastian Salas-Vega, Felix Cornehl, Harlan M Krumholz, Elias Mossialos) • On selecting quality indicators: preferences of patients with breast and colon cancers regarding **hospital quality indicators** (Benjamin H Salampessy, Ward R Bijlsma, Eric van der Hijden, Xander Koolman, France R M Portrait) • Logic model framework for considering the inputs, processes and outcomes of a **healthcare organisation–research partnership** (Amir Alishahi Tabriz, Susan A Flocke, Deirdre Shires, Karen E Dyer, Michelle Schreiber, Jennifer Elston Lafata)

Online resources

Drs4Drs
https://www.drs4drs.com.au/
This resource – solely for medical professionals and medical students – has been developed to promote the health and wellbeing of doctors and medical students. DRS4DRS was established as a response to the growing concern for doctors' wellbeing. The role of DRS4DSR is to coordinate doctors' health programs, advocate for doctors' wellbeing, and build a supportive medical community in Australia. Using a network of doctors' health advisory and referral services, DRS4DRSoffers an independent, safe, supportive and confidential service for the medical profession.

[USA] Effective Health Care Program reports
https://effectivehealthcare.ahrq.gov/
The US Agency for Healthcare Research and Quality (AHRQ) has an Effective Health Care (EHC) Program. The EHC has released the following final reports and updates:

- *Achieving Health Equity in* ***Preventive Services***
  https://effectivehealthcare.ahrq.gov/products/health-equity-preventive/research