On the Radar

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On the Radar
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Reports

The Salzburg Statement on Moving Measurement into Action: Global Principles for Measuring Patient Safety
Institute for Healthcare Improvement and Salzburg Global Seminar
2019

| Notes | This resource stems from a meeting convened by the Salzburg Global Seminar and the Institute for Healthcare Improvement. The meeting led to the statement elucidating eight global principles for the measurement of patient safety. The eight principles are: |
| | • The purpose of measurement is to collect and disseminate knowledge that results in action and improvement. |
| | • Effective measurement requires the full involvement of patients, families, and communities within and across the health system. |
| | • Safety measurement must advance equity. |
• Selected measures must illuminate an integrated view of the health system across the continuum of care and the entire trajectory of the patient’s health journey.
• Data should be collected and analyzed in real time to proactively identify and prevent harm as often as possible.
• Measurement systems, evidence, and practices must continuously evolve and adapt.
• The burden of measures collected and analyzed must be reduced.
• Stakeholders must intentionally foster a culture that is safe and just to fully optimize the value of measurement.

Journal articles

Diagnostic error in the emergency department: learning from national patient safety incident report analysis
DOI https://doi.org/10.1186/s12873-019-0289-3

This paper is another drawing on the UK’s National Reporting and Learning System (NRLS) to learn about safety issues. In this instance, the NRLS was used to examine diagnostic errors in hospital emergency departments (EDs). The data covered EDs in England and Wales from 2013 to 2015 and revealed 2288 cases of confirmed diagnostic error, of which 1973 (86%) were delayed and 315 (14%) wrong diagnoses. The authors report that ‘One in seven incidents were reported to have severe harm or death. Fractures were the most common condition (44%), with cervical-spine and neck of femur the most frequent types. Other common conditions included myocardial infarctions (7%) and intracranial bleeds (6%). Incidents involving both delayed and wrong diagnoses were associated with insufficient assessment, misinterpretation of diagnostic investigations and failure to order investigations. Contributory factors were predominantly human factors, including staff mistakes, healthcare professionals’ inadequate skillset or knowledge and not following protocols.’

Preventing critical failure. Can routinely collected data be repurposed to predict avoidable patient harm? A quantitative descriptive study
Nowotny BM, Davies-Tuck M, Scott B, Stewart M, Cox E, Cusack K, et al
DOI https://dx.doi.org/10.1136/bmjqs-2019-010141

Australian paper reporting on an examination into whether routinely collected data could have been used to predict ‘a critical safety failure at an Australian maternity service.’ A public hospital maternity service in Victoria, Australia experienced a doubling in annual birth numbers over a 4-year period while bed capacity remained unchanged. During this period 36 newborn deaths occurred, with 11 later considered to have been avoidable. This study sought to examine if sharing of routinely collected health service performance data could have foreshadowed this. The author concluded that ‘While clinical activity data and direct-to-service patient complaints appear to offer promise as potential predictors of health service stress, complaints to regulators and medicolegal activity are less promising as predictors of system failure. Significant changes to how all data are handled would be required to progress such an approach to predicting health service failure.’
Global, regional, and national sepsis incidence and mortality, 1990–2017: analysis for the Global Burden of Disease Study
Rudd KE, Johnson SC, Agesa KM, Shackelford KA, Tsoi D, Kieven DR, et al
The Lancet. 2020;395(10219):200-211.

DOI
https://doi.org/10.1016/S0140-6736(19)32989-7

Notes
There has been a growing recognition that sepsis is common and potentially life-threatening. This paper has substantially revised the estimates of global mortality due to sepsis. From their analyses, the authors estimate that ‘In 2017, an estimated **48.9 million** (95% uncertainty interval [UI] 38.9–62.9) incident cases of sepsis were recorded worldwide and **11.0 million** (10.1–12.0) sepsis-related deaths were reported, representing 19.7% (18.2–21.4) of all global deaths.’

BMJ Quality & Safety
February 2020 - Volume 29 - 2

URL
https://qualitysafety.bmj.com/content/29/2

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: Mind the gap: how vulnerable patients fall through the cracks of cancer quality metrics** (Christopher Manz, Katharine Rendle, J Bekelman)
- **Editorial: The ageing surgeon** (Natalia Kurek, Ara Darzi)
- **Editorial: Methods for scaling simulation-based teamwork training** (Megan Delisle, Jason C Pradarelli, N Panda, A B Haynes, A A Hannenberg)
- **Failure to administer recommended chemotherapy**: acceptable variation or cancer care quality blind spot? (Ryan J Ellis, Cary Jo R Schlick, Joe Feinglass, Mary F Mulcahy, Al B Benson, Sheetal M Kircher, Tony D Yang, David D Odell, Karl Bilimoria, Ryan P Merkow)
- **The ageing surgeon**: a qualitative study of expert opinions on assuring performance and supporting safe career transitions among older surgeons (Rupert Sherwood, Marie Bismark)
- Effect of hands-on interprofessional simulation training for local emergencies in Scotland: the THISTLE stepped-wedge design randomised controlled trial
  Editor's Choice (Erik Lenguerrand, Cathy Winter, Dimitrios Siassakos, Graeme MacLennan, Karen Innes, Pauline Lynch, Alan Cameron, Joanna Crofts, Alison McDonald, Kirsty McCormack, Mark Forrest, John Norrie, Siladitya Bhattacharya, Tim Draycott)
- ‘This is our liver patient…’: use of narratives during resident and nurse handoff conversations (Thomas Kannampallil, Steve Jones, J Abraham)
- **Medication-related harm in older adults following hospital discharge**: development and validation of a prediction tool (Nikesh Parekh, Khalid Ali, John Graham Davies, Jennifer M Stevenson, Winston Banya, Stephen Nyangoma, Rebekah Schiff, T van der Cammen, J Harchowal, C Rajkumar)
- **Measuring low-value care**: learning from the US experience measuring quality (Leah M Marcotte, Linnea Schutten, Joshua M Liao)
- Preventing *Clostridioides difficile* infection in hospitals: what is the endgame? (Susy S Hota, Michelle Doll, Gonzalo Bearman)
- Novel tools for a learning health system: a combined difference-in-difference/regression discontinuity approach to evaluate effectiveness of a readmission reduction initiative (Allan J Walkey, Jacob Bor, N J Cordella)
Obstetric care navigation: results of a quality improvement project to provide accompaniment to women for facility-based maternity care in rural Guatemala (Kirsten Austad, Michel Juarez, H Shryer, C Moratoya, P Rohloff)

_American Journal of Medical Quality_
Volume: 35, Number: 1 (January/February 2020)

URL [https://journals.sagepub.com/toc/ajmb/35/1](https://journals.sagepub.com/toc/ajmb/35/1)

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:

- Addressing the Opioid Crisis One Surgical Patient at a Time: Outcomes of a Novel _Perioperative Pain_ Program (Ronen Shechter, Traci J Speed, Erin Blume, Sarabdeep Singh, Kayode Williams, Colleen G Koch, and M N Hanna)
- Effects of Practice Turnover on _Primary Care Quality Improvement Implementation_ (Andrea N Baron, Jennifer R Hemler, Shannon M Sweeney, Tanisha Tate Woodson, Allison Cuthel, Benjamin F Crabtree, and D J Cohen)
- Hospitalized After Medical Readiness for Discharge: A Multidisciplinary Quality Improvement Initiative to Identify _Discharge Barriers in General Medicine Patients_ (Nicholas Meo, Joshua M Liao, and Ashok Reddy)
- Aggregating Claims Data Across Payers: Approaches, Challenges, and Lessons Learned From the Comprehensive Primary Care Initiative (Anne Mutti, Erin Fries Taylor, Deborah Peikes, Janel Jin, Kristie Liao, and Ha Tu)
- _Reducing Three Infections Across Cardiac Surgery_ Programs: A Multisite Cross-Unit Collaboration (Bickey H Chang, Yea-Jen Hsu, Michael A Rosen, Ayse P Gurses, S Huang, A Xie, K Speck, J A Marsteller, and D A Thompson)
- Weighting of Measures in the Safety of Care Group of the Overall _Hospital Quality Star Rating Program_: An Alternative Approach (David R Nerenz, Jianhui Hu, Brian Waterman, and Jack Jordan)
- _Engaging Patients in Primary Care Quality Improvement_ Initiatives: Facilitators and Barriers (Nancy Pandhi, Nora Jacobson, Madison Crowder, Andrew Quanbeck, Mollie Hass, and Sarah Davis)
- Validity of the _Health Systems Science Examination_: Relationship Between Examinee Performance and Time of Training (Michael Dekhtyar, L P Ross, J D’Angelo, J Guernsey, K E Hauer, L Lawson, M V Pusic, and R E Hawkins)
- _Students Adding Value_: Improving Patient Care Measures While Learning Valuable Population Health Skills (Amy W Shaheen, Kelly Bossenbroek Fedoriw, Susanna Khachaturyan, Beat Steiner, Julie Golding, Julie S Byerley, Erika S Helgeson, and Gary L Beck Dallaghan)
- _Hospital-Acquired Infections and Readmissions_: Let’s Refocus on the Person (Adam Corson, Ira Byock, and Christopher R Dale)
- Utilizing Lean Methodology to Optimize _Operating Room Efficiency_: A Multidisciplinary Process Mapping Exercise (Alysha Nensi, Andrea Simpson, Sari Kives, Rebecca Lei, Jacqueline D’Souza, and Deborah Robertson)
- A Strategy for Noise Reduction to Improve _Patient Experiences With Sleep_ (SNORES) (Vikas Sunder, Eitan Frankel, Neelam Upadhayaya, Merlin Mathew, Ritu Nahar, Michael Brister, Nicholas Young, and Yair Lev
- Improved Assessment and Documentation of Vital Signs in the Emergency Department (Katie Deitrick and Joshua Davis)

**BMJ Quality and Safety online first articles**

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<td></td>
<td>- Novel quality improvement method to <strong>reduce cost while improving the quality of patient care</strong>: retrospective observational study (Kedar S Mate, Jeffrey Rakover, Kay Cordiner, Amy Noble, Noura Hassan)</td>
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<td>- Association of <strong>open communication and the emotional and behavioural impact of medical error on patients and families</strong>: state-wide cross-sectional survey (Julia C Prentice, Sigall K Bell, Eric J Thomas, Eric C Schneider, Saul N Weingart, Joel S Weissman, Mark J Schlesinger)</td>
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<td>- Ensuring successful <strong>implementation of communication-and-resolution programmes</strong> (Michelle M Mello, Stephanie Roche, Yelena Greenberg, Patricia Henry Folcarelli, Melinda Biocchi Van Niel, Allen Kachalia)</td>
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<td>- Time series evaluation of improvement interventions to <strong>reduce alarm notifications</strong> in a paediatric hospital (Colleen M Pater, Tina K Sosa, Jacqueelyn Boyer, Rhonda Cable, Melinda Egan, Timothy K Knilans, Amanda C Schondelmeyer, Christine L Schuler, Nicolas L Madsen)</td>
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<td>- Editorial: Approach to making the <strong>availability heuristic</strong> less available (Donald A Redelmeier, Kelvin Ng)</td>
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**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 NG150 Supporting adult carers  
https://www.nice.org.uk/guidance/ng150

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