AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

Issue 448
Tuesday 28 January 2020

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On the Radar
Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

Reports

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

URL	https://www.salzburgglobal.org/news/statements/article/salzburg-global-fellows-design-new-global-principles-for-measuring-patient-safety.html
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
Hussain F, Cooper A, Carson-Stevens A, Donaldson L, Hibbert P, Hughes T, et al
BMC Emergency Medicine. 2019;19(1):77.

DOI	https://doi.org/10.1186/s12873-019-0289-3
Notes	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
BMJ Quality & Safety. 2020:bmjqs-2019-010141. [epub]

DOI	https://dx.doi.org/10.1136/bmjqs-2019-010141
Notes	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, Kievlan 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 trialEditor'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, Linnaea Schuttner, 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
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: • 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) • Impact of Locally Adopted Simulation-Based Crew Resource Management Training on P**atient Safety Culture**: Comparison Between Operating Room Personnel and General Health Care Populations Pre and Post Course (Adeline P N Man, Carmen K M Lam, Benny C P Cheng, K-S Tang, and P-F Tang) • **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 Upadhyaya, 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

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Novel quality improvement method to **reduce cost while improving the quality of patient care**: retrospective observational study (Kedar S Mate, Jeffrey Rakover, Kay Cordiner, Amy Noble, Noura Hassan) • Association of **open communication and the emotional and behavioural impact of medical error on patients and families**: 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) • Ensuring successful **implementation of communication-and-resolution programmes** (Michelle M Mello, Stephanie Roche, Yelena Greenberg, Patricia Henry Folcarelli, Melinda Biocchi Van Niel, Allen Kachalia) • Time series evaluation of improvement interventions to **reduce alarm notifications** in a paediatric hospital (Colleen M Pater, Tina K Sosa, Jacquelyn Boyer, Rhonda Cable, Melinda Egan, Timothy K Knilans, Amanda C Schondelmeyer, Christine L Schuler, Nicolas L Madsen) • Editorial: Approach to making the **availability heuristic** less available (Donald A Redelmeier, Kelvin Ng)

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