AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Australian Register of Clinical Registries

https://www.safetyandquality.gov.au/our-work/national-arrangements-clinical-quality-registries#australian-register-of-clinical-registries

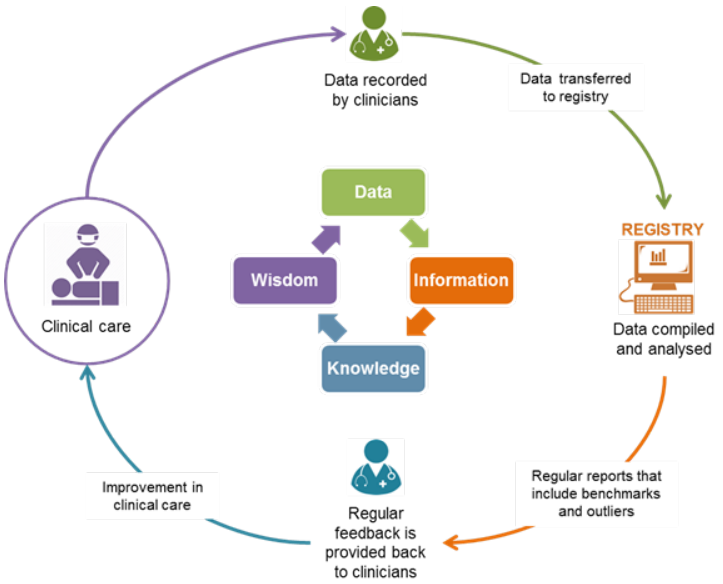
Clinical quality registries (CQRs) have the potential to report on retrospective, current and prospectively collected data to a wide range of stakeholders including clinicians, patients, hospital administrators, government, funders and insurers. The collected data may includes processes of care, health outcomes, patient reported outcome measures (PROMs), patient reported experience measures (PREMs) and health system costs. Each component of the collected data contributes to our understanding of the benefit and cost-effectiveness of treatment and care from the perspectives of the patient, clinician, health service provider, health insurer and government. There is enormous potential for CQRs to inform care delivery at the patient, clinician, local, national and international levels.

The Australian Commission on Safety and Quality in Health Care has developed the Australian Register of Clinical Registries to facilitate collaboration and awareness of registry activity among key stakeholders. Once a clinical registry is registered via the online form, Commission staff curate the information provided. In due course, a brief summary of the registry, web link and registry contact details will be published on the Commission's website.

The Commission plans to publish a list of the registered clinical registries on the Commission website following review of the information provided. The first publication is due in March 2020.

Register your clinical registry on our website at https://www.safetyandquality.gov.au/our-work/national-arrangements-clinical-quality-registries#australian-register-of-clinical-registries

Contact us
Enquiries about the register may be sent to CQR@safetyandquality.gov.au



Reports

Developing an assessment tool for Australian general practices transforming to a Patient-Centred Medical Home model of care
Deeble Institute Evidence Brief No. 19
Elliott A, Sweeney S, Langford-Ely A, Bruce A, Harvey S, Silk K
Canberra: Australian Healthcare and Hospitals Association; 2020. p. 15.

URL	https://ahha.asn.au/publication/health-policy-evidence-briefs/evidence-brief-no-19-developing-assessment-tool-australian
Notes	This evidence brief published by the Australian Healthcare and Hospitals Association's Deeble Institute looks at the topic of 'medical home' in primary care. Specifically the authors describe the development of a tool for assessing how GP practices have adopted a 'Patient-Centred Medical Home' (PCMH) model of care. The authors observe that the PCMH model has been associated with high-performing primary care and can offer a framework for assisting general practice to deliver more person-centred care. The Brisbane South Primary Health Network (PHN) – in partnership with the Australian Healthcare and Hospitals Association – developed a short-form survey tool; the Person-Centred Care Practice Assessment (PCC-PA). This tool is designed to assist general practices to measure their degree of 'medical homeness' and identify practical areas for improvement. The brief describes the development and testing of the tool and the authors argue that this testing demonstrated its suitability, feasibility, acceptability, relevance and rating consistency compared to an internationally validated survey tool, the Patient-Centred Medical Home Assessment (PCMH-A), for general practices in the Brisbane South PHN region.

Journal articles

Association of open communication and the emotional and behavioural impact of medical error on patients and families: state-wide cross-sectional survey
Prentice JC, Bell SK, Thomas EJ, Schneider EC, Weingart SN, Weissman JS, et al
BMJ Quality & Safety. 2020 [epub].

DOI	https://dx.doi.org/10.1136/bmjqs-2019-010367
Notes	Errors in healthcare can range in their severity from being trivial to catastrophic. The impacts can remain with people for a long time after the event. How clinicians and others in the care system respond, react and communicate is important. This paper reports on a survey that sought to examine whether greater open communication is associated with fewer persisting emotional impacts, the avoidance of healthcare by those affected and loss of trust. From a survey, the authors found that '**Negative emotional impacts from medical error can persist for years**. **Open communication** is associated with **reduced emotional impacts** and **decreased avoidance** of doctors/facilities involved in the error. Communication and resolution programmes could facilitate transparent conversations and reduce some of the negative impacts of medical error.' This adds to the existing literature on open disclosure and clinical communication.

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

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

Ensuring successful implementation of communication-and-resolution programmes
Mello MM, Roche S, Greenberg Y, Folcarelli PH, Van Niel MB, Kachalia A
BMJ Quality & Safety. 2020 [epub].

DOI	https://dx.doi.org/10.1136/bmjqs-2019-010296
Notes	This study was conducted in the same US state as the previous item and touches on the same issues. In this instance the focus is on how communication and resolution programs (CRP) aimed at improving transparency around adverse events were implemented successfully. According to the authors the 'identified facilitators of the hospitals' success as: (1) the **support of top institutional leaders**, (2) heavy **investments in educating physicians** about the programme, (3) active cultivation of the **relationship between hospital risk managers and representatives from the liability insurer**, (4) the use of **formal decision protocols**, (5) effective **oversight** by full-time project managers, (6) **collaborative group implementation**, and (7) **small institutional size**.'

Novel quality improvement method to reduce cost while improving the quality of patient care: retrospective observational study
Mate KS, Rakover J, Cordiner K, Noble A, Hassan N
BMJ Quality & Safety. 2020 [epub].

DOI	https://dx.doi.org/10.1136/bmjqs-2019-009825
Notes	Paper describing an approach taken to both reduce costs and improve care that was undertaken as a pilot in the National Health Service Scotland. The method, termed Continuous Value Management (CVM) included the development of a standard care model with local teams then tracking system performance and applying quality improvement methods. The project covered 5806 patients in an inpatient respiratory

	ward over 18 months. The authors report that during the 18-month pilot, the ward realised: • a **21.8% reduction in cost per patient** admitted to the ward • **agency nursing spend decreased by 30.8%** • **28.9% increase in the number of patients admitted** to the ward per week.

Time series evaluation of improvement interventions to reduce alarm notifications in a paediatric hospital
Pater CM, Sosa TK, Boyer J, Cable R, Egan M, Knilans TK, et al
BMJ Quality & Safety. 2020 [epub].

DOI	https://dx.doi.org/10.1136/bmjqs-2019-010368
Notes	Many pieces of healthcare equipment provide alarm notifications – lights, bells, beeps, etc.. Indeed, there are so many of these alarms that the problem of alarm fatigue is well-known. This paper reports on the efforts undertaken in one US children's hospital to reduce 'non-actionable' or less important alarms in their equipment. The study team found that, at baseline, there was an average of 71 initial alarm notifications per monitored bed per day. Over the course of the 3 ½ year project, the **rate decreased by 68% to 22 initial alarm notifications per monitored bed per day**. This change was allied with an increase in nurses saying that they were able to respond to alarms appropriately from 32% to 76%.

Estimating the magnitude of cancer overdiagnosis in Australia
Glasziou PP, Jones MA, Pathirana T, Barratt AL, Bell KJL
Medical Journal of Australia. 2020;[epub]

DOI	https://doi.org/10.5694/mja2.50455
Notes	Issues of diagnosis, including diagnostic error, mis-diagnosis and over-diagnosis, have been attracting increased attention in recent years. This paper presents an attempt to estimate the scale of the issue of over-diagnosis of cancers in Australia. The study used routinely collected national data were analysed to estimate recent (2012) and historical (1982) lifetime risks (adjusted for competing risk of death and changes in risk factors) of diagnoses with five cancers: prostate, breast, renal, thyroid cancers, and melanoma. From their analyses, the authors 'estimated that **18% of all cancers diagnosed in women** (ie, 11 000 diagnoses each year), and **24% of those in men** (18 000 each year) are **overdiagnosed cancers**.'

Healthcare Quarterly
Vol. 22, Special issue February 2020

URL	https://www.longwoods.com/publications/healthcare-quarterly/26038
Notes	A new issue of *Healthcare Quarterly* has been published. This is a special issue focused on **Patient Safety**. Articles in this issue of *Healthcare Quarterly* include: • Editorial: **Patient Safety**: We've Come a Long Way (W Nicklin and L Hughes) • **National Patient Safety Consortium**: Learning from Large-Scale Collaboration (Sandi Kossey, Chris Power, Leslee Thomson, Kathleen Morris, Shelagh Maloney, Lee Fairclough, Deborah Prowse and Hina Laeeque) • **Patient Engagement in a Large-Scale Change Initiative**: "As Safe as Possible, as Soon as Possible" (Katharina Kovacs Burns, Donna Davis, Ioana Popescu, Hina Laeeque, Sandi Kossey, Renee Misfeldt and Christopher Thrall) • Commentary: Three Ideas About "**Post-Vention**" (Allison Kooijman, Robin McGee and Robert Robson) • Patient Safety **Never Events**: Cross-Canada Checkup (Hina Laeeque, Barb Farlow and Sandi Kossey)

	• **Empowering Patients**: 5 Questions to Ask About Your **Medications** (Alice Watt, Maryann Murray, Donna Herold, S Hyland, C Hoffman and M Cass) • Accelerating **Post-Surgical Best Practices** Using Enhanced Recovery After Surgery (Carla Williams, Claude Laflamme and Brian Penner) • **Patient Safety Culture Bundle for CEOs and Senior Leaders** (Markirit Armutlu, Donna Davis, Alain Doucet, A Down, D Schierbeck and P Stevens) • Commentary: We Must Look at **Multiple Perspectives** (Scott W Livingstone) • **Homecare Safety** Virtual Quality Improvement Collaboratives (Wayne Miller, Maaike Asselbergs, Jeanne Bank, Mike Cass, V Flintoft and N Henningsen) • Commentary: **Patient Safety in the Home** (Shirlee Sharkey and H Lacroix) • Measuring and Monitoring **Healthcare-Associated Infections**: A Canadian Collaboration to Better Understand the Magnitude of the Problem (Anne MacLaurin, Kanchana Amaratunga, Chantal Couris, Charles Frenette, Riccarda Galioto, G Hansen, J Happe, K Neudorf, L Pelude, C Quach and S R Rose) • Patient Safety: **Patient Involvement Matters** (Linda Hughes)

Australian Health Review
Volume 44 Number 1 2020

URL	https://www.publish.csiro.au/ah/issue/9731
Notes	A new issue of *Australian Health Review* has been published. Articles in this issue of *Australian Health Review* include: • 'We get so task orientated at times that we forget the people': **staff communication experiences when caring for Aboriginal cardiac patients** (Janet Kelly, Anna Dowling, Katharine McBride, Wendy Keech and A Brown) • Customised approaches to vocational education can dramatically improve **completion rates of Australian Aboriginal students** (Kylie Gwynne, Jorge Rojas, Monique Hines, Kim Bulkeley, M Irving, D McCowen and M Lincoln) • Profile of the **most common complaints for five health professions** in Australia (Merrilyn Walton, Patrick J. Kelly, E. Mary Chiarella, Terry Carney, Belinda Bennett, Marie Nagy and Suzanne Pierce) • **Work-related injury and illness in the Victorian healthcare sector**: a retrospective analysis of workers' compensation claim records (Ting Xia and Alex Collie) • **Psychiatric morbidity, burnout and distress in Australian physician trainees** (Carmen Axisa, Louise Nash, Patrick Kelly and Simon Willcock) • **Allied health pre-entry student clinical placement capacity**: can it be sustained? (Liza-Jane McBride, Cate Fitzgerald, Claire Costello and K Perkins) • Supporting **Northern Territory Top End allied health graduates and early career staff** by means of an interprofessional graduate program (Prasha Sooful, Justine Williams and Renae Moore) • 'Right fit, right job, right time': case study of a new model for **allied health recruitment** in public health settings (Toni Withiel, Lucinda Marr and G Juj) • **Allied health professionals in Queensland Health** returning to work after maternity leave: hours of work and duration of time on part-time hours (Julie Hulcombe, Sandra Capra and Gillian Whitehouse) • Going digital: a narrative overview of the effects, quality and utility of mobile apps in **chronic disease self-management** (Ian A. Scott, Paul Scuffham, Deepali Gupta, Tanya M Harch, John Borchi and Brent Richards)

	• Community-based case management does not reduce **hospital admissions for older people**: a systematic review and meta-analysis (Nerissa Poupard, Clarice Y. Tang and Nora Shields) • **Readmissions following hospitalisations for cardiovascular disease**: a scoping review of the Australian literature (Clementine Labrosciano, Tracy Air, Rosanna Tavella, John F Beltrame and Isuru Ranasinghe) • Investment in **Australian mental health carer services**: how much and does it reflect evidence of effectiveness? (Jaclyn Schess, Sandra Diminic, Emily Hielscher, Meredith G Harris, Yong Yi Lee, Jan Kealton and H A Whiteford) • **Paramedic involvement in health education** within metropolitan, rural and remote Australia: a narrative review of the literature (Tegwyn McManamny, Paul A Jennings, Leanne Boyd, Jade Sheen and Judy A Lowthian) • **Road deaths** relating to the attendance of **medical appointments** in Queensland (Edwin Phillip Greenup and Boyd Alexander Potts) • Prevalence and characteristics associated with **concurrent smoking and alcohol misuse within Australian general practice patients** (Breanne Hobden, Jamie Bryant, Kristy Forshaw, Christopher Oldmeadow, Tiffany-Jane Evans and Rob Sanson-Fisher) • Barriers to and facilitators of **health services utilisation by refugees** in resettlement countries: an overview of systematic reviews (Jamuna Parajuli and Dell Horey) • Examination of the dependency and complexity of patients admitted to **in-patient rehabilitation** in Australia (Duncan McKechnie, Julie Pryor, Murray J Fisher and Tara Alexander) • Characteristics and clinical outcomes of **index versus non-index hospital readmissions** in Australian hospitals: a cohort study (Yogesh Sharma, Chris Horwood, Paul Hakendorf, John Au and Campbell Thompson) • Taking the pulse of the **health services research community**: a cross-sectional survey of research impact, barriers and support (Elizabeth A Fradgley, Jon Karnon, Della Roach, Katherine Harding, Laura Wilkinson-Meyers, Catherine Chojenta, Megan Campbell, Melissa L Harris, Jacqueline Cumming, Kim Dalziel, Janet McDonald, Tilley Pain, K Smiler and C L Paul)

Health Affairs
Volume 39, No. 2, February 2020

URL	https://www.healthaffairs.org/toc/hlthaff/39/2
Notes	A new issue of *Health Affairs* has been published with the themes '**Opioids**, Investing in **Social Determinants** & More'. Articles in this issue of *Health Affairs* include: • The Old Asylum Is Gone: Today **A Mental Health System Serves All** (Rob Waters) • Quantifying Health Systems' **Investment In Social Determinants Of Health**, By Sector, 2017–19 (Leora I Horwitz, Carol Chang, Harmony N Arcilla, and James R Knickman) • Upstream With A Small Paddle: How ACOs Are Working Against The Current To Meet **Patients' Social Needs** (Genevra F Murray, Hector P Rodriguez, and Valerie A Lewis) • Evidence-Based Community Health Worker Program Addresses **Unmet Social Needs** And Generates Positive Return On Investment (Shreya Kangovi, Nandita Mitra, David Grande, Judith A Long, and David A Asch)

	• **Health Care Spending And Use Among People Experiencing Unstable Housing** In The Era Of Accountable Care Organizations (Katherine A Koh, Melanie Racine, Jessie M Gaeta, John Goldie, Daniel P Martin, Barry Bock, Mary Takach, James J O'Connell, and Zirui Song) • Renovating Subsidized Housing: The Impact On **Tenants' Health** (Ingrid Gould Ellen, Kacie L Dragan, and Sherry Glied) • Gaps In **Access To Opioid Use Disorder Treatment** For Medicare Beneficiaries (Samantha J Harris, Amanda J Abraham, Christina M Andrews, and Courtney R Yarbrough) • **Hospital Use Declines After Implementation** Of Virginia Medicaid's **Addiction And Recovery Treatment Services** (Andrew J Barnes, Peter J Cunningham, Lauryn Saxe-Walker, Erin Britton, Yaou Sheng, Melanie Boynton, K Harper, A Harrell, C Bachireddy, E Montz, and K Neuhausen) • Five-Year Outcomes Among Medicaid-Enrolled Children With **In Utero Opioid Exposure** (Marian P Jarlenski, Elizabeth E Krans, Joo Yeon Kim, Julie M Donohue, A E James III, D Kelley, B D Stein, and D L Bogen) • Differences In **Starting Pay For Male And Female Physicians** Persist; Explanations For The Gender Gap Remain Elusive (Anthony T Lo Sasso, David Armstrong, Gaetano Forte, and Susan E Gerber) • **Clinician-Directed Performance Improvement**: Moving Beyond Externally Mandated Metrics (Lara Goitein) • Implications Of The Rapid Growth Of The **Nurse Practitioner Workforce** In The US (David I Auerbach, Peter I Buerhaus, and Douglas O Staiger) • Non-Infection-Related And Non-Visit-Based **Antibiotic Prescribing** Is Common Among Medicaid Patients (Michael A Fischer, Mufaddal Mahesri, Joyce Lii, and Jeffrey A Linder) • Copayment Incentive Increased **Medication Use And Reduced Spending Among Indigenous Australians** After 2010 (A N Trivedi, and M Kelaher) • **Dental, Vision, And Hearing Services**: Access, Spending, And Coverage For Medicare Beneficiaries (Amber Willink, Nicholas S Reed, Bonnielin Swenor, Leah Leinbach, Eva H DuGoff, and Karen Davis) • When Should Medicare Mandate Participation In **Alternative Payment Models**? (Joshua M Liao, Mark V Pauly, and Amol S Navathe • There's **No Algorithm For Empathy** (Hannah B Wild)

Journal of Patient Safety and Risk Management
Volume: 25, Number: 1 (February 2020)

URL	https://journals.sagepub.com/toc/cric/25/1
Notes	A new issue of the *Journal of Patient Safety and Risk Management* has been published. Articles in this issue of the *Journal of Patient Safety and Risk Management* include: • Editorial: My eye – The importance of **clinician well-being** in 2020 (Albert W Wu) • Automation and interoperability of a **nurse-managed insulin infusion protocol** as a model to improve safety and efficiency in the delivery of high-alert medications (Noah Barasch, Mark C Romig, Zoe O Demko, C Dwyer, A Dietz, M Rosen, S M Griffiths, A D Ravitz, P J Pronovost, and A Sapirstein) • **Mindfulness instruction for community-hospital physicians** for burnout and patient care: A pilot study (Sheila M Hofert, Sean Tackett, Neda Gould, and Erica Sibinga)

	• Peer support for **nurses as second victims**: Resilience, burnout, and job satisfaction (Cheryl A Connors, Vadim Dukhanin, Alice L March, Joyce A Parks, Matt Norvell, and Albert W Wu) • **The approachable team leader**: Front line perspectives on leadership in critical care (Joseph Swani and Peter Isherwood) • Determinants of **patient safety culture** among healthcare providers in the Upper East Region of Ghana (Aaron A Abuosi, Alexander Akologo, and Emmanuel A Anaba)

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: • A patient and public involvement investigation into healthy **eating and weight management advice during pregnancy** (J C Abayomi, M S Charnley, L Cassidy, M T Mccann, J Jones, M Wright, L M Newson)

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: • Editorial: Leveraging natural experiments to **evaluate interventions in learning health systems** (Sunita Desai, Eric Roberts) • Validation of **automated sepsis surveillance** based on the Sepsis-3 clinical criteria against physician record review in a general hospital population: observational study using electronic health records data (John Karlsson Valik, Logan Ward, Hideyuki Tanushi, Kajsa Müllersdorf, Anders Ternhag, Ewa Aufwerber, Anna Färnert, Anders F Johansson, Mads Lause Mogensen, Brian Pickering, Hercules Dalianis, Aron Henriksson, Vitaly Herasevich, P Nauclér) • **De-implementing wisely**: developing the evidence base to **reduce low-value care** (Jeremy M Grimshaw, Andrea M Patey, Kyle R Kirkham, Amanda Hall, Shawn K Dowling, Nicolas Rodondi, Moriah Ellen, Tijn Kool, Simone A van Dulmen, Eve A Kerr, Stefanie Linklater, Wendy Levinson, R Sacha Bhatia) • 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) • **Learning from complaints in healthcare**: a realist review of academic literature, policy evidence and front-line insights (Jackie van Dael, Tom W Reader, Alex Gillespie, Ana Luisa Neves, Ara Darzi, Erik K Mayer) • Applying thematic synthesis to interpretation and commentary in epidemiological studies: identifying what contributes to successful interventions to **promote hand hygiene in patient care** (Nicholas Drey, Dinah Gould, Edward Purssell, Jane Chudleigh, Donna Moralejo, Rose Gallagher, Annette Jeanes, Neil Wigglesworth, Didier Pittet) • Editorial: Improving **cardiac surgical quality**: lessons from the Japanese experience (David Shahian)

Online resources

[UK] How-to guide: non face-to-face clinics
https://uclpartners.com/non-face-to-face-clinics-resource/
This online guide has been developed in collaboration with NHS clinicians, managers and patients. It provides a comprehensive guide to setting up non face-to-face clinics (also known as virtual clinics). These clinics are hoped to help reduce unnecessary outpatient visits. In the UK, the NHS aims to avoid up to a third of the number of face-to-face outpatient visits over five years, removing the need for up to 30 million outpatient appointments each year. The guide is free to use, delivered through both text and videos, and includes how to develop a project plan and business case.

[USA] Are medical errors really the third most common cause of death in the U.S.?
https://sciencebasedmedicine.org/medical-errors-2020/
In this opinion piece published on the *Science-based Medicine* site, the author (a surgical oncologist) critically reviews the widely reported claim that medical errors are the third leading cause of death in the USA, and asserts that this claim was made on 'shaky evidence'. A short history is provided which goes back to 2000 with the Institute of Medicine's *To Err is Human: Building a Safer Health System* (https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system), which estimated that the death rate due to medical error was 44,000 to 96,000, roughly one to two times the death rate from automobiles. A recent meta-analysis by Rodwin et al (https://doi.org/10.1007/s11606-019-05592-5) is discussed which estimates the number of preventable deaths at just over 22,000 per year and that preventable deaths due to medical error represent less than 1% of all deaths.
It is concluded that while any number of deaths due to medical error is too high that it is nowhere near the third leading cause of death in the USA. Efforts to decrease the number should continue and interestingly the author states 'It can never be zero, given that medicine is a system run by human beings, who are inherently imperfect and sometimes make mistakes'.
