AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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This week's content

Safety and Quality Improvement Guides and Accreditation Workbooks

Notes	The Commission developed the National Safety and Quality Health Service (NSQHS) Standards to improve the quality of health service provision in Australia. The Standards provide a nationally consistent statement of the level of care consumers should be able to expect from health services. The Commission has developed a number of resources to assist health service organisations implement the NSQHS Standards. **Accreditation Workbooks:** • Hospital Accreditation Workbook • Day Procedure Services Accreditation Workbook **Safety and Quality Improvement Guides:** • Standard 1: Governance for Safety and Quality in Health Service Organisations • Standard 2: Partnering with Consumers • Standard 3: Preventing and Controlling Healthcare Associated Infections • Standard 4: Medication Safety • Standard 5: Patient Identification and Procedure Matching

	• Standard 6: Clinical Handover • Standard 7: Blood and Blood Products • Standard 8: Preventing and Managing Pressure Injuries • Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care • Standard 10: Preventing Falls and Harm from Falls **Advice Centre** The Commission has set up an Advice Centre. It is open for enquiries from health service organisations, surveyors and accrediting agencies and support can be accessed by telephone and email. Email: accreditation@safetyandquality.gov.au Phone: 1800 304 056
URL	http://www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/

Journal articles

Unnecessary care: are doctors in denial and is profit driven healthcare to blame?
Lenzer J
BMJ 2012;345:e6230

Notes	An interesting examination of overtreatment, particularly in the US, and the movement to 'avoid avoidable care' which is gaining momentum. Medical training and payment models for physicians are identified as central factors in overtreatment, and are useful starting points to address the issue. Additional proposed solutions include using guideline writers free of conflicts of interest, **implementing and supporting shared decision making**, and reforming tort law. The movement will also have to contend with the accusation of rationing.
DOI	http://dx.doi.org/10.1136/bmj.e6230

Introducing Decision Aids At Group Health Was Linked To Sharply Lower Hip And Knee Surgery Rates And Costs
Arterburn D, Wellman R, Westbrook E, Rutter C, Ross T, McCulloch D, et al.
Health Affairs 2012;31(9):2094-2104.

Notes	An important dimension of quality of health care is appropriateness. Appropriateness can also involve discussions of over and under-utilisation. This observational study looked at how decision aids were used by patients and clinicians is making choices about care, in this instance the choices about hip and knee surgery. The authors report that the decision aids contributed to reductions in surgical intervention. **After introducing decision aids** for hip and knee osteoarthritis in a large health system in Washington State the authors report **26 percent fewer hip replacement** surgeries, **38 percent fewer knee replacements**, and **12–21 percent lower costs over six months**. The authors suggest that "these findings support the concept that patient decision aids for some health conditions, for which treatment decisions are highly sensitive to both patients' and physicians' preferences, may reduce rates of elective surgery and lower costs".
DOI	http://dx.doi.org/10.1377/hlthaff.2011.0686

Evidence Of No Benefit From Knee Surgery For Osteoarthritis Led To Coverage Changes And Is Linked To Decline In Procedures
Howard D, Brophy R, Howell S
Health Affairs 2012;31(10):2242-2249.

Notes	Another *Health Affairs* paper reporting reductions in knee surgery. Here the authors report how evidence that knee surgery for osteoarthritis was of no benefit contributed to changes in funding and practice and a reduction in such interventions. Proponents of clinical registries suggest such analyses are a major product of registries and can provide valuable real-world evidence on the safety and efficacy of interventions.
DOI	http://dx.doi.org/10.1377/hlthaff.2012.0644

Five Reasons That Many Comparative Effectiveness Studies Fail To Change Patient Care And Clinical Practice
Timbie JW, Schneider EC, Van Busum K, Fox DS
Health Affairs 2012;31(10):2168-2175.

Notes	This paper, also from the October issue of *Health Affairs*, may identify some of the reasons that papers such as the Brophy et al are not more comment. That is, why evidence on comparative effectiveness does not always influence practice as much as it might. The five causes that this group identify as underlying the failure of many comparative effectiveness studies to alter patient care are: • **financial incentives**, such as fee-for-service payment, that may militate against the adoption of new clinical practices • **ambiguity of study results** that hamper decision making • **cognitive biases** in the interpretation of new information • **failure** of the research **to address the needs of end users**; and • **limited use of decision support** by patients and clinicians. The authors suggest that "Policies that encourage the development of consensus objectives, methods, and evidentiary standards before studies get under way and that provide strong incentives for patients and providers to use resources efficiently may help overcome at least some of these barriers and enable comparative effectiveness results to alter medical practice more quickly."
DOI	http://dx.doi.org/10.1377/hlthaff.2012.0150

Patients' engagement in primary care: powerlessness and compounding jeopardy. A qualitative study
Sheridan NF, Kenealy TW, Kidd JD, Schmidt-Busby JIG, Hand JE, Raphael DL, et al
Health Expectations 2012 [epub]

Notes	Patient engagement in primary care is not always readily achieved. This can be compounded where there are existing barriers, such as exclusion and poverty. This qualitative study based on 42 in-depth interviews of patients living in poor neighbourhoods in Auckland, New Zealand sought to what poor older adults with chronic conditions – who mostly belong to ethnic minority groups – say they want from clinicians. The participants had chronic conditions severe enough to require hospital admission more than twice in the previous 12 months. The authors report that the participants display an outward acceptance of health care that belied an underlying dissatisfaction with low engagement. **Participants did not feel heard** and wanted information conveyed in a way that indicated

	clinicians understood them in the context of their lives. **Powerlessness**, **anger**, **frustration** and **non-concordance** were frequent responses. The authors note that these patients pursue the (unrealised) ideal of an engaged therapeutic relationship with an understanding clinician. They go on to suggest that "[p]owerlessness means that **the onus is upon the health system and the clinician to engage**. Engagement means building a relationship on the basis of social, cultural and clinical knowledge and demonstrating a shift in the way clinicians choose to think and interact in patient care. **Respectful listening and questioning** can deepen clinicians' awareness of patients' most important concerns. Enabling patients to direct the consultation is a way to integrate clinician expertise with what patients need and value." It might be expected that if engagement with patients in difficult circumstances and with complex condition can be achieved, then it should be achievable for all patients.
DOI	http://dx.doi.org/10.1111/hex.12006

For information on the Commission's work on patient and consumer centred care, see http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Guidelines should reflect all knowledge, not just clinical trials
Zuiderent-Jerak T, Forland F, Macbeth F
BMJ 2012;345:e6702

Notes	An opinion piece discussing hierarchies of evidence and their application to clinical guidelines. The authors are affiliated with the Guidelines International Network, network of organisations and individuals whose mission is to lead, strengthen and support collaboration and work within the guideline development, adaptation and implementation community. The authors suggest that it is time to consider **the application and integration of different types of knowledge into guideline development** worldwide, rather than relying upon randomised clinical trials and systematic reviews to provide the best evidence.
DOI	http://dx.doi.org/10.1136/bmj.e6702

Routine versus clinically indicated replacement of peripheral intravenous catheters: a randomised controlled equivalence trial
Rickard CM, Webster J, Wallis MC, Marsh N, McGrail MR, French V, et al
The Lancet 2012;380(9847):1066-1074.u

Notes	Millions of peripheral intravenous catheters are used each year. It is recommended that these are replaced every 72–96 hours. This study sought to examine the effectiveness of this when compared with replacement when clinically indicated. This study was a multicentre, randomised, non-blinded equivalence trial of 3283 adult patients (5907 catheters) with an intravenous catheter of expected use longer than 4 days from three hospitals in Queensland, Australia, between 20 May 2008, and 9 September 2009. 1593 patients had their catheters replaced when clinically indicated, 1690 had routine replacement. Mean dwell time for catheters in situ on day 3 was 99 hours when replaced as clinically indicated and 70 hours when routinely replaced. Phlebitis occurred in 114 of 1593 (7%) patients in the clinically indicated group and in 114 of 1690 (7%) patients in the routine replacement group. No serious adverse events related to study interventions occurred. The authors suggest that "**Peripheral intravenous**

	catheters can be removed as clinically indicated; this policy will avoid millions of catheter insertions, associated discomfort, and substantial costs in both equipment and staff workload. Ongoing close monitoring should continue with timely treatment cessation and prompt removal for complications."
DOI	http://dx.doi.org/10.1016/S0140-6736(12)61082-4

Making Greater Use Of Dedicated Hospital Observation Units For Many Short-Stay Patients Could Save $3.1 Billion A Year
Baugh CW, Venkatesh AK, Hilton JA, Samuel PA, Schuur JD, Bohan JS
Health Affairs 2012 [epub].

Notes	Paper suggesting hospital 'observation units' may be a cost-effective approach to caring for patients who do not need to be admitted, but can also safely be moved from emergency departments. The authors claim that using "observation units in hospitals to provide care to certain patients can be **more efficient than admitting** them to the hospital and can result in **shorter lengths-of-stay** and **lower costs**" and they suggest that "policies intended to increase the cost-efficiency of hospital care should include support for observation unit care as an alternative to short-stay inpatient admission." This study may not be directly transferable to the non-American context due to the role of the ED/ER in US healthcare.
DOI	http://dx.doi.org/10.1377/hlthaff.2011.0926

Chocolate Consumption, Cognitive Function, and Nobel Laureates
Messerli FH
New England Journal of Medicine 2012 [epub].

Notes	Maybe not a direct safety and quality issue, but an item that may have appeal. The key line: "**Chocolate consumption enhances cognitive function**". Perhaps some would like to advance an argument that enhanced cognitive function aids in being more mindful, engaged and vigilant and thus influences the safety and quality of care?
DOI	http://dx.doi.org/10.1056/NEJMon1211064

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Use of in situ simulation and human factors engineering to assess and improve emergency department clinical systems for timely telemetry-based detection of life-threatening arrhythmias (Leo Kobayashi, Ramakrishna Parchuri, Fenwick G Gardiner, G A Paolucci, N M Tomaselli, R S Al-Rasheed, K S Bertsch, J Devine, R M Boss, F J Gibbs, E Goldlust, J E Monti, B O'Hearn, D C Portelli, N A Siegel, D Hemendinger, G D Jay) • Editorial. Anatomy of a successful multimodal hand hygiene campaign (Andrew Stewardson, Didier Pittet)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

The Quantum Leap: Measurement - redefining Health's boundaries? conference presentations
http://ahha.asn.au/content/quantum-leap-conference-2012-speaker-presentations
The Australian Healthcare and Hospitals Association has made the presentations from the recent *Quantum Leap: Measurement - redefining Health's boundaries?* conference available.

APAC Forum on Quality Improvement in Health Care
http://www.ihi.org/offerings/Conferences/APACForum2012/Pages/materials.aspx
The [US] Institute for Healthcare Improvement and [NZ] Ko Awatea have made material from the recent *APAC Forum on Quality Improvement in Health Care* conference available.

[US] AHRQ Web M&M
http://webmm.ahrq.gov/
The October issue of the Agency for Healthcare Research and Quality's *Web Morbidity and Mortality Round* is now available.
The Perspectives on Safety section explores **designing for safety**. The accompanying perspective piece discusses the effect of environment on health care–associated infections, medication safety, and falls.
The Spotlight Case, "CA-MRSA Skin Infections: An Ounce of Prevention is Worth a Pound of Cure," examines a case of a teenage athlete who contracted community-acquired methicillin-resistant *staphylococcus aureus* infection (CA-MRSA)
The second case, "Looking For Meds in All the Wrong Places," describes how a patient had an order written to receive intravenous administration of an anti-seizure medication but was administered a 10-fold overdose and died. The commentary explains how to identify warning signs of medication errors.
The third case, "Buprenorphine and the Medically Ill Patient", discusses risks associated with medical withdrawal for opioid dependence.
