AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

Issue 127
20 May 2013

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On the Radar
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Reports

National Healthcare Quality Report 2012
Agency for Healthcare Research and Quality
Rockville MD. Agency for Healthcare Research and Quality, 2013.

Notes	The US Agency for Healthcare Research and Quality has released its tenth *National Healthcare Quality Report* covering trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care in the USA. This, and the related *National Healthcare Disparities Report*, indicate that the "quality of U.S. health care is slowly improving, while access to health care remains a great challenge for some Americans". The reports note that "urgent attention" is needed to ensure continued improvements in the quality of diabetes care, maternal and child health care, and treatment for conditions such as pressure ulcers and blood clots.
URL	http://www.ahrq.gov/research/findings/nhqrdr/index.html
TRIM	79765

Does integrated care deliver the benefits expected? Findings from 16 integrated care pilot initiatives in England. Research brief
RAND Europe

Notes	The role of good care co-ordination, either along the patient journey as the patient moves back and forth between different aspects of their care and different providers or for the management of co-morbid conditions, is well appreciated. This RAND research brief indicates how challenging the co-ordination of care can be. In 2009 the English Department of Health initiated a programme of integrated care pilots. Some 16 projects were selected, representing a mixed range of target populations, interventions and care providers, with a particular focus on elderly care and management of complex long-term conditions. RAND Europe co-led an evaluation of these projects and report that no single approach suits all circumstances [context matters] and change often took longer than anticipated. They also report that staff were more positive about new ways of working than patients, who did not always feel that new approaches had improved care. Hospital utilisation changed, with fewer planned admissions and outpatient visits, but emergency admissions increased. The brief concludes that "**Local decisionmakers should not underestimate the challenges involved in coordinating care across boundaries, nor lose sight of the needs and preferences of service users.**"
URL	http://www.rand.org/pubs/research_briefs/RB9703.html

Journal articles

Let the patient revolution begin
Richards T, Montori VM, Godlee F, Lapsley P, Paul D
BMJ 2013;346:f2614

Notes	An editorial from BMJ writers announcing a new focus on patient centred care in the BMJ and a plan "to develop a strategy for patient partnership that will be reflected across the entire journal". The article gives an overview of patient opportunities for involvement in care, including shared decision making.
DOI	http://dx.doi.org/10.1136/bmj.f2614

Close calls in patient safety: Should we be paying closer attention?
Wu AW, Marks CM
Canadian Medical Association Journal 2013 [epub].

Notes	The importance of learning from events is exemplified by the attention paid to serious adverse events through reporting and investigative processes such as RCA. However, should such attention also be paid to 'lesser' events, events that caused little or no harm, to near misses? This short commentary piece discusses the value of analysing near misses/good catches/close calls, with examples of near miss reporting systems. The authors suggest that **close calls may occur as much as 300 times more often than adverse events** and that this volume of information could be a valuable resource, even if only a portion of it is captured. Further, as no harm has been caused it may be easier to report and discuss near misses.
DOI	http://dx.doi.org/10.1503/cmaj.130014

Reducing errors in emergency surgery
Watters DAK, Truskett PG
ANZ Journal of Surgery 2013 [epub].

Notes	The authors of this particle sought to review surgical error, in the emergency setting, and to develop a classification system of those errors. The article discusses error classification, error prevention strategies, and techniques for responding to adverse events in emergency surgery. In their abstract the authors noted that: "Errors may be classified as being the result of commission, omission or inition. An error of inition is a failure of effort or will and is a failure of professionalism. The risk of error can be minimized by good situational awareness, matching perception to reality, and, during treatment, reassessing the patient, team and plan. It is important to recognize and acknowledge an error when it occurs and then to respond appropriately. The response will involve rectifying the error where possible but also disclosing, reporting and reviewing at a system level all the root causes. This should be done without shaming or blaming. However, the individual surgeon still needs to reflect on their own contribution and performance."
DOI	http://dx.doi.org/10.1111/ans.12194

Communication interventions to improve adherence to infection control precautions: a randomised crossover trial
Ong MS, Magrabi F, Post J, Morris S, Westbrook J, Wobcke W, et al.
BMC Infectious Diseases 2013;13:72.

Notes	This study looked at a particular facet of clinical handover, that of infection control and the transmission of appropriate information at handover. The authors note that "Ineffective communication of infection control requirements during transitions of care is a potential cause of non-compliance with infection control precautions by healthcare personnel" and they sought to examine interventions to enhance communication during inpatient transfers between wards and radiology that sought to improve adherence to precautions during transfers. Two interventions were implemented: (i) a pre-transfer checklist used by radiology porters to confirm a patient's infectious status; (ii) a coloured cue to highlight written infectious status information in the transfer form. The effectiveness of the interventions in promoting adherence to standard precautions by radiology porters when transporting infectious patients was evaluated using a randomised crossover trial at an Australian teaching hospital in which 300 transfers were observed over a period of 4 months. The authors report that c**ompliance with infection control precautions** in the intervention groups was **significantly improved** relative to the control group. Adherence rate in the control group was 38%; applying the coloured cue led to a compliance rate of 73%; pre-transfer checklist intervention achieved a comparable compliance rate of 71%. When both interventions were applied, a compliance rate of 74% was attained. Acceptability of the coloured cue was high, but adherence to the checklist was low (40%). The authors conclude that "**Simple measures to enhance communication through the provision of a checklist and the use a coloured cue brought about significant improvement in compliance with infection control precautions by transport personnel during inpatient transfers**."

DOI	http://dx.doi.org/10.1186/1471-2334-13-72

For more 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/

For more information on the Commission's work on clinical communications, including clinical handover, see http://www.safetyandquality.gov.au/our-work/clinical-communications/

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • A Dutch regional **trauma registry**: quality check of the registered data (D C Olthof, J S K Luitse, F M J de Groot, J C Goslings) • The **Patient-Reported Incident in Hospital Instrument** (PRIH-I): assessments of data quality, test–retest reliability and hospital-level reliability (Oyvind Bjertnaes, Kjersti Eeg Skudal, Hilde Hestad Iversen, Anne Karin Lindahl) • Organising a manuscript reporting quality improvement or patient safety research (Christine G Holzmueller, Peter J Pronovost) • Anastomotic leakage as an outcome measure for quality of colorectal cancer surgery (H S Snijders, D Henneman, N L van Leersum, M ten Berge, M Fiocco, T M Karsten, K Havenga, T Wiggers, J W Dekker, R A E M Tollenaar, M W J M Wouters)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[UK] Acute care toolkit 6: The medical patient at risk
http://www.rcplondon.ac.uk/resources/acute-care-toolkit-6-medical-patient-risk
The (UK) Royal College of Physicians (RCP) has produced this toolkit on the medical patient at risk: recognition and care of the seriously ill or deteriorating medical patient.
From the RCP website:
"This acute care toolkit concentrates on the recognition of the altered physiology induced by ill health and the responses appropriate to these findings. The toolkit contains advice and examples of effective responses to the National Early Warning Score (NEWS) trigger system, including advice on resource and staff implications.
However it is also important to recognise that there are certain clinical situations which define a patient at high risk. These include clinical red flags, severe sepsis, acute kidney injury and patients at risk of medical complications, where they may not be associated with altered physiology.
The toolkit also discusses the importance of agreed care escalation plans and has advice on appropriate documentation and staffing considerations.
The toolkit includes four appendices covering NEWS, acute kidney injury and severe sepsis."