AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Free public lecture – Shared Decision Making
Shared Decision Making: Building on research to help it happen in practice
Wednesday 16 October 2013-09-12

The Australian Commission on Safety and Quality in Health Care invites you to a public lecture by Professor France Légaré – an international expert in the field of shared decision making in health care.
Shared decision making involves clinicians and patients making decisions together using the best available evidence. In partnership with their clinician, patients are encouraged to consider available screening, treatment, or management options and the likely benefits and harms of each, to communicate their preferences, and help select the course of action that best fits these.

Join us for Professor Légaré's discussion on shared decision making and how public interest in this area is leading to changes in practice.
Time: 5:00pm to 6:30pm
Venue: Mercure Hotel, 818-820 George Street, Haymarket, Sydney
RSVP: By Friday, 4 October 2013 by emailing ACSQHCevents@safetyandquality.gov.au

For further information see http://www.safetyandquality.gov.au/our-work/shared-decision-making/

Reports

Large simple trials and knowledge generation in a learning health system: Workshop summary
Institute of Medicine
Washington, DC: The National Academies Press., 2013.

Observational Studies in a Learning Health System: Workshop Summary
Institute of Medicine
Washington, DC: The National Academies Press., 2013.

Notes	The (US) Institute of Medicine has released these two reports that suggest how health services and health workers (and their patients) can contribute to medical knowledge and enable their facilities to become more reflective, learning organisations. Learning organisations are arguable more responsive to patient needs and preferences and have been claimed to provide safer and higher quality care. The August/September 2013 *Quality Matters* from the Commonwealth Fund carried an item on Learning Health Care Systems.
URL	Large simple trails report: http://iom.edu/Reports/2013/Large-Simple-Trials-and-Knowledge-Generation-in-a-Learning-Health-System.aspx Observational studies report: http://iom.edu/Reports/2013/Observational-Studies-in-a-Learning-Health-System.aspx Commonwealth Fund *Quality Matters* item: http://www.commonwealthfund.org/Newsletters/Quality-Matters/2013/August-September/In-Focus-Learning-Health-Care-Systems.aspx

Journal articles

Health economic evaluation of an infection prevention and control program: Are quality and patient safety programs worth the investment?
Raschka S, Dempster L, Bryce E
American Journal of Infection Control 2013;41(9):773-777.

Notes	In the previous issue of *On the Radar* there was an item on the estimate that the five most common healthcare associated infections (HAIs) have an estimated cost to the US health care system of nearly $10 billion per annum. This article reports on the experience of a Canadian health authority, particularly looking at the cost benefit analysis of their infection prevention and control program over a 4-year period. The authors report that the Health Authority spent more than $66.3 million managing 24,937 HAI cases over the 4-year evaluation period. Urinary tract infections, methicillin-resistant *Staphylococcus aureus*, and bacteremias incurred the greatest costs. **A reduction of 4,739 HAI cases led to avoided costs of $9.1 million in 4 years**; the IPC program budget was $6.7 million during this period. The authors conclude that "Regionalization of the IPC program with standardized policies, procedures, and initiatives led to **a 19% reduction in selected HAIs over 4 years and a cost avoidance of at least $9 million**. This was particularly evident in years 3 and 4 of the program when $7.2 million (79% of the total) savings were realized."
DOI	http://dx.doi.org/10.1016/j.ajic.2012.10.026
TRIM	87969

For information about the Commission's work on healthcare associated infection, see
http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Clinical transfusion practice update: haemovigilance, complications, patient blood management and national standards
Engelbrecht S, Wood EM, Cole-Sinclair MF
Medical Journal of Australia 2013;199(6):397-401.

Notes	Blood transfusions are associated with potential harms beyond transmitting infections. This paper describes recent policy and research in the area of best practice blood management. Major hazards identified by haemovigilance programs include sepsis from bacterial contamination, and events relating to clinical procedures and clerical tasks such as incorrect patient identification. With increasing emphasis internationally on patient blood management rather than product safety alone, the paper describes new Australian National guidelines for patient blood management, and reviews those on critical bleeding and massive transfusion, and peri-operative care. In Australia, systems and processes to improve the safety and quality of blood management have been specified in the *National Safety and Quality Health Service* (NSQHS) *Standards*, which the authors say "promote an institutional culture where transfusion safety is viewed as paramount, and they support clinicians and other team members involved in the transfusion process."
DOI	http://dx.doi.org/10.5694/mja13.10070

For information about the *National Safety and Quality Health Service (NSQHS) Standards*, see
http://www.safetyandquality.gov.au/our-work/accreditation/nsqhss/

Variation in Surgical-Readmission Rates and Quality of Hospital Care
Tsai TC, Joynt KE, Orav EJ, Gawande AA, Jha AK
New England Journal of Medicine 2013;369(12):1134-1142

Notes	This US study used national Medicare data to examine **30-day readmission rates** after hospitalization for the following procedures: • coronary-artery bypass grafting, • pulmonary lobectomy, • endovascular repair of abdominal aortic aneurysm, • open repair of abdominal aortic aneurysm, • colectomy, and • hip replacement. Researchers sought to "**assess the relationships between readmission rates and other measures of surgical quality**, including adherence to surgical process measures, procedure volume, and mortality." The found that close adherence to reported surgical process measures was "only marginally associated with reduced readmission rates (highest quartile vs. lowest quartile, 13.1% vs. 13.6%; P=0.02)" and "**nearly one in seven patients hospitalized for a major surgical procedure is readmitted to the hospital within 30 days after discharge**".
DOI	http://dx.doi.org/10.1056/NEJMsa1303118

6 strategies hospitals should steal from the airline industry
Burroughs, J H
Hospital Impact September 17th, 2013

Notes	Over the years various authors have encouraged those in the health system to look to other industries to lessons and strategies that can (possibly) be applied to healthcare to make it safer or better. Many of these have been examining individual actions (seeing health workers as somewhat analogous to pilots) or have been looking to what have been termed high-reliability industries. In these piece, we are encouraged to look again to the airline industry, this time at the systems approach. The 6 key strategies Burroughs identifies are: **1. Air traffic control is managed as a system, not a place** …we will never master hospital flow until we master the flow of the entire system. **2: Airport operations function 24/7** … Flow should be managed around the clock and utilization managers should be replaced with flow coordinators who hand off their oversight continuously based on time of day and setting of care …Ideally, the term "discharge" should be replaced with "care transition" so we stop thinking of moving from one environment to another as a beginning or end. **3: All departures are scheduled in advance** …The vast majority of delays …involve the discharge planning process … Ironically, most discharges are predictable to within one hundredth of a day based upon risk and severity-adjusted length-of-stay data bases …for each diagnosis-related group. Therefore, most discharges should be scheduled at least 24 hours to 48 hours in advance … **4: All arrivals are scheduled in advance** …the vast majority [of admissions, including ED and ICU] are predictable. … Truly random variation can and should be managed by policy whereas non-random variation should be eliminated by standardizing flow **5: Flight schedules are smoothed throughout the day and week**…The system needs to be viewed holistically so all of the units and outpatient facilities coordinate flow in a synchronized and synergistic way to accommodate flow throughout the system and not within a unit alone. **6: Delayed flights are taken off of main runways and taxiways** …Delayed discharges, transfers and admissions should not sit in beds blocking patient flow but should be immediately moved to a comfortable and appropriately supervised holding area where they can be safely managed and not delay the timely diagnosis and treatment of non-stabilized patients. Burroughs argues that these can allow us to "treat patient flow systemically as a 24/7, inpatient/outpatient, continuous operation that requires continuous management and oversight to standardize processes, exploit bottle-necks, manage random variation and eliminate non-random variation. By doing so, we can reduce costs, improve quality/safety/service and successfully compete globally for high quality-low costs services."
URL	http://www.hospitalimpact.org/index.php/2013/09/17/6_strategies_hospitals_should_steal_from

Diverse Sources of C. difficile *Infection Identified on Whole-Genome Sequencing*
Eyre DW, Cule ML, Wilson DJ, Griffiths D, Vaughan A, O'Connor L, Ip CLC, Golubchik T, Batty EM, Finney JM, Wyllie DH, Didelot X, Piazza P, Bowden R, Dingle KE, Harding RM, Crook DW, Wilcox MH, Peto TEA, Walker AS
New England Journal of Medicine 2013;369(13):1195-1205

Notes	Researchers in the UK have performed whole-genome sequencing on 1223 isolates obtained from all symptomatic patients with *C. difficile* infection identified in health care settings or in the community in Oxfordshire between 2007 and 2011. Over that period they found that **45% of *C. difficile* cases in Oxfordshire were genetically distinct from all previous cases**, indicating a considerable reservoir of *C. difficile* in the environment.
DOI	http://dx.doi.org/10.1056/NEJMoa1216064

American Journal of Medical Quality
September 2013; Vol. 28, No. 5

Notes	A new issue of the *American Journal of Medical Quality* has been published. This issue of *American Journal of Medical Quality* includes the following items: • Improving **Hypertension Control in Diabetes**: A Multisite Quality Improvement Project That Applies a 3-Step Care Bundle to a Chronic Disease Care Model for Diabetes With Hypertension (Mark E Lindsay, Michael J Hovan, James R Deming, Vicki L Hunt, S G Witwer, et al) • Do Patients "Like" Good Care? **Measuring Hospital Quality** via Facebook (Alex Timian, Sonia Rupcic, Stan Kachnowski, and Paloma Luisi) • Understanding and Execution of **Discharge Instructions** (E A Coleman, A Chugh, M V Williams, J Grigsby, J J Glasheen, M McKenzie, and S-J Min) • Using Lean Methodology to **Teach Quality Improvement** to Internal Medicine Residents at a Safety Net Hospital (Charlene Weigel, Winnie Suen, and Gouri Gupte) • **Perioperative Hypothermia** in the Pediatric Population: A Quality Improvement Project (Paul Kim, T Taghon, M Fetzer, and J D Tobias) • **Disaster Preparedness**: What Training Do Our Interns Receive During Medical School? (Edward Jasper, Katherine Berg, Matthew Reid, P Gomella, D Weber, A Schaeffer, A Crawford, K Mealey, and D Berg) • A Closer Look at Associations Between Hospital Leadership **Walkrounds** and **Patient Safety Climate** and **Risk Reduction**: A Cross-Sectional Study (René Schwendimann, Judy Milne, Karen Frush, Dietmar Ausserhofer, Allan Frankel, and J Bryan Sexton) • **Colorectal Cancer Screening** in the Framework of the Medical Home Model: Findings From Focus Groups and Interviews (Mona Sarfaty, Brian Stello, Melanie Johnson, Randa Sifri, Amanda Borsky, and R M Myers) • The Development of a Validated **Checklist for Nasogastric Tube Insertion**: Preliminary Results (LA Riesenberg, K Berg, D Berg, A Schaeffer, K Mealey, J Davis, D Weber, D King, E M Justice, et al) • Survey on the **Culture of Patient Safety** Among Spanish Health Care Residents (Joaquín Morís de la Tassa, Diana Galiana Martín, Elisa Luño Fernández, Mª José Gómez Castro, and Gonzalo Solís Sánchez) • **Patient Transition** From a Free Clinic to a Medical Home (Anthony Bowen, Sophia L. Ryan, Julie Sogani, A Cortijo, S C Nosal, and P Joo)
URL	http://ajm.sagepub.com/content/vol28/issue5/?etoc

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Editorial: Interventions to **reduce urinary catheter use**: it worked for them, but will it work for us? (Jennifer Meddings)

	• Editorial: **Making improvement interventions** happen—the work before the work: four leaders speak (Paul Batalden) • Editorial: **Diagnosis and diagnostic errors**: time for a new paradigm (Gordon D Schiff) • Characterising the **complexity of medication safety** using a human factors approach: an observational study in two intensive care units (Pascale Carayon, Tosha B Wetterneck, Randi Cartmill, Mary Ann Blosky, Roger Brown, R Kim, S Kukreja, M Johnson, B Paris, K E Wood, J Walker) • Improving **patient waiting times**: a simulation study of an obesity care service (Antuela A Tako, K Kotiadis, C Vasilakis, A Miras, C W le Roux) • A qualitative study examining the influences on situation awareness and the identification, mitigation and escalation of **recognised patient risk** (Patrick W Brady, Linda M Goldenhar) • Conventional evaluations of **improvement interventions**: more trials or just more tribulations? (Kaveh G Shojania) • Reducing unnecessary **urinary catheter** use and other strategies to prevent catheter-associated urinary tract infection: an integrative review (Jennifer Meddings, M A M Rogers, S L Krein, M G Fakih, R N Olmsted, S Saint)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

Notes	The *International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Linking **quality of healthcare** and health-related **quality of life** of patients with type 2 **diabetes**: an evaluative study in Mexican family practice (Svetlana V. Doubova, Dolores Mino-León, and Ricardo Pérez-Cuevas) • Do older patients and their family caregivers agree about the **quality of chronic illness care**? (Erin R. Giovannetti, Lisa Reider, Jennifer L. Wolff, Kevin D. Frick, Chad Boult, Don Steinwachs, and Cynthia M. Boyd)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

[UK] Raising concerns: guidance for nurses and midwives
http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Raising-and-escalating-concerns.pdf
The UK Nursing and Midwifery Council has release this guidance to aid nurses and midwives thinking through the issues and take appropriate action in the public interest. This new edition includes information on recent UK legislation that offers protection to whistleblowers as well as updated information on organisations nurses and midwives can go to for further advice.

[USA] Eliminating CAUTI: A National Patient Safety Imperative
http://www.ahrq.gov/professionals/quality-patient-safety/cusp/cauti-interim/index.html
The US Agency for Healthcare Research and Quality (AHRQ) has released an interim data report on a US effort to promote the use of the Comprehensive Unit-based Safety Program (CUSP) to prevent catheter-associated urinary tract infection (CAUTI) in US hospitals. **Hospital units that have completed 14 months of CUSP implementation have achieved an average 16 percent reduction in the CAUTI rate**.

CUSP combines general approaches to improve safety culture, teamwork, and communications in a particular unit or hospital coupled with evidence-based interventions focusing on the technical aspects of CAUTI prevention. *Eliminating CAUTI: A National Patient Safety Imperative* reports on the progress of the national On the CUSP: Stop CAUTI project, which aims to reduce the CAUTI rate in participating hospital units by the end of the 4-year project.

For information about the Commission's work on healthcare associated infection, see http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

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