AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Books

A Life in Error: From Little Slips to Big Disasters
Reason J
Ashgate, 2013. ISBN: 978-1-4724-1841-8.

Notes	James Reason's latest book is partly autobiographical while raising issues about human error and their prevention and amelioration. Though his personal journey "in pursuit of the nature and varieties of human error" (as the publisher's website puts it)this work charts the development of his seminal and influential work from its original focus into individual cognitive psychology through the broadening of scope to embrace social, organizational and systemic issues. Reason has, through his work, been influential in how human error is conceptualised and studied. This book is aimed safety professionals, students and academic interested in avoiding errors that can cause serious harm to people, assets and the environment.
URL	http://www.ashgate.com/default.aspx?page=637&calcTitle=1&title_id=19947&edition_id=1209350204

Reports

Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety 2013
The Joint Commission
Oakbrook Terrace, IL. Joint Commission, 2013.

Notes	The (US) Joint Commission's annual report summaries the performance of US hospitals across 47 accountability measures. "Top Performers" are determined by those hospitals meeting three 95% performance thresholds; 1099 hospitals were identified. This represents 33% of all Joint Commission-accredited hospitals that report core measure performance data. According to this report, US hospitals have measurably improved the quality of care over the past year for heart attacks, pneumonia, surgical care, children's asthma care, inpatient psychiatric services, venous thromboembolism, and stroke patients.
URL	http://www.jointcommission.org/annualreport.aspx

Journal articles

Antibiotic resistance and prescribing in Australia: current attitudes and practice of GPs
Hardy-Holbrook R, Aristidi S, Chandnani V, DeWindt D, Dinh K
Healthcare Infection 2013;18(4):147-151.

Notes	A cross-sectional survey of 730 GPs found that while GPs perform very well in areas such as recommending symptomatic management rather than prescribing an antibiotic, there is some confusion about the factors that increase antibiotic resistance. Patient expectation also plays a role in the decision to prescribe antibiotics with almost 40% of GPs saying they would prescribe antibiotics if the patient expected it - but antibiotic resistance is generally not discussed with patients. The authors conclude that programs to address the prescribing of antibiotics must be informed by existing knowledge, attitudes, awareness and practice of GPs.
DOI	http://dx.doi.org/10.1071/HI13019

November 18–24 is Antibiotic Awareness Week
For further information and resources, see www.safetyandquality.gov.au/aaw2013

Meta-Analysis of Surgical Safety Checklist Effects on Teamwork, Communication, Morbidity, Mortality, and Safety
Lyons VE, Popejoy LL
Western Journal of Nursing Research 2013 [epub].

Notes	This meta-analysis sought to examine the effectiveness of surgical safety checklists on teamwork, communication, morbidity, mortality, and compliance with safety measures by conducting four analyses on 19 studies that met their inclusion criteria. The authors recognise that this is a small number of studies and that it may not be more generalisable. The authors report that "**surgical safety checklists improve teamwork and communication, reduce morbidity and mortality, and improve compliance with safety measures**".
DOI	http://dx.doi.org/10.1177/0193945913505782

Review article: Improving the hospital clinical handover between paramedics and emergency department staff in the deteriorating patient
Dawson S, King L, Grantham H
Emergency Medicine Australasia 2013;25(5):393-405.

Notes	Paper reporting on a literature review that looked at the issue of clinical handover between paramedics and emergency departments, particular in relation to deteriorating patient. The analysis of the seventeen peer-reviewed English-language original quantitative and qualitative studies identified revealed the following themes: professional relationships, respect and barriers to communication; multiple or repeated handovers; identification of staff in the ED; significance of vital signs; need for a structured handover tool; documentation and other communication methods and education and training to improve handovers. The issues raised in the literature included the need to: produce more complete and concise handovers, create respectful and effective communication, and identify staff in the ED. The author suggest that: • **structured handover tool** such as ISBAR (a mnemonic covering Introduction, Situation, Background, Assessment and Recommendations) may address many of the issues. • **recording of vital signs** and transfer of these data might be improved with better observation systems incorporating early warning strategies • more **effective teamwork** could be achieved with further clinical communications training.
DOI	http://dx.doi.org/10.1111/1742-6723.12120

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

For information about the Commission's work on recognition and response to clinical deterioration, see http://www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/

Mental health research and evaluation in multicultural Australia: developing a culture of inclusion
Minas H, Kakuma R, Too LS, Vayani H, Orapeleng S, Prasad-Ildes R, et al
International Journal of Mental Health Systems 2013;7(1):23.

Notes	This Australian study uses three methods to address gaps in mental health service delivery to people from culturally and linguistically diverse (CALD) backgrounds. The study briefly reviews data about mental health service use by immigrant and refugee communities, critically addresses national data collections, and examines published Australian research on mental health for the inclusion and exclusion of CALD participants. The authors argue that there is a gap between statements of intent at policy level and the uptake of mental health services by people from CALD backgrounds. They identify that current data collection and research methods perpetuate the invisibility of the problem. They make eight recommendations including translating mental health policy statements into explicit implementation objectives, providing resources for this implementation, and reporting on progress in relation to the objectives.
DOI	http://dx.doi.org/10.1186/1752-4458-7-23

Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries
Schoen C, Osborn R, Squires D, Doty MM
Health Affairs 2013 [epub].

Notes	Each year the (US) Commonwealth Fund conducts a multi-national survey of health systems, in this instance covering 11 countries, including Australia. This year's survey, reported in this article in *Health Affairs*, looked at issues of access, cost and insurance for health consumers in the eleven countries surveyed. While the focus of the paper – and the associated material available from the Commonwealth Fund – tends to be on the USA, particularly how it tends to perform unfavourably in such comparisons, such work can also help us understand our systems, including Australia's. In such comparisons, including in the past Commonwealth Fund surveys, Australia tends to perform quite well. In most measures Australia lies to the more favourable end of the scale. However, this is not always the case and such results can indicate areas of potential improvement.
DOI	http://dx.doi.org/10.1377/hlthaff.2013.0879
URL	Commonwealth Fund http://www.commonwealthfund.org/Publications/In-the-Literature/2013/Nov/Access-Affordability-and-Insurance.aspx

Cancer screening a shared decision
MacKee N
MJA InSight 2013 [epub]

Notes	Awareness of the risks of overdiagnosis is increasing, and requires consideration of the costs and consequences of unnecessary treatments. This discussion piece quotes Australian experts in evidence-based practice and suggests that a shared decision making process between a clinician and a consumer is the best approach to deciding if the benefits of undergoing cancer screening outweigh the risks of overdiagnosis in each individual's situation.
URL	https://www.mja.com.au/insight/2013/41/cancer-screening-shared-decision

News article: The right choice: Doctor–patient collaboration is at the heart of moves to make health care more collaborative
McGilvray A
Med J Aust November 2013

Notes	Shared-decision making experts came together recently in Sydney and the Gold Coast to discuss how to improve the use of patient decision aids and shared decision-making approaches. As the article reports, there is evidence that this approach not only engages consumers in their care but can "reduce overdiagnosis, improve compliance and potentially save money for both patients and governments". Professor France Légaré visited Australia as a guest of the Commission.
URL	https://www.mja.com.au/careers/199/9/right-choice

Public Reporting, Consumerism, and Patient Empowerment
Huckman RS, Kelley MA
New England Journal of Medicine 2013;369(20):1875-1877

Notes	This is an interesting perspective piece which raises important questions about the way in which information is presented to consumers and the choices they make as a consequence of this information. More and more data on quality is being made available to the public, but with little support to interpret that data, is it of value to consumers? And how does it assist the personal decision making requirements of individuals facing a treatment decision? **Shared decision making**, a process that involves collaboration between clinicians and consumers to examine, interpret and evaluate the best available clinical evidence alongside a consumer's personal values, priorities and goals, in order to achieve appropriate health care decisions, fulfils this need for the delivery of valuable quality data in a meaningful way to consumers. As economic conditions and changing models of healthcare funding continue to influence the costs of health care – both individual and national – we can expect to see change in the choices consumers make about health services. The authors see this moving in the direction of other, more traditional, consumerist industries like the retail sector, to a point where healthcare consumers will be "smart shoppers" and health services will be responsive to their preferences.
DOI	http://dx.doi.org/10.1056/NEJMp1310419

Power to the people: what will bring about the patient centred revolution?
Hodgkin P, Taylor J
BMJ 2013;347 [epub]

Notes	Focussing on the UK, the authors suggest three trends which are likely to make a difference in empowering patients in the coming years: 1. The growing population of people with multiple long term conditions, disabilities, and frailty will demand **a different model of care and support which is primarily social rather than medical**; 2. The slow march towards **greater transparency about performance** will continue to shift power from an often secretive and defensive national health systems towards citizens; and 3. Exponential growth in **digital technologies**, including personal access and curation of electronic health records and social media supported behaviour change.
DOI	http://dx.doi.org/10.1136/bmj.f6701

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

Delayed Medical Emergency Team Calls and Associated Outcomes
Boniatti MM, Azzolini N, Viana MV, Ribeiro BS, Coelho RS, Castilho RK, et al.
Critical Care Medicine 2013 [epub].

Impact of rapid response system implementation on critical deterioration events in children
Bonafide CP, Localio A, Roberts KE, Nadkarni VM, Weirich CM, Keren R
JAMA Pediatrics 2013 [epub].

Notes	A pair of papers on rapid response or MET (medical emergency team) calls. Boniatti at al report on the impact of delays in MET calls as measured in a Brazilian tertiary referral hospital. This prospective observational study examined all patients for whom there was a MET call July 2008 to December 2009. Of the 1,481 calls for 1,148 patients, calls for 46 were delayed (21.4%). The reported **mortality at 30 days** after medical emergency team review was **higher** among patients **with delayed medical emergency team activation** (152 [61.8%]) than patients receiving timely medical emergency team activation (378 [41.9%] The authors conclude that "Delayed medical emergency team calls are common and are independently associated with higher mortality. This result reaffirms the concept and need for a rapid response system." Bonafide et al report on the impact of the implementation of a hospital-wide rapid response system inclusive of a medical emergency team and an early warning score in February 2010 in a US urban, tertiary care children's hospital. The study evaluated 1810 unplanned transfers from the general medical and surgical wards to the paediatric and neonatal intensive care units that occurred during 370□504 non–intensive care patient-days between 1 July 2007 and 31 May 2012. The authors argued that implementation of a **rapid response system reversed an increasing trend of critical deterioration** in this hospital. Cardiac arrest and death were extremely rare in this child population at baseline, and reductions were not statistically significant despite using nearly 5 years of data. They suggest that "Hospitals seeking to measure rapid response system performance may consider using valid proximate outcomes like critical deterioration in addition to rare, catastrophic outcomes."
DOI	Boniatti et al http://dx.doi.org/10.1097/CCM.0b013e31829e53b9 Bonafide et al http://dx.doi.org/10.1001/jamapediatrics.2013.3266

For information about Hand Hygiene Australia, see http://www.hha.org.au/

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

Development of a theory-based instrument to identify barriers and levers to best hand hygiene practice among healthcare practitioners
Dyson J, Lawton R, Jackson C, Cheater F
Implementation Science 2013;8(1):111

Notes	The authors developed and tested an instrument to **assess barriers and levers to hand hygiene** in order to allow the subsequent tailoring of theoretically informed implementation strategies. They also examined the relationship between self-reported compliance with hand hygiene and barriers and levers to hand hygiene. The instrument tested well. Results showed that the relationship between self-reported compliance with hand hygiene moderately correlated with barriers identified by participants (total barrier score) ($r=0.41$, $n=276$, $p<0.001$). The greater the number of barriers reported, the lower the level of compliance. They also found that **compliance was highest for practitioners:** • with high levels of **motivation**, • with strong beliefs about **capabilities**, • when there were **positive social influences**, and • when hand hygiene was central to participants' sense of **professional identity**.
DOI	http://dx.doi.org/10.1186/1748-5908-8-111

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Prevalence, patterns and predictors of **nursing care left undone** in European hospitals: results from the multicountry cross-sectional RN4CAST study (Dietmar Ausserhofer, Britta Zander, Reinhard Busse, Maria Schubert, Sabina De Geest, Anne Marie Rafferty, Jane Ball, Anne Scott, Juha Kinnunen, Maud Heinen, Ingeborg Strømseng Sjetne, Teresa Moreno-Casbas, Maria Kózka, Rikard Lindqvist, Marianna Diomidous, Luk Bruyneel, Walter Sermeus, Linda H Aiken, René Schwendimann, on behalf of the RN4CAST consortium)
URL	http://qualitysafety.bmj.com/content/early/recent

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: • Editorial: **Collaboration, capacity building and co-creation** as a new mantra in global health (Jacqueline DePasse and Leo Anthony Celi) • Association of healthcare expenditures with aggressive versus palliative care for **cancer patients at the end of life**: a cross-sectional study using claims data in Japan (Toshitaka Morishima, Jason Lee, Tetsuya Otsubo, and Yuichi Imanaka) • Associations between rates of unassisted **inpatient falls and levels of** registered and non-registered **nurse staffing** (Vincent S. Staggs and Nancy Dunton) • Bridging the science-to-service gap in schizophrenia care in the Netherlands: the **Schizophrenia Quality Improvement Collaborative** (Danielle Van Duin, Gerdien Franx, Bob Van Wijngaarden, Mark Van der Gaag, Jaap Van Weeghel, Cees Slooff, and Michel Wensing)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

[USA] 5 Fierce patient safety videos
www.fiercehealthcare.com/special-reports/5-fierce-patient-safety-videos-0
FierceHealthcare have selected five training videos that show the best hospitals have to offer in terms of catching the attention of staff and patients, as well as encouraging safe practices. The five videos are:
1. CAUTI Block
2. Teamwork and Patient Safety at Kaleida Health
3. Patient Safety- Are You Smarter Than a Fifth Grader?
4. Three Words: Patient Safety at Newton-Wellesley Hospital
5. Speak Up for Patient Safety
