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On the Radar

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On the Radar
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Consultation on the Draft National Consensus Statement on End-of-Life Care in Acute Hospitals
Consultation closing 31 March 2014

As part of its work on improving the safety and quality of end-of-life care in acute hospitals, the Commission has developed the *Draft National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care in Acute Hospitals* (the Consensus Statement).

The draft Consensus Statement aims to provide guidance for health services to develop their own systems for delivering safe, timely and high quality end-of-life care in a way that is tailored to their population, resources and available personnel, whilst being in line with relevant jurisdictional or other programs.

The Commission is holding an open consultation process from 31 January to 31 March 2014. The Commission is accepting written submissions on the draft Consensus Statement and is conducting a series of workshops in each of Australia's capital cities during the consultation period.
Interested parties are invited to provide feedback through completing a brief survey or by making a detailed written submission.

For more information please visit: http://www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/end-of-life-care-in-acute-hospitals/consultation-on-draft-national-consensus-statement-on-end-of-life-care-in-acute-hospitals/

To download a copy of the draft Consensus Statement, and for more information on the consultation process, please visit http://www.safetyandquality.gov.au/wp-content/uploads/2014/01/Draft-National-Consensus-Statement-Essential-Elements-for-Safe-and-High-Quality-End-of-Life-Care-in-Acute-Hospitals.pdf

Reports

Ripping off the sticking plaster: Whole-system solutions for urgent and emergency care
NHS Confederation
London. NHS Confederation, 2014.

Notes	The pressures on—and the apparent failings of—UK accident and emergency (A&E) departments have been will aired in the British media. It could be argued that these issues are not dissimilar elsewhere. Hence this brief (28-page) report from the NHS Confederation's Urgent and Emergency Care Forum may have relevance beyond the NHS England setting. It is intended that the report "acts as a roadmap to the fundamental changes required to create a sustainable and high-quality urgent and emergency care system that can meet the needs of patients now and in the future." The report contains sections on Understanding demand, Emergency care networks, Improving access and navigation, and A system and workforce fit for the future.
URL	http://www.nhsconfed.org/Publications/reports/Pages/ripping-off-the-sticking-plaster.aspx

Journal articles

Shift change handovers and subsequent interruptions: potential impacts on quality of care
Estryn-Behar MR, Milanini-Magny G, Chaumon E, Deslandes H, Fry C, Garcia F, et al.
Journal of Patient Safety 2014;10(1):29-44.

Notes	For many of us an ideal workplace would be one free of interruptions. The clinical workplace is rarely free of interruptions and distractions. This French observational study found that registered nurses (RNs), physicians, and nursing aides have **frequent interruptions and limited time for shift-change handovers** (or handoffs). This suggests that attempts to ensure adequate time and reduce interruptions have not been entirely successful to date. The study reported that "the average time available to RNs for sharing information during SCHs was 15 minutes at the beginning of the work session and 13 minutes at the end. There were, on average, **50 interruptions** of activity, and these **interruptions occupied 16% of the working time**. Consequently, less time was available for direct care…The mean number of changes of activity was very large: 260 per work session. …For physicians, [handovers] were even shorter and, in many cases, nonexistent. The mean number of interruptions was 30 (11.4% of their working time, 153 changes of activity). Shift change handovers were mostly conducted separately for RNs, NAs, and physicians."
DOI	http://dx.doi.org/10.1097/PTS.0000000000000066

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

Adverse Drug Event Nonrecognition in Emergency Departments: An Exploratory Study on Factors Related to Patients and Drugs
Roulet L, Ballereau F, Hardouin J-B, Chiffoleau A, Potel G, Asseray N
The Journal of Emergency Medicine 2014 [epub].

Notes	Adverse drug events are among the more common reasons for hospitalisation. However, this French study reveals how often they may not be recognised as such in the emergency department (ED). This paper reports on an observational study undertaken in the medical ED of a French tertiary care hospital between January and December 2009 that included 465 patients. The authors report that 90 (**19.4%**) **experienced an ADE at ED visit** and that **ED physicians** correctly **recognized** 36 (**40.0%**) **of these** cases. They note that ADE non-recognition was significantly associated with non-relation between the ADE and the patient's chief complaint; daily prescription of four or more drugs; and hospitalization ADE severity category.
DOI	http://dx.doi.org/10.1016/j.jemermed.2013.11.124

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

Redesigning hospital alarms for patient safety: Alarmed and potentially dangerous
Chopra V, McMahon Jr. LF.
Journal of the American Medical Association 2014 [epub].

Notes	Alarms of various forms are all but ubiquitous in the modern hospital. The issues of **alarm failure** and **alarm fatigue**, leading to the disregarding or misprioritising of alarms, are widely recognised. This commentary piece contains describes what makes an alarm effective, how alarms can contribute to adverse events, and some strategies for reducing the risks. These strategies include considering **alarm priority** and better **integration of alarms into workflow** and with **decision making** utilising more intelligent alarms and links with other information sources. The authors argue that hospitals need to go from being "alarmed and potentially dangerous" to having alarms as part of a "biologically valid, clinically relevant, patient-centered model".
DOI	http://dx.doi.org/10.1001/jama.2014.710

An evidence-based framework to measure quality of allied health care
Grimmer K, Lizarondo L, Kumar S, Bell E, Buist M, Weinstein P
Health Research Policy and Systems 2014;12(1):10.

Notes	In this paper the (Australian-based) authors propose a framework for measuring the quality of allied health (AH). The authors developed a "realist synthesis framework describing what AH does, how it does it, and what is achieved" informed by the findings of a systematic review of literature published since 1980. The literature review identified 24 measures of quality, with 15 potentially relating to what AH does, 17 to how AH delivers care, 8 relating to short term functional outcomes, and 9 relating to longer term functional and health system outcomes.
DOI	http://dx.doi.org/10.1186/1748-5908-7-56
TRIM	D14-10013

BMJ Quality and Safety
April 2014, Volume 23, Suppl 1, Ten years of improvement innovation in cystic fibrosis care

Notes	*BMJ Quality and Safety* has published a supplement on 'Ten years of improvement innovation in **cystic fibrosis care**'. This supplement includes: • A decade of healthcare improvement in cystic fibrosis: **lessons for other chronic diseases** (David P Stevens, Bruce C Marshall) • **Improving chronic care delivery** and outcomes: the impact of the cystic fibrosis Care Center Network (Peter J Mogayzel, Jr, Jordan Dunitz, Laura C Marrow, Leslie A Hazle) • The **Cystic Fibrosis Foundation Patient Registry** as a tool for use in quality improvement (Michael S Schechter, A K Fink, K Homa, C H Goss) • Key findings of the US Cystic Fibrosis Foundation's **clinical practice benchmarking** project (Michael P Boyle, Kathryn A Sabadosa, Hebe B Quinton, Bruce C Marshall, Michael S Schechter) • **Accelerating the rate of improvement** in cystic fibrosis care: contributions and insights of the **learning and leadership collaborative** (Marjorie M Godfrey, Brant J Oliver) • Improving inpatient cystic fibrosis pulmonary exacerbation care: two success stories (Nicholas J Antos, Diana R Quintero, Christine M Walsh-Kelly, Julie E Noe, Michael S Schechter) • **Redesigning care** to meet national recommendation of four or more yearly clinic visits in patients with cystic fibrosis (A Berlinski, M J Chambers, L Willis, K Homa, G Com) • The impact of re-education of airway clearance techniques (REACT) on adherence and pulmonary function in patients with cystic fibrosis (Robert L Zanni, Eduardo U Sembrano, Doantrang T Du, B Marra, R Bantang) • The impact of **transforming healthcare delivery** on cystic fibrosis outcomes: a decade of quality improvement at Cincinnati Children's Hospital (Christopher M Siracusa, Jeanne L Weiland, J D Acton, A K Chima, B A Chini, A J Hoberman, J D Wetzel, R S Amin, G L McPhail) • **Improving transition** from paediatric to adult cystic fibrosis care: programme implementation and evaluation (Megumi J Okumura, T Ong, D Dawson, D Nielson, N Lewis, M Richards, C D Brindis, M E Kleinhenz) • Improved patient safety through **reduced airway infection rates** in a paediatric cystic fibrosis programme after a quality improvement effort to enhance infection prevention and control measures (Adrienne P Savant, Catherine O'Malley, Stacy Bichl, Susanna A McColley) • Sustained improvement in **nutritional outcomes** at two paediatric cystic fibrosis centres after quality improvement collaboratives (Adrienne P Savant, LaCrecia J Britton, K Petren, S A McColley, H H Gutierrez) • The interdependent **roles of patients, families and professionals** in cystic fibrosis: a system for the coproduction of healthcare and its improvement (Kathryn A Sabadosa, Paul B Batalden) • **Accelerating implementation** of biomedical research advances: critical elements of a successful 10 year Cystic Fibrosis Foundation healthcare delivery improvement initiative (Bruce C Marshall, Eugene C Nelson) • **Healthcare improvement is incomplete until it is published**: the cystic fibrosis initiative to support scholarly publication (David P Stevens, Bruce C Marshall)
DOI	http://qualitysafety.bmj.com/content/23/Suppl_1

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Contribution of hospital mortality variations to socioeconomic disparities in **in-hospital mortality** (Yoon Kim, Juhwan Oh, Ashish Jha) • **Quality of care** in systemic lupus erythematosus: the association between **process and outcome measures** in the **Lupus Outcomes** Study (Jinoos Yazdany, Laura Trupin, Gabriela Schmajuk, Patricia P Katz, E H Yelin) • **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)
URL	http://qualitysafety.bmj.com/content/early/recent

Online resources

Cochrane Clinical Answers
http://cochraneclinicalanswers.com/
Cochrane Clinical Answers have been developed as a subscription service to (according to the website) "provide a readable, digestible, clinically focused entry point to rigorous research from Cochrane systematic reviews. They are designed to be actionable and to inform decision making at the point of care. Each Cochrane Clinical Answer contains a clinical question, a short answer, and an opportunity to 'drill down' to the evidence from relevant Cochrane reviews. The evidence is displayed in a user friendly format, mixing narrative, numbers and graphics. The target audience for Cochrane Clinical Answers is healthcare practitioners and professionals, and other informed health care decision-makers."

[USA] Always Events Getting Started Kit
http://www.ihi.org/resources/Pages/Tools/AlwaysEventsGettingStartedKit.aspx
'Always events' are "aspects of the patient experience that are so important to patients and families that health care providers must perform them consistently for every patient, every time."
The US Institute for Healthcare Improvement (IHI) has developed this kit to assist healthcare providers understand what an Always Event is, select a set of practices for an Always Event initiative, and design the steps for implementing the initiative.
The kit includes two case studies of successful implementation of an Always Event initiative, as well as practical guidance regarding the four foundational elements of an Always Event: leadership, patient and family partnership, staff engagement, and measurement.

[USA] Open Notes
http://www.myopennotes.org/toolkit/
It has been contended that sharing or 'opening' medical notes to patients can enhance care. OpenNotes is an initiative that invites patients to review their visit notes written by their doctors, nurses, or other clinicians. This toolkit has been developed to provide step-by-step strategies to guide health care workers in implementing open notes and offers tips for both patients and clinicians on maximizing the benefits of open notes.
The toolkit includes a handout and template PowerPoint presentation to help make the case for open notes, policy and communications suggestions for successful implementation of open notes, sample FAQs for patients and clinicians, and more.

[USA] Patient's Toolkit for Diagnosis
http://www.npsf.org/wp-content/uploads/2014/02/The-Patients-Toolkit-for-Diagnosis.pdf
This toolkit has been developed by the Society to Improve Diagnosis in Medicine (SIDM) Patient Engagement Committee. It is intended for use by "people who are not feeling well or visiting their doctor or nurse with a health concern" and contains a "set of prompts and questions to help you participate and partner with your medical care team – doctors, nurses, and other health care professionals and support staff". The toolkit encourages patients to prepare for their consultations by collating relevant information and considering the issues and questions they may have.
