AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Draft Clinical Care Standard for Stroke

In collaboration with consumers, clinicians, researchers and health organisations, the Commission has developed the draft *Clinical Care Standard for Stroke*.
A Clinical Care Standard provides a small number of quality statements that describe the clinical care that a patient should be offered for a specific condition.
The Commission is currently seeking feedback on the draft *Clinical Care Standard for Stroke* from healthcare professionals, peak healthcare and consumer organisations, consumers and any other interested parties. Public consultation on this draft *Clinical Care Standard for Stroke* is open until 23 May 2014. Feedback can be provided in the form of written submissions or via an online survey.
Copies of the draft *Clinical Care Standard for Stroke*, along with information about its development and the consultation process are available at http://www.safetyandquality.gov.au/our-work/clinical-care-standards/consultation/

Consultation on training and competencies for recognising and responding to clinical deterioration in acute care
Consultation now open

The Commission is seeking advice about what should be the minimum requirements for training and competencies for recognising and responding to physiological deterioration in acute care. The Commission is interested in the application of these minimum requirements for doctors, nurses and allied health professionals.

This consultation process is being conducted in the context of the National Safety and Quality Health Service (NSQHS) Standards which require the clinical workforce to be trained and proficient in basic life support. The Commission has received feedback which questions whether such training ensures adequate competency in the skills required to recognise, escalate and respond to clinical deterioration. Currently there are varied approaches to providing education and training about recognising and responding to clinical deterioration, and a lack of clear guidance about what knowledge should be required as a minimum for all clinicians.

To provide clarity to the requirements of the NSQHS Standards and ensure patients are protected from harm, the Commission is now seeking further advice on this issue.

A consultation paper, *National Safety and Quality Health Service Standards: Training and Competencies for Recognising and Responding to Clinical Deterioration in Acute Care* is available at http://www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/training-and-competencies/

Information about the process of making a submission is included in the paper and the Commission will accept submissions until Friday 27 June 2014.

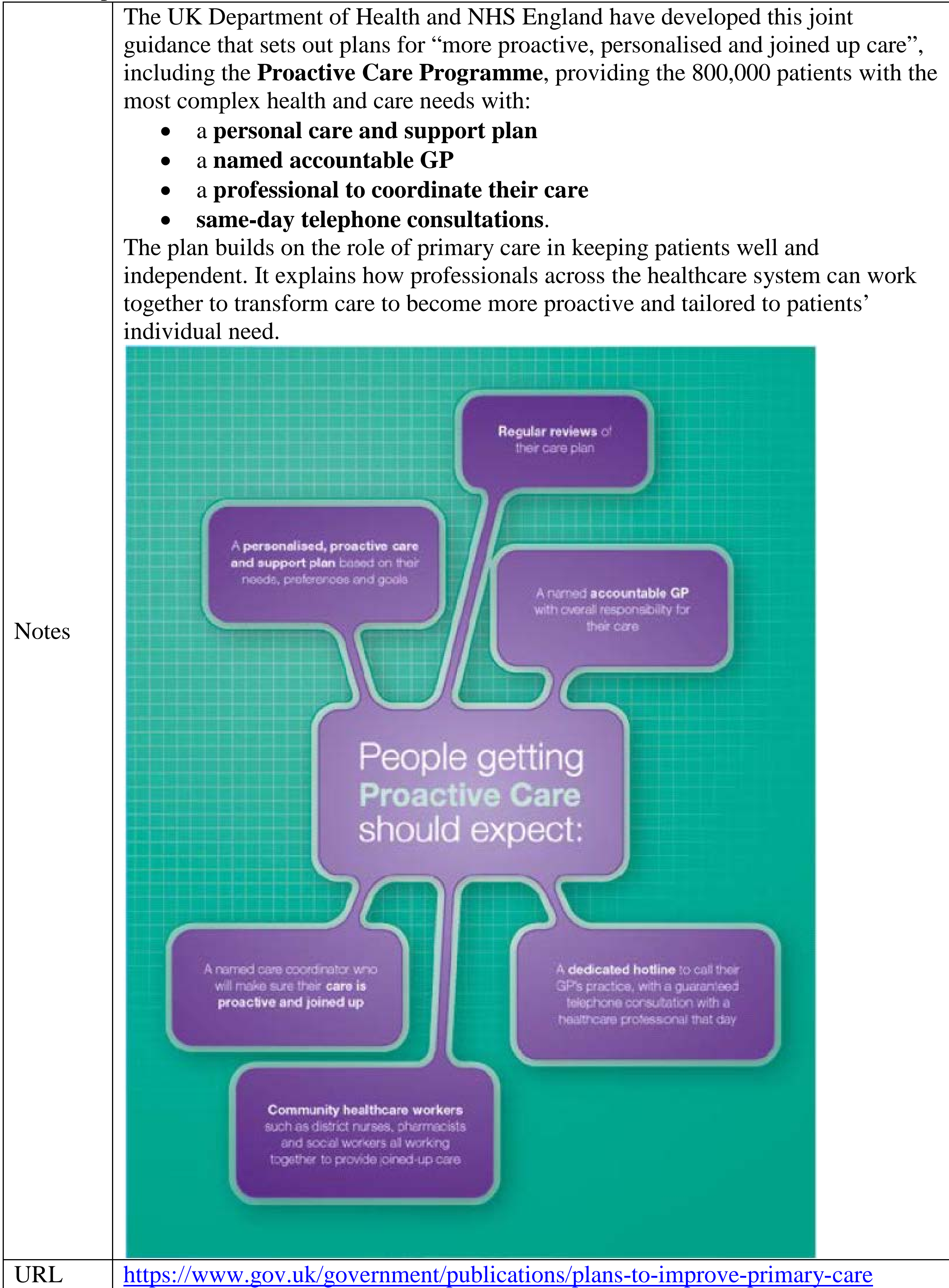
The contact person for this consultation is Ms Jennifer Hill, Senior Project Officer, Recognising and Responding to Clinical Deterioration Program. Ms Hill can be contacted on (02) 9126 3527 or via email at rrconsultation@safetyandquality.gov.au.

Reports

Healthcare in Focus 2013: How does NSW measure up?
Bureau of Health Information
Sydney. Bureau of Health Information, 2014.

Notes	For this report the NSW Bureau of Health Information (BHI) partnered with the US's Commonwealth Fund. This allowed the BHI to have NSW residents surveyed and allowed their input to be compared with those of 11 other health systems around the world. The survey canvassed the views of 20,045 adults in 11 developed nations who were asked about their experiences with their country's healthcare system, particularly in relation to accessing and affording care. It includes the responses of 1,524 adults in NSW who were surveyed between March and June 2013. As is generally the case when Australian health systems are compared with those elsewhere, the NSW system compares favourably with those other systems.
URL	http://bhi.nsw.gov.au/publications/annual_performance_report_series/healthcare_in_focus_2013

Transforming Primary Care: Safe, proactive, personalised care for those who need it most
Department of Health (UK) and NHS England
London. Department of Health, 2014.

Notes	The UK Department of Health and NHS England have developed this joint guidance that sets out plans for "more proactive, personalised and joined up care", including the **Proactive Care Programme**, providing the 800,000 patients with the most complex health and care needs with: • a **personal care and support plan** • a **named accountable GP** • a **professional to coordinate their care** • **same-day telephone consultations**. The plan builds on the role of primary care in keeping patients well and independent. It explains how professionals across the healthcare system can work together to transform care to become more proactive and tailored to patients' individual need. 
URL	https://www.gov.uk/government/publications/plans-to-improve-primary-care

Journal articles

Leadership, safety climate, and continuous quality improvement: Impact on process quality and patient safety
McFadden KL, Stock GN, Gowen CR, 3rd.
Health Care Manage Rev 2014 [epub].

Notes	In this paper the authors suggest a model that shows how transformational leadership, safety climate, and continuous quality improvement (CQI) initiatives are related to objective quality and patient safety outcome measures. Using survey and administrative data the authors argue that "that a **safety climate**, which is connected to the chief executive officer's **transformational leadership** style, is related to **CQI** initiatives, which are linked to **improved process quality**." The authors also report that while "CQI initiatives are positively associated with improved process quality, they are also associated with higher hospital-acquired condition rates, a measure of patient safety. Likewise, **safety climate is directly related to improved patient safety outcomes**." The authors conclude that this confirms "the importance of using CQI to effectively enhance process quality in hospitals, and patient safety climate to improve patient safety outcomes. The overall pattern of findings suggests that **simultaneous implementation of CQI initiatives and patient safety climate produces greater combined benefits**".
DOI	http://dx.doi.org/10.1097/HMR.0000000000000006

Patient Safety Incidents in Home Hospice Care: The Experiences of Hospice Interdisciplinary Team Members
Smucker DR, Regan S, Elder NC, Gerrety E
Journal of Palliative Medicine 2014 [epub].

Notes	Acute hospitals are only one of the settings for health care. This paper looks at another setting, home hospice care, and some of the patient safety issues in that setting. This qualitative and descriptive study surveyed 'hospice leaders', nurses, physicians, social workers, chaplains, and home health aides. The authors report that emerging themes included "concern for unnecessary harm to family caregivers or unnecessary disruption of the natural dying process. The most commonly described categories of patient harm were injuries from falls and inadequate control of symptoms. The most commonly cited contributing factors were related to patients, family caregivers, or the home setting." The participants also perceived fewer incidents relating to errors in medications, evaluation, treatment, or communication by the hospice team. These perceptions may seem a tad optimistic.
DOI	http://dx.doi.org/10.1089/jpm.2013.0111

BMJ Quality and Safety
May 2014, Vol 23, Issue 5

Notes	A new issue of *BMJ Quality and Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality and Safety* include: • Editorial: **Simulation modelling** and resource allocation in complex services (Steffen Bayer) • A **just culture** after Mid Staffordshire (Sidney W A Dekker, Thomas B Hugh)

	• **Team-training in healthcare**: a narrative synthesis of the literature (Sallie J Weaver, Sydney M Dy, Michael A Rosen) • Improving **patient waiting times**: a simulation study of an obesity care service (Antuela A Tako, Kathy Kotiadis, Christos Vasilakis, Alexander Miras, Carel W le Roux) • Using 'nudge' principles for order set design: a before and after evaluation of an **electronic prescribing** template in critical care (Christopher P Bourdeaux, Keith J Davies, Matthew J C Thomas, J S Bewley, T H Gould) • Internal consistency, factor structure and construct validity of the French version of the **Hospital Survey on Patient Safety Culture** (Thomas V Perneger, Anthony Staines, François Kundig) • Errors in **after-hours phone consultations**: a simulation study (Erel Joffe, J P Turley, K O Hwang, T R Johnson, C W Johnson, E V Bernstam) • Association of **note quality and quality of care**: a cross-sectional study (Samuel T Edwards, Pamela M Neri, Lynn A Volk, G D Schiff, D W Bates) • Are interventions to reduce **interruptions and errors during medication administration** effective?: a systematic review (Magdalena Z Raban, Johanna I Westbrook) • **Building clinical networks**: a developmental evaluation framework (Peter Carswell, Benjamin Manning, Janet Long, Jeffrey Braithwaite) • Using quality improvement to optimise **paediatric discharge** efficiency (Christine M White, Angela M Statile, D L White, D Elkeeb, K Tucker, D Herzog, S D Warrick, D M Warrick, J Hausfeld, A Schondelmeyer, P J Schoettker, P Kiessling, M Farrell, U Kotagal, F C Ryckman)
URL	http://qualitysafety.bmj.com/content/23/5

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Development of a **patient safety climate survey** for Chinese hospitals: cross-national adaptation and psychometric evaluation (Junya Zhu, Liping Li, Hailei Zhao, Guangshu Han, Albert W Wu, Saul N Weingart) • In the spotlight: healthcare inspections as an opportunity for **trainee clinicians to be the leaders of today** (Parashar Pravin Ramanuj, Howard Ryland, Edward W Mitchell, Nassim Parvizi, Krishna Chinthapalli) • 'Between the flags': **implementing a rapid response system** at scale (Clifford Hughes, Charles Pain, Jeffrey Braithwaite, Kenneth Hillman) • **Burnout** in the NICU setting and its relation to **safety culture** (Jochen Profit, Paul J Sharek, Amber B Amspoker, Mark A Kowalkowski, Courtney C Nisbet, Eric J Thomas, Whitney A Chadwick, J Bryan Sexton) • The effect of the electronic transmission of prescriptions on **dispensing errors and prescription enhancements** made in English community pharmacies: a naturalistic stepped wedge study (Bryony Dean Franklin, Matthew Reynolds, Stacey Sadler, Ralph Hibberd, Anthony J Avery, Sarah J Armstrong, Rajnikant Mehta, Matthew J Boyd, Nick Barber) • **Adverse drug events** and **medication errors** in Japanese paediatric inpatients: a retrospective cohort study (Mio Sakuma, Hiroyuki Ida, Tsukasa Nakamura, Yoshinori Ohta, Kaori Yamamoto, Susumu Seki, Kayoko Hiroi, Kiyoshi Kikuchi, K Nakayama, D W Bates, T Morimoto)

	• The frequency of **diagnostic errors in outpatient care**: estimations from three large observational studies involving US adult populations (Hardeep Singh, Ashley N D Meyer, Eric J Thomas) • **Tweets about hospital quality**: a mixed methods study (Felix Greaves, A A Laverty, D Ramirez Cano, K Moilanen, S Pulman, A Darzi, C Millett) • The use of **report cards** and **outcome measurements** to improve the **safety of surgical care**: the American College of Surgeons National Surgical Quality Improvement Program (Melinda Maggard-Gibbons) • **Safety measurement and monitoring in healthcare**: a framework to guide clinical teams and healthcare organisations in maintaining safety (Charles Vincent, Susan Burnett, Jane Carthey) • Clinician perspectives on considering **radiation exposure** to patients when ordering imaging tests: a qualitative study (Jenna F Kruger, Alice Hm Chen, Alex Rybkin, Kiren Leeds, Dominick L Frosch, L Elizabeth Goldman)
URL	http://qualitysafety.bmj.com/content/early/recent

International Journal for Quality in Health Care online first articles

Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • **Patient care transitions** from the emergency department to the medicine ward: evaluation of a standardized electronic signout tool (Jed D Gonzalo, Julius J Yang, H L Stuckey, C M Fischer, L D Sanchez, and S J Herzig) • Does **public reporting** improve the quality of hospital care for acute myocardial infarction? Results from a regional outcome evaluation program in Italy (Cristina Renzi, Federica Asta, Danilo Fusco, Nera Agabiti, Marina Davoli, and Carlo Alberto Perucci) • **PACIC Instrument**: disentangling dimensions using published validation models (K. Iglesias, B. Burnand, and I. Peytremann-Bridevaux) • Derivation and validation of a formula to estimate **risk for 30-day readmission** in medical patients (Mohammad Taha, Aroop Pal, Jonathan D. Mahnken, and Sally K. Rigler) • Does **regulating private long-term care facilities** lead to better care? A study from Quebec, Canada (Gina Bravo, Marie-France Dubois, Louis Demers, Nicole Dubuc, D Blanchette, K Painter, C Lestage, and C Corbin) • **Health service accreditation** reinforces a mindset of high-performance human resource management: lessons from an Australian study (D Greenfield, A Kellner, K Townsend, A Wilkinson, and S A Lawrence) • Assessing the role of regulatory bodies in managing **health professional issues and errors** in Europe (Isabelle Risso-Gill, H Legido-Quigley, D Panteli, and M Mckee) • Involving patients in detecting quality gaps in a fragmented healthcare system: development of a questionnaire for **Patients' Experiences Across Health Care Sectors** (PEACS) (Stefan Noest, Sabine Ludt, Anja Klingenberg, Katharina Glassen, Friederike Heiss, Dominik Ose, Justine Rochon, Kayvan Bozorgmehr, Michel Wensing, and Joachim Szecsenyi) • Feasibility and evaluation of a pilot **community health worker intervention** to **reduce hospital readmissions** (Marguerite E. Burns, Alison A. Galbraith, Dennis Ross-Degnan, and Richard B. Balaban)
DOI	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

Evidently Cochrane
http://www.evidentlycochrane.net/
Evidently Cochrane is a site that aims to make Cochrane evidence really accessible, and to encourage discussion about it, through weekly blogs, which usually feature new or updated Cochrane reviews on a health topic. It is designed for everyone who is interested in finding and using the best quality evidence to inform decisions about health, including

- patients and carers
- people looking for evidence to help them make healthy lifestyle choices
- healthcare professionals, commissioners and policy-makers
- health researchers
- people interested in social media for sharing evidence.

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