



On the Radar

Issue 174
19 May 2014

On the Radar is a summary of some of the recent publications in the areas of safety and quality in health care. Inclusion in this document is not an endorsement or recommendation of any publication or provider.

Access to particular documents may depend on whether they are Open Access or not, and/or your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

On the Radar is available online, via email or as a PDF document from <http://www.safetyandquality.gov.au/publications-resources/on-the-radar/>

If you would like to receive *On the Radar* via email, you can subscribe on our website <http://www.safetyandquality.gov.au/> or by emailing us at mail@safetyandquality.gov.au. You can also send feedback and comments to mail@safetyandquality.gov.au.

For information about the Commission and its programs and publications, please visit <http://www.safetyandquality.gov.au>
You can also follow us on Twitter @ACSQHC.

On the Radar

Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

Draft Clinical Care Standard for Stroke

Consultation closes 23 May 2014

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

OECD Health Care Quality Indicators for Australia 2011–12

Australian Institute for Health and Welfare

Canberra: AIHW, 2014.

URL	http://www.aihw.gov.au/publication-detail/?id=60129547042
Notes	The AIHW has published this report on the information provided to the OECD Health Care Quality Indicators. The report also compares the 2011–12 data to previous years, and to data reported by other OECD countries in the OECD's <i>Health at a glance 2013: OECD indicators</i> report.

Journal articles

Ten clinician-driven strategies for maximising value of Australian health care

Scott I

Australian Health Review 2014;38(2):125-133.

DOI	http://dx.doi.org/10.1071/AH13248
Notes	<p>In this paper an Australian clinician has identified ten strategies that clinicians should adopt or lead in order to improve the value of care.</p> <p>It is important to remember that value is not simply a cost issue. Scott argues that a “fundamental shift of medical practice to maximising high-value care” is necessary and that clinicians must “show leadership and critically appraise the value of current practice and take concerted action... towards minimising inappropriate and costly (i.e. low-value) care and maximising highly appropriate, less expensive (i.e. high-value) care”</p> <p>The ten (interdependent) strategies include:</p> <ol style="list-style-type: none"> (1) minimise errors in diagnosis; (2) discontinue low- or no-value practices that provide little benefit or cause harm; (3) defer the use of unproven interventions; (4) select care options according to comparative cost-effectiveness; (5) target clinical interventions to those who derive greatest benefit; (6) adopt a more conservative approach nearing the end of life; (7) actively involve patients in shared decision making and self-management; (8) minimise day-to-day operational waste; (9) convert healthcare institutions into rapidly learning organisations; and (10) advocate for integrated patient care across all clinical settings

Interventions to improve safe and effective medicines use by consumers: an overview of systematic reviews

Ryan R, Santesso N, Lowe D, Hill S, Grimshaw J, Prictor M, et al.

Cochrane Database Syst Rev 2014;4:CD007768.

DOI	http://dx.doi.org/10.1002/14651858.CD007768.pub3
Notes	<p>This is an update of a 2011 overview of systematic reviews on the effectiveness of interventions to improve consumers' medicines use. Researchers in the Cochrane Collaboration reviewed the evidence from systematic reviews about the effects of interventions to improve safe and effective medicines use by consumers, irrespective of disease, medicine type, population or setting. This overview summarised the evidence from 75 systematic reviews on consumers' medicine use published to March 2012.</p> <p>The results suggest that there are many different potential pathways through which consumers' use of medicines could be targeted to improve outcomes. However, no single strategy improved all medicines-use outcomes across all diseases, populations or settings.</p> <p>Strategies that appear to improve medicines use include medicines self-monitoring and self-management programmes, while simplified dosing regimens and directly involving pharmacists in medicines management (eg medicines reviews) appear promising. Other strategies, such as delayed antibiotic prescriptions; practical management tools (eg reminders, packaging); education or information combined with other strategies (eg self-management skills training, counselling); and financial incentives, may also have some positive effects, but their effects are less consistent.</p>

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

Preventing health care–associated harm in children

Walsh KE, Bundy DG, Landrigan CP

Journal of the American Medical Association 2014;311(17):1731-1732.

DOI	http://dx.doi.org/10.1001/jama.2014.2038
Notes	Short (2-page) piece in <i>JAMA</i> drawing attention to how common iatrogenic harm is, particularly to children in this instance (15–35% of hospitalised children) and also the different nature of the risks to children (such as the complexity of weight-based medication dosing, a lack of medication solutions made in concentrations for children, etc.). The authors go on to argue that the development and implementation of standard safety measures, research about multisite interventions, and collaboration between research and operations in hospitals are needed to enhance safety in paediatric care.

Harnessing implementation science to improve care quality and patient safety: a systematic review of targeted literature

Braithwaite J, Marks D, Taylor N

International Journal for Quality in Health Care 2014 [epub].

DOI	http://dx.doi.org/10.1093/intqhc/mzu047
Notes	This review of a select literature focused on implementing for safety and quality improvements. The reviewers identified eight common elements in the final 57 selected journal articles. These ‘ success factors ’ were: “ preparing for change , capacity for implementation— people , capacity for implementation— setting, types of implementation, resources, leverage , desirable implementation enabling features , and sustainability .”

Australian Health Review

Vol. 38, No. 2, 2014

URL	http://www.publish.csiro.au/nid/270/issue/7053.htm
Notes	The latest issue of <i>Australian Health Review</i> has been published. Articles in this issue include: <ul style="list-style-type: none"> • The future of Medicare: what's in store? (Anne-Marie Boxall) • Ten clinician-driven strategies for maximising value of Australian health care (Ian Scott) • Analysing risk factors for poorer breast cancer outcomes in residents of lower socioeconomic areas of Australia (David Roder, Helen M Zorbas, J Kollias, C M Pyke, D Walters, I D Campbell, C Taylor and F Webster) • Challenges to pharmaceutical policymaking: lessons from Australia’s national medicines policy (W Lipworth, E Doran, I Kerridge and R Day) • Medical emergency response in a sub-acute hospital: improving the model of care for deteriorating patients (Philip Visser, Alison Dwyer, Juli Moran, Mary Britton, Melodie Heland, Filomena Ciavarella, Sandy Schutte and Daryl Jones) • First impressions: towards becoming a health-literate health service (Anne Johnson)

	<ul style="list-style-type: none"> • Mental health service delivery: a profile of mental health non-government organisations in south-east Queensland, Australia (Louise Byrne, Michael Wilson, Karena J Burke, Cadeyrn J Gaskin and Brenda Happell) • Applications of the balanced scorecard for strategic management and performance measurement in the health sector (Farshad Behrouzi, Awaluddin Mohamed Shaharoun and Azanizawati Ma'aram) • Documentation of limitation of medical therapy at the time of a rapid response team call (K Sundararajan, A Flabouris, Alexander Keeshan and Tracey Cramey) • Dying in two acute hospitals: would usual care meet Australian national clinical standards? (Katherine Clark, Naomi Byfieldt, Malcolm Green, Peter Saul, Jill Lack and Jane L Philips) • Clinical networks influencing policy and practice: the establishment of advanced practice pharmacist roles for specialist palliative care services in South Australia (Kate Swetenham, Debra Rowett and David Stephenson)
--	--

BMJ Quality and Safety

June 2014, Vol 23, Issue 6

URL	http://qualitysafety.bmj.com/content/23/6
Notes	<p>A new issue of <i>BMJ Quality and Safety</i> has been published. Many of the papers in this issue have been referred to in previous editions of <i>On the Radar</i> (when they were released online). Articles in this issue of <i>BMJ Quality and Safety</i> include:</p> <ul style="list-style-type: none"> • Editorial: Using balanced metrics and mixed methods to better understand QI interventions (Peter J Kaboli, Hilary J Mosher) • Early warnings, weak signals and learning from healthcare disasters (Carl Macrae) • Safely and effectively reducing inpatient length of stay: a controlled study of the General Internal Medicine Care Transformation Initiative (Finlay A McAlister, Jeffrey A Bakal, Sumit R Majumdar, Stafford Dean, Rajdeep S Padwal, Narmin Kassam, Maria Bacchus, Ann Colbourne) • Using data and quality monitoring to enhance maternity outcomes: a qualitative study of risk managers' perspectives (Rebecca A Simms, Andrew Yelland, Helen Ping, Antonia J Beringer, Timothy J Draycott, Robert Fox) • Creating a safe, reliable hospital at night handover: a case study in implementation science (Annette McQuillan, Jane Carthey, Ken Catchpole, Peter McCulloch, Deborah A Ridout, Allan P Goldman) • Governance of quality of care: a qualitative study of health service boards in Victoria, Australia (Marie M Bismark, David M Studdert) • Interactive questioning in critical care during handovers: a transcript analysis of communication behaviours by physicians, nurses and nurse practitioners (Michael F Rayo, Austin F Mount-Campbell, James M O'Brien, Susan E White, Alexandra Butz, Kris Evans, Emily S Patterson) • Caring for critically ill children in the community: a needs assessment (Jonathan Gilleland, Jennifer McGugan, Sandy Brooks, Maureen Dobbins, Jenny Ploeg) • Oral antibiotics at discharge for children with acute osteomyelitis: a rapid cycle improvement project (Patrick W Brady, William B Brinkman, Jeffrey M Simmons, Connie Yau, Christine M White, Eric S Kirkendall, Joshua K Schaffzin, Patrick H Conway, Michael T Vossmeier)

	<ul style="list-style-type: none"> • The experiences of professionals with using information from patient-reported outcome measures to improve the quality of healthcare: a systematic review of qualitative research (Maria B Boyce, John P Browne, Joanne Greenhalgh) • How can the criminal law support the provision of quality in healthcare? (Karen Yeung, Jeremy Horder)
--	--

American Journal of Medical Quality
Vol. 29(3) May/June 2014

URL	http://ajm.sagepub.com/content/29/3?etoc
Notes	<p>A new issue of the <i>American Journal of Medical Quality</i> has been published. Articles in this issue include:</p> <ul style="list-style-type: none"> • The Human Factors Analysis Classification System (HFACS) Applied to Health Care (Thomas Diller, George Helmrich, Sharon Dunning, Stephanie Cox, April Buchanan, and Scott Shappell) • Standardizing Central Line Safety: Lessons Learned for Physician Leaders (Jeff T Mueller, Alan J Wright, Leslie A Fedraw, M Hassan Murad, Daniel R Brown, K M Thompson, R Flick, M T A Seville, and W C Huskins) • Decreasing Avoidable Hospital Admissions With the Implementation of an Emergency Department Case Management Program (Ghazala Q. Sharieff, Matt Cantonis, M Tressler, M Whitehead, J Russe, and E Lovell) • Association Between Outpatient Visits Following Hospital Discharge and Readmissions Among Medicare Beneficiaries With Atrial Fibrillation and Other Chronic Conditions (Mai Hubbard, Sloane Frost, Kimberly Siu, Nicole Quon, and Dominick Esposito) • Using AHRQ Patient Safety Indicators to Detect Postdischarge Adverse Events in the Veterans Health Administration (Hillary J Mull, Ann M Borzecki, Qi Chen, Marlena H Shin, and Amy K Rosen) • Preventability of 30-Day Readmissions for Heart Failure Patients Before and After a Quality Improvement Initiative (Jason Ryan, Rebecca Andrews, Mary Beth Barry, Sangwook Kang, A Iskandar, P Mehla, and R Ganeshan) • Which Outpatient Wait-Time Measures Are Related to Patient Satisfaction? (Julia C Prentice, Michael L Davies, and Steven D Pizer) • Improving Medication Administration Safety in Solid Organ Transplant Patients Through Barcode-Assisted Medication Administration (Josesph Bonkowski, Robert J Weber, Joseph Melucci, Todd Pesavento, Mitchell Henry, and Susan Moffatt-Bruce) • The Development of a Validated Checklist for Radial Arterial Line Placement: Preliminary Results (Katherine Berg, Lee Ann Riesenberg, Dale Berg, Arielle Schaeffer, J Davis, E M Justice, G Tinkoff, and E Jasper) • Agreement and Disagreement on Health Care Quality Concepts Among Academic Health Professionals: The Saudi Case (Mohamed Saad Mahrous) • Teaching for Quality: Where Do We Go From Here? (Robert B Baron, Nancy L Davis, David A Davis, and Linda A Headrick) • “Nurses, Docs, and Drugs”: Interprofessional Facilitation to Implement Opioid Risk Mitigation Within the Patient-Centered Medical Home (Michael Saenger, Ingrid Duva, and Corrine Abraham) • Assessing the Effects of Executive WalkRounds on Safety Climate Attitudes in the OR Setting at a Tertiary Hospital (Michael E Chua and Saturnino L Luna, Jr)

	<ul style="list-style-type: none"> • The Differences Between Doctors’ and Nurses’ Attitudes Toward Adverse Event Reporting and Assessments of Factors That Inhibit Reporting (Qin Shu, Hong-bing Tao, John Fu, Ru-ning Zhang, Jun Zhou, and Zhao-hui Cheng)
--	---

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Exposure to Leadership WalkRounds in neonatal intensive care units is associated with a better patient safety culture and less caregiver burnout (J Bryan Sexton, Paul J Sharek, Eric J Thomas, Jeffrey B Gould, C C Nisbet, A B Amspoker, M A Kowalkowski, R Schwendimann, J Profit)

International Journal for Quality in Health Care online first articles

DOI	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
Notes	<p><i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Failure mode and effects analysis applied to the maintenance and repair of anesthetic equipment in an austere medical environment (Michael A Rosen, Benjamin H Lee, John B Sampson, Rahul Koka, Adaora M Chima, O U Ogbuagu, M K Marx, T B Kamara, M Koroma, and E V Jackson, Jr) • Does stewardship make a difference in the quality of care? Evidence from clinics and pharmacies in Kenya and Ghana (Connor P Spreng, Ifelayo P Ojo, Nicholas E Burger, Neeraj Sood, J W Peabody, and L M Demaria)

Disclaimer

On the Radar is an information resource of the Australian Commission on Safety and Quality in Health Care. The Commission is not responsible for the content of, nor does it endorse, any articles or sites listed. The Commission accepts no liability for the information or advice provided by these external links. Links are provided on the basis that users make their own decisions about the accuracy, currency and reliability of the information contained therein. Any opinions expressed are not necessarily those of the Australian Commission on Safety and Quality in Health Care.