



On the Radar

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On the Radar

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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 rconsultation@safetyandquality.gov.au.

Reports

Supporting people to manage their health: An introduction to patient activation

Hibbard J, Gilbert H

London: The King's Fund, 2014.

URL	http://www.kingsfund.org.uk/publications/supporting-people-manage-their-health
TRIM	D14-17788
Notes	<p>The role – and importance – of patients in their care has been garnering greater attention in recent years. This report provides a way of conceptualisation and means measuring patient engagement or 'patient activation'. The report describes the robust patient-reported measure (PAM) used to gauge patient activation. PAM measures an individual's knowledge, skill, and confidence for self-management. The report discusses how interventions can increase patients' levels of activation, with associated health benefits and explores how this is being achieved in practice and offers recommendations for extending use of the PAM.</p> <p>Among the finding discussed are:</p> <ul style="list-style-type: none"> • Patient activation is a better predictor of health outcomes than known socio-demographic factors such as ethnicity and age. • People who are more activated are significantly more likely to attend screenings, check-ups and immunisations, to adopt positive behaviours, and have clinical indicators in the normal range. • Patients who are less activated are significantly less likely to prepare questions for a medical visit, know about treatment guidelines or be persistent in clarifying advice. • Patient activation scores and cost correlations show less-activated patients have costs approximately 8 per cent higher than more-activated patients in the baseline year, and 21 per cent higher in the subsequent year. • Studies of interventions to improve activation show that patients who start with the lowest activation scores tend to increase their scores the most, suggesting that effective interventions can help engage even the most disengaged.

Developing collective leadership for health care

West M, Eckert R, Steward K, Pasmore B

London: The King's Fund, 2014.

URL	http://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care
TRIM	D14-18326
Notes	<p>Leadership is something that is not the sole preserve of senior management. In this King's Fund report the authors argue that collective leadership provides “the optimum basis for caring cultures. Collective leadership entails distributing and allocating leadership power to wherever expertise, capability and motivation sit within organisations.”</p> <p>This paper explains the interaction between collective leadership and cultures that value compassionate care, by drawing on wider literature and case studies of good organisational practice. It outlines the main characteristics of a collective leadership strategy and the process for developing this.</p> <p>The report's key messages include:</p> <ul style="list-style-type: none">• Collective leadership means everyone taking responsibility for the success of the organisation as a whole – not just for their own jobs or area. This contrasts with traditional approaches focused on developing individual capability.• If leaders and managers create positive, supportive environments for staff, those staff then create caring, supportive environments for patients, delivering higher quality care.• Where there is a culture of collective leadership, all staff members are likely to intervene to solve problems, to ensure quality of care and to promote responsible, safe innovation.• Organisational performance does not rest simply on the number or quality of individual leaders. Research shows that where relationships between leaders are well developed, organisations will benefit from direction, alignment and commitment.• Vision and mission statements must be translated into clear, aligned, agreed and challenging objectives at all levels of the organisation, from the board to frontline teams and individuals.

Placing Diagnosis Errors on the Policy Agenda

Berenson RA, Upadhyay DK, Kaye DR

Washington D. C. Urban Institute, 2014.

URL	http://www.urban.org/publications/413104.html
TRIM	D14-18280
Notes	<p>One of the issues that has become more prominent in recent years is that diagnostic error, with estimates that suggest 5–15% of health care encounters involve an error in diagnosis. The (US) Urban Institute and the Robert Wood Johnson Foundation have published this brief that explores the different reasons for diagnosis errors, the challenges of measuring them, and fruitful approaches to reducing their prevalence and harm to patients. A number of strategies for better identification of such errors are discussed, including patient and provider surveys, case review, voluntary reporting, claims review, audits, and trigger tools in electronic medical records. The report also suggests that increased research funding, greater government oversight, formal diagnostic feedback mechanisms, and payment and medical education reform are all necessary.</p>

Journal articles

Measuring Quality at a System Level: An Impossible Task? The Toronto Central LHIN Experience
Solomon R, Damba C, Bryant S
Healthcare Quarterly 2013;16(4):36-42.

DOI	http://dx.doi.org/10.12927/hcq.2014.23654
TRIM	D14-18271
Notes	<p>This article describes how one Canadian health organisation (Toronto Central Local Health Integration Network) approached the challenge of measuring health quality at a system level. The authors set out to describe “a highly consultative and iterative process used to measure quality across the continuum of care, and the challenges experienced in approaching this type of measurement, and they highlight some of the early findings.”</p> <p>For this organisation three themes emerged as being critical to quality at a system level, these being:</p> <ol style="list-style-type: none"> 1. Appropriate access to care 2. Transitions of care, focusing on patient experience 3. Care for patients with complex needs. <p>Eventually, six ‘big dot’ indicators (and subsequently further ‘small dot’ indicators) were selected to match the themes.</p> <p>The challenges that emerged or were identified raise some of the more interesting elements in this paper. They can also be seen to reinforce the need to be cognizant of the context or setting. Conducting a similar process in another health organisation – or at a different point in time – is likely to produce a varying set of themes, relevant indicators and challenges. Among the lessons the authors identify were the importance of patient-relevant indicators, the need for a flexible and iterative process and indicators as a starting point rather than an endpoint through a shared communication and improvement process.</p>

Power imbalance prevents shared decision making
Joseph-Williams N, Edwards A, Elwyn G.
BMJ 2014;348.

DOI	http://dx.doi.org/10.1136/bmj.g3178
Notes	<p>This article presents the findings of a systematic review which identified that many patients feel that they cannot participate in shared decision making, rather than not wanting to as some clinicians may believe.</p> <p>Attitudinal barriers to participation and power imbalance in the clinical encounter are identified as hindering progress in implementing shared decision making.</p> <p>Two important barriers to patient participation are:</p> <ul style="list-style-type: none"> • patients’ undervaluing their ability to understand the information given to them, which can lead to decision deferral to the expert; and • the adoption of the role of the ‘good patient’, characterised by passivity and compliance, which is often due to fear of being labelled as ‘difficult’ and receiving lower quality of care. <p>Patients’ capacity to participate, appears to be linked not only to how much knowledge they have but also their perceived ability to use their knowledge and influence in the decision making encounter.</p> <p>The authors suggest that achieving shared decision making in routine practice requires intervention targeted at both clinicians and patients. As the shared</p>

	<p>decision making encounter may be considerably different from the appointments that many patients are used to, patients need to believe that they can and should be involved. The paper also suggests that clinicians and organisations need to make efforts to understand patients' preferences and promote interventions which make patients feel that they have permission to participate in decision making.</p> <p>Interventions delivered in two stages are promoted:</p> <ul style="list-style-type: none"> • Preparation – this involves providing patients with information prior to the consultation to promote and support their informed decision to participate • Enablement – which may include decision support tools to assist the patient to participate in shared decision making.
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An observational study: associations between nurse-reported hospital characteristics and estimated 30-day survival probabilities

Tvedt C, Sjetne IS, Helgeland J, Bukholm G

BMJ Quality & Safety 2014 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2013-002781
Notes	This paper reporting on a Norwegian observational study involving 30 hospitals (all with more than 85 beds) found that nurses' perceptions of adequate staffing and quality in inpatient settings were associated with improved 30-day mortality rates. The authors report that the “Survival probabilities were correlated with nurse-assessed quality of nursing. Furthermore, the subjective perception of staffing adequacy was correlated with overall survival.”

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"> • Differences in case-mix can influence the comparison of standardised mortality ratios even with optimal risk adjustment: an analysis of data from paediatric intensive care (Bradley N Manktelow, T Alun Evans, Elizabeth S Draper)

Online resources

[USA] Carbapenem-Resistant Enterobacteriaceae (CRE) Control and Prevention Toolkit

<http://www.ahrq.gov/cretoolkit>

The (US) Agency for Healthcare Research and Quality (AHRQ) has released has a toolkit to help hospitals control and prevent *Klebsiella pneumoniae* carbapenemase (KPC), a highly dangerous, antibiotic-resistant pathogen.

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