



On the Radar

Issue 179
23 June 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.

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On the Radar

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

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.

Consultation on Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study

Consultation now open

The Australian results of an Organisation for Economic Co-operation and Development (OECD) study on healthcare variation were published in the *Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study* discussion paper authored by the Australian Commission on Safety and Quality in Health Care (the Commission) and the Australian Institute of Health and Welfare. The paper is available at <http://www.safetyandquality.gov.au/publications/exploring-healthcare-variation-in-australia/>

The paper examines variation in the rates of several common procedures, selected by the OECD, including: knee surgery (knee arthroscopy and knee replacement); cardiac procedures (cardiac catheterisation, percutaneous coronary interventions and coronary artery bypass grafting; caesarean section; and hysterectomy. The procedures measured were undertaken in hospitals and day procedure centres, both public and private, during 2010-11. Variation was measured according to the Medicare Local area where patients lived, but the approach can be applied to any desired geographic scale.


































The Commission is inviting comment and feedback on the paper. Consultation is open until 20 July 2014. Details about how to make a submission are included in the paper.

The contact person for this consultation is Mr Luke Slawomirski, Program Manager, Implementation Support. Mr Slawomirski can be contacted on (02) 9126 3600 or via email at medicalpracticevariation@safetyandquality.gov.au

Reports

Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally

Davis K, Stremikis K, Squires D, Schoen C
New York. Commonwealth Fund, 2014:32.

URL	http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror																																																																																																																																																																																				
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Notes	<p>Once more the (US) Commonwealth Fund’s annual report on the health systems of 11 nations reveals that the USA pays the most for its health system but that system underperforms relative to the other nations studied (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom).</p> <p>The report incorporates patients’ and physicians’ survey results on care experiences and ratings on various dimensions of care. It includes information from the three most recent Commonwealth Fund international surveys of patients and primary care physicians about medical practices and views of their countries’ health systems (2011–2013). It also includes information on health care outcomes featured in The Commonwealth Fund’s most recent (2011) national health system scorecard, and from the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD).</p> <p>Across the various measures and rankings used Australia tends to rate in the middle while having one of the lowest levels of expenditure of the 11 nations, but less positively having some issues of access and out-of-pocket costs. Overall Australia is ranked fourth, while ranking second for quality.</p> <p style="text-align: center;">EXHIBIT ES-1. OVERALL RANKING</p> <div style="display: flex; align-items: flex-start;"> <div style="margin-right: 20px;"> <p>COUNTRY RANKINGS</p> <ul style="list-style-type: none"> Top 2* Middle Bottom 2* </div> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> <tr> <th></th> <th>AUS</th> <th>CAN</th> <th>FRA</th> <th>GER</th> <th>NETH</th> <th>NZ</th> <th>NOR</th> <th>SWE</th> <th>SWIZ</th> <th>UK</th> <th>US</th> </tr> </thead> <tbody> <tr> <td>OVERALL RANKING (2013)</td> <td>4</td> <td>10</td> <td>9</td> <td>5</td> <td>5</td> <td>7</td> <td>7</td> <td>3</td> <td>2</td> <td>1</td> <td>11</td> </tr> <tr> <td>Quality Care</td> <td>2</td> <td>9</td> <td>8</td> <td>7</td> <td>5</td> <td>4</td> <td>11</td> <td>10</td> <td>3</td> <td>1</td> <td>5</td> </tr> <tr> <td> Effective Care</td> <td>4</td> <td>7</td> <td>9</td> <td>6</td> <td>5</td> <td>2</td> <td>11</td> <td>10</td> <td>8</td> <td>1</td> <td>3</td> </tr> <tr> <td> Safe Care</td> <td>3</td> <td>10</td> <td>2</td> <td>6</td> <td>7</td> <td>9</td> <td>11</td> <td>5</td> <td>4</td> <td>1</td> <td>7</td> </tr> <tr> <td> Coordinated Care</td> <td>4</td> <td>8</td> <td>9</td> <td>10</td> <td>5</td> <td>2</td> <td>7</td> <td>11</td> <td>3</td> <td>1</td> <td>6</td> </tr> <tr> <td> Patient-Centered Care</td> <td>5</td> <td>8</td> <td>10</td> <td>7</td> <td>3</td> <td>6</td> <td>11</td> <td>9</td> <td>2</td> <td>1</td> <td>4</td> </tr> <tr> <td>Access</td> <td>8</td> <td>9</td> <td>11</td> <td>2</td> <td>4</td> <td>7</td> <td>6</td> <td>4</td> <td>2</td> <td>1</td> <td>9</td> </tr> <tr> <td> Cost-Related Problem</td> <td>9</td> <td>5</td> <td>10</td> <td>4</td> <td>8</td> <td>6</td> <td>3</td> <td>1</td> <td>7</td> <td>1</td> <td>11</td> </tr> <tr> <td> Timeliness of Care</td> <td>6</td> <td>11</td> <td>10</td> <td>4</td> <td>2</td> <td>7</td> <td>8</td> <td>9</td> <td>1</td> <td>3</td> <td>5</td> </tr> <tr> <td>Efficiency</td> <td>4</td> <td>10</td> <td>8</td> <td>9</td> <td>7</td> <td>3</td> <td>4</td> <td>2</td> <td>6</td> <td>1</td> <td>11</td> </tr> <tr> <td>Equity</td> <td>5</td> <td>9</td> <td>7</td> <td>4</td> <td>8</td> <td>10</td> <td>6</td> <td>1</td> <td>2</td> <td>2</td> <td>11</td> </tr> <tr> <td>Healthy Lives</td> <td>4</td> <td>8</td> <td>1</td> <td>7</td> <td>5</td> <td>9</td> <td>6</td> <td>2</td> <td>3</td> <td>10</td> <td>11</td> </tr> <tr> <td>Health Expenditures/Capita, 2011**</td> <td>\$3,800</td> <td>\$4,522</td> <td>\$4,118</td> <td>\$4,495</td> <td>\$5,099</td> <td>\$3,182</td> <td>\$5,669</td> <td>\$3,925</td> <td>\$5,643</td> <td>\$3,405</td> <td>\$8,508</td> </tr> </tbody> </table> </div> <p style="font-size: small; margin-top: 10px;">Notes: * Includes ties. ** Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010. Sources: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).</p>														AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11	Quality Care	2	9	8	7	5	4	11	10	3	1	5	Effective Care	4	7	9	6	5	2	11	10	8	1	3	Safe Care	3	10	2	6	7	9	11	5	4	1	7	Coordinated Care	4	8	9	10	5	2	7	11	3	1	6	Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4	Access	8	9	11	2	4	7	6	4	2	1	9	Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11	Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5	Efficiency	4	10	8	9	7	3	4	2	6	1	11	Equity	5	9	7	4	8	10	6	1	2	2	11	Healthy Lives	4	8	1	7	5	9	6	2	3	10	11	Health Expenditures/Capita, 2011**	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508
																																																																																																																																																																																					
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Journal articles

A framework for overcoming disparities in management of acute coronary syndromes in the Australian Aboriginal and Torres Strait Islander population. A consensus statement from the National Heart Foundation of Australia

Ilton MK, Walsh WF, Brown AD, Tideman PA, Zeitz CJ, Wilson J.

Med J Aust 2014;200(11):639-643.

DOI	http://dx.doi.org/10.5694/mja12.11175
Notes	As well as a higher rate of death from coronary heart disease, Aboriginal and Torres Strait Islander peoples have 40% lower rates of coronary angiography and percutaneous coronary intervention (PCI or ‘stenting’) than other Australians. This consensus statement clearly describes a best practice framework and pathways of care for overcoming these disparities, which exist in both urban and non-urban communities, and points out some of the particular barriers for this population. The Consensus statement dovetails with the Commission’s draft Clinical Care Standard for Acute Coronary Syndromes , which identifies the key aspects of care that all Australians should expect to receive, and is consistent with the published consensus statement. The value of a Clinical Care Standard depends on its clear description of quality care which can be measured – in turn allowing variation to be identified. Understanding the systemic, cultural and other population specific factors that contribute to that variation is vital for quality improvement efforts.

For information on the Commission’s work on clinical care standards, including the draft *Clinical Care Standard for Acute Coronary Syndromes*, see <http://www.safetyandquality.gov.au/our-work/clinical-care-standards/>

Aboriginal community controlled health services: leading the way in primary care

Panaretto KS, Wenitong M, Button S, Ring IT

Med J Aust 2014;200(11):649-652.

DOI	http://dx.doi.org/10.5694/mja13.00005
Notes	This article on the effectiveness of Aboriginal community controlled health services (ACCHS) illustrates the benefits of a health delivery model based on community preferences. While developed specifically for the Aboriginal community, the authors point out that there are commonalities with the patient-centred medical home, now of interest in mainstream health care. These include “Care: is patient-focused; may encompass the family; has significant physician input; is integrated with allied health specialists, mental health professionals and community services, preferably delivered in the home; and is underpinned by participation in clinical quality-improvement programs.” Achievements of the ACCHSs are described, including significant more patients at high cardiovascular risk who are taking preventive medicines, compared to general practice.

Developing a good practice model to evaluate the effectiveness of comprehensive primary health care in local communities

Lawless A, Freeman T, Bentley M, Baum F, Jolley G

BMC Family Practice 2014;15(1):99.

DOI	http://dx.doi.org/10.1186/1471-2296-15-99
Notes	This paper describes how a model of Comprehensive Primary Health Care (CPHC), particularly for the Australian context, was developed in a partnership involving six Australian primary health care services. The authors argue that this model offers

	“a framework for evaluation that allows the tracking of progress towards desired outcomes and exploration of the particular aspects of context and mechanisms that produce outcomes.”
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What Are the Key Ingredients for Effective Public Involvement in Health Care Improvement and Policy Decisions? A Randomized Trial Process Evaluation

Boivin A, Lehoux P, Burgers J, Grol R

Milbank Quarterly 2014;92(2):319-350.

DOI	http://dx.doi.org/10.1111/1468-0009.12060
Notes	<p>This Canadian study explores some of the key factors affecting how non-clinicians can work productively with professionals and influence collective health care choices. The authors report that “Legitimacy, credibility, and power explain the variations in the public members’ influence”. The go on to explain that for these factors:</p> <p>“Credibility was supported by their personal experience as patients and caregivers, the provision of a structured preparation meeting, and access to population-based data from their community.</p> <p>Legitimacy was fostered by the recruitment of a balanced group of participants and by the public members’ opportunities to draw from one another’s experience.</p> <p>The combination of small-group deliberations, wider public consultation, and a moderation style focused on effective group process helped level out the power differences between professionals and the public.</p> <p>The engagement of key stakeholders in the intervention design and implementation helped build policy support for public involvement.”</p>

For information on the Commission’s work on patient and consumer centred care, see

<http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/>

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"> • Identifying patient safety problems during team rounds: an ethnographic study (A Reema Lamba, Kelly Linn, Kathlyn E Fletcher) • Editorial: The need for independent evaluations of government-led health information technology initiatives (Aziz Sheikh, Rifat Atun, D W Bates) • User-generated quality standards for youth mental health in primary care: a participatory research design using mixed methods (Tanya Graham, Diana Rose, Joanna Murray, Mark Ashworth, André Tylee)

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"> • Towards a measurement instrument for determinants of innovations (Margot A.H. Fleuren, Theo G.W.M. Paulussen, Paula Van Dommelen, and Stef Van Buuren)

Online resources

Minimum Standards for the Management of Hip Fracture in the Older Person

<http://www.eih.health.nsw.gov.au/initiatives/minimum-standards-for-the-management-of-hip-fracture-in-the-older-person>

The New South Wales Agency for Clinical Innovation (ACI) has developed the Minimum Standards for the management of hip fractures to assist hospitals to identify key components of best-practice management to support optimal patient care across NSW. The standards are intended to improve outcomes for patients with hip fractures requiring surgery and management in NSW. Seven Standards have been identified:

1. Orthogeriatric clinical management of each patient
2. Optimal pain management
3. Surgery within 48 hours and in daytime hours (regardless of inter-hospital transfers)
4. Surgery is not cancelled
5. Commencement of mobilisation within 24 hours of surgery
6. Refracture prevention
7. Local ownership of data systems/processes to drive improvements in care.

[UK] Evidence for Person Centred Care

<http://www.nationalvoices.org.uk/evidence>

The UK Charity National Voices has released a series of booklets intended to make it easy to access, understand and make use of the best evidence for various approaches to involving people in their health and healthcare. The materials are focused on the following five areas:

- supporting self-management
- supporting shared decision-making
- enhancing experience of healthcare
- improving information and understanding, and
- promoting prevention.

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