AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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Four years of On the Radar

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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
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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

Spreading improvement ideas: Tips from empirical research. Evidence Scan, No 20
de Silva D
London: The Health Foundation; 2014.

URL	http://www.health.org.uk/publications/spreading-improvement-ideas/
Notes	The Health Foundation has published this report drawing together techniques for spreading innovation and improvement. The focus is on identifying practical things that teams and organisations can do to publicise and spread new ideas and ways of working. The report's ten tips for spreading good practice, drawn from the empirical research are: 1. Get a range of people involved in both implementation and dissemination of ideas, including clinical and managerial leaders. 2. View people as active change agents, not passive recipients. 3. Emphasise how initiatives address people's priorities. 4. Target messages differently for different audiences. 5. Provide support and training to help people understand and implement change. 6. Plan dissemination strategies from the outset. 7. Dedicate time for dissemination. 8. Dedicate funds for dissemination. 9. Make use of a wide range of approaches such as social media, opinion leaders and existing professional networks. 10. Evaluate the success of innovations and improvements, but also the extent of uptake and dissemination within teams, organisations and more broadly. The things that are measured tend to get more emphasis, so measuring dissemination may help to ensure that it is a priority.

Journal articles

Putting Quality on the Global Health Agenda
Scott KW, Jha AK
New England Journal of Medicine. 2014;371(1):3-5.

DOI	http://dx.doi.org/10.1056/NEJMp1402157
Notes	NEJM piece pointing that while access and universal health care are common refrains of the global health push, there is also a "need to simultaneously ensure that the care provided is of sufficiently high quality" and is safe. Safety and quality of care are not luxuries of the developed world but key aspects of all health care. As the authors note, **"for improved access to translate into better health, we need to ensure that care is safe, effective, and patient-centred."** Among the features suggested as helping achieve this are data collection, performance measurement, feedback, transparency, incentives, and information and communication technology, with meaningful quality metrics being "foundational". As the piece concludes: "We need to prioritize both access and quality, because doing more isn't better. Doing better is better."

Walkrounds in Practice: Corrupting or Enhancing a Quality Improvement Intervention? A Qualitative Study
Martin G, Ozieranski P, Willars J, Charles K, Minion J, McKee L, et al.
Joint Commission Journal on Quality and Patient Safety. 2014;40(7):303-10.

URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2014/00000040/00000007/art00003
Notes	The question of whether walk arounds work and what it is that can make them contribute to an improved safety and quality climate has interested many. This UK qualitative study suggests that the perceived purpose can be important. If the major purpose appears to be for monitoring and surveillance rather than identifying specific, actionable knowledge about safety issues there is a risk that the walk around becomes a less positive tool. Local context and sensitivity to that is, as always, a key factor.

An analysis of electronic health record-related patient safety concerns
Meeks DW, Smith MW, Taylor L, Sittig DF, Scott JM, Singh H
Journal of the American Medical Informatics Association. 2014 [epub].

DOI	http://dx.doi.org/10.1136/amiajnl-2013-002578
Notes	Paper reporting a study by the US Veterans Health Administration's Informatics Patient Safety Office that used a sociotechnical framework (taking into account technical and human factors aspects) in examining 100 safety incidents relating to the electronic health record. The study revealed how technology issues could intersect with other issues/errors. As the authors note, "non-technical dimensions such as workflow, policies, and personnel interacted in a complex fashion with technical dimensions such as software/hardware, content, and user interface to produce safety concerns." Further, the majority of the "safety concerns related to either unmet data-display needs in the EHR (ie, displayed information available to the end user failed to reduce uncertainty or led to increased potential for patient harm), software upgrades or modifications, data transmission between components of the EHR, or 'hidden dependencies' within the EHR. " For the authors this suggests that when implementing EHR systems there is a need to "build **a robust infrastructure to monitor and learn**" from issues.

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

Chief Resident for Quality Improvement and Patient Safety: a description
Cox LM, Fanucchi LC, Sinex NC, Djuricich AM, Logio LS
American Journal of Medicine. 2014;127(6):565-8.

DOI	http://dx.doi.org/10.1016/j.amjmed.2014.02.034
Notes	US paper describing the potential role, purpose and benefits of a hospital having a Chief Resident for Quality Improvement and Patient Safety. Drawing on the experience of the role in two US hospitals the authors argue that having such a dedicated position "yields tangible and sustained benefits for residency education and the larger hospital organization."

International Journal for Quality in Health Care online first articles

DOI	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • International variation in the definition of **'main condition' in ICD-coded health data** (H Quan, L Moskal, A J Forster, S Brien, R Walker, P S Romano, V Sundararajan, B Burnand, G Henriksson, O Steinum, S Droesler, H A Pincus, and W A Ghali) • Can **preventable adverse events** be predicted among hospitalized older patients? The development and validation of a predictive model (L van de Steeg, M Langelaan, and C Wagner)