AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

# On the Radar

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**On the Radar**
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## Reports

*Improving NHS Care by Engaging Staff and Devolving Decision-Making: Report of the Review of Staff Engagement and Empowerment in the NHS*
London. 2014.

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| URL | http://www.kingsfund.org.uk/publications/articles/improving-nhs-care-engaging-staff-and-devolving-decision-making |
| Notes | The UK's King's Fund have contributed to an independent review that found compelling evidence that NHS **organisations with high levels of staff engagement** – where staff are strongly committed to their work and involved in decision-making – **deliver better quality care**. Organisations with high levels of staff engagement report:<br>• lower mortality rates<br>• better patient experience<br>• lower rates of sickness absence and staff turnover. |

*Medical engagement: A journey not an event*
Clark J, Nath V
London: The King's Fund; 2014.

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| URL | http://www.kingsfund.org.uk/publications/medical-engagement |
| Notes | This report from the UK group the King's Fund sought to examine what is good medical engagement and has good medical engagement been created and sustained? Based on case studies of four NHS trusts its intent is to help other organisations that are seeking to create cultures in which clinicians want to engage more in the management, leadership and improvement of services.<br>The report notes:<br>• Medical engagement **needs to be part of an overall organisational approach**, from board to ward, and needs time to evolve. It is a journey that requires doctors to be motivated and to assume greater engagement with and responsibility for improving the quality of patient care in partnership with clinical and non-clinical colleagues and with input from patients.<br>• The four trusts studied have all enjoyed long-term **stable leadership**, creating a firm foundation for cultural change. Senior leaders have shown total **commitment to medical engagement and leadership**.<br>• All four trusts have **clear strategies based on quality** running throughout the organisations. The distinguishing feature is that these strategies form a way of working for the organisation – they are not isolated programmes.<br>• Each trust has embraced a **strong medical leadership** structure with doctors in leadership roles at divisional and departmental levels, supported by managers.<br>• Each trust puts considerable **effort and resources into selecting senior staff** including consultants, and none takes the stance that clinical expertise is sufficient.<br>• Well-developed **appraisal and revalidation** processes exist in all four trusts. Talent management and leadership development are taken seriously, through **education and training**, and learning from other organisations. |

**Journal articles**

*Shared decision making: what do clinicians need to know and why should they bother?*
Hoffmann TC, Légaré F, Simmons MB, McNamara K, McCaffery K, Trevena LJ, et al.
Medical Journal of Australia. 2014;201(1):35-9.

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| DOI | http://dx.doi.org/10.5694/mja14.00002 |
| Notes | In this paper, the authors define **shared decision making as a process**, rather than a single step in a consultation, **that enables a clinician and patient to jointly participate in health decision making**. It can be viewed as a continuum, along which the extent to which a patient or a clinician takes responsibility for the decision process varies.<br>Internationally, shared decision making is seen as **a hallmark of good practice** and a way of **enhancing patient engagement and activation**. It may also help reduce unwarranted healthcare variation. The relationship between shared decision and evidence-based practice is becoming increasingly recognised.<br>The paper presents an approach to guide the process of shared decision making that prompts clinicians to ask their patients five questions: |

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| | 1. **What will happen if we wait and watch?**<br>2. **What are your test or treatment options?**<br>3. **What are the benefits and harms of these options?**<br>4. **How do the benefits and harms weigh up for you?**<br>5. **Do you have enough information to make a choice?**<br>The paper identifies several benefits of shared decision making including: enabling evidence and patient's preferences to be integrated within the consultation; improving patient knowledge, risk perception accuracy and patient-clinician communication; and reducing the inappropriate over use of tests and treatment. Through a synthesis of research, the authors also refute several misconceptions about shared decision making, including that consultation duration will be lengthened. Research to date does not support this belief.<br>The authors identify several key challenges in the wide-spread use of shared decision making within the Australian health care system. These include:<br>• Skill development in shared decision making is essential for uptake, however limited training opportunities exist in Australia for clinicians and students.<br>• Shared decision making is dependent on clinicians having access to high-quality, preferably synthesised, evidence. However, decision support tools only exist for a minority of health care decisions, are of varying quality, can be difficult to find and internationally developed aids may not be readily applicable to the Australians context for use with vulnerable populations.<br>The authors suggest that Australia is "drastically lagging behind" many other countries in shared decision making and note the need for a coordinated national effort.<br>The Australian Commission on Safety and Quality in Health Care (the Commission) was a co-sponsor of the inaugural national shared decision making symposium from which this paper arose. The Commission continues to promote shared decision making in Australia. In 2014, this work includes:<br>• Sponsoring visits to Australia in October 2014 by two international experts in shared decision making and patient decision aids, Professor Richard Thomson (United Kingdom) and Professor Dawn Stacey (Canada).<br>• Leading Australian's contribution to an OECD study exploring inter and intra country health care variation (a publication arising from this study, co-authored by the Commission and the Australian Institute of Health and Welfare can be found at http://www.safetyandquality.gov.au/publications/exploring-healthcare-variation-in-australia/) and the first Australian Atlas of Health Care Variation is in development. In areas where there appears to be substantial variation, or where it is not clear that variation is warranted, the Commission will work with clinical and consumer groups to identify areas where greater use of shared decision making and patient decision aids may be of value. |

For information on the Commission's work on shared decision making, see http://www.safetyandquality.gov.au/our-work/shared-decision-making/

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

*Cost-Effectiveness of a Computerized Provider Order Entry System in Improving Medication Safety Ambulatory Care*
Forrester SH, Hepp Z, Roth JA, Wirtz HS, Devine EB
Value in Health. 2014;17(4):340-9.

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| DOI | http://dx.doi.org/10.1016/j.jval.2014.01.009 |
| Notes | There have been various articles and reports on the safety and efficacy of 'computerised provider order entry' (CPOE) systems. This paper extends that by looking at the cost-effectiveness. This study reports on a modelling study that sought to estimate the cost-effectiveness of CPOE in reducing medication errors and adverse drug events (ADEs) in the ambulatory setting for a mid-sized (400 providers) multi-disciplinary medical group over a 5-year time horizon. The modelling led the authors to conclude that "the **adoption of CPOE** in the ambulatory setting provides **excellent value** for the investment, and is **a cost-effective strategy to improve medication safety** over a wide range of practice sizes". |

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

*Patient involvement in medication safety in hospital: an exploratory study*
Mohsin-Shaikh S, Garfield S, Franklin B
International Journal of Clinical Pharmacy. 2014;36(3):657-66.

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| DOI | http://dx.doi.org/10.1007/s11096-014-9951-8 |
| Notes | The involvement of patients across the range of activities in a health service is increasingly seen as a way of enhancing care delivery. This paper offers an exploratory study of how the involvement of patients may improve medication safety in the hospital setting.<br>The researchers surveyed 100 patients and 104 healthcare professionals across 10 wards in a London NHS hospital trust. The authors report that a "majority of patients and healthcare professionals were supportive of hospital inpatients being involved with their medication. However there was a significant gap between desire for patient involvement and what patients reported having experienced. Female patients and those under 65 wanted a significantly higher level of involvement than males and over 65s." They also noted that "pharmacists and nurses were significantly more likely to report supporting patients asking questions about their medicines and self administering their own medicines than doctors."<br>Given that professionals and patients desire a higher level of patient involvement with their medication while in hospital than is currently reported the authors suggest that "Interventions need to be developed to bridge the gap between desired and actual patient involvement." |

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/

*American Journal of Medical Quality*
July/August 2014; 29 (4)

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| URL | http://ajm.sagepub.com/content/29/4?etoc |
| Notes | A new issue of the *American Journal of Medical Quality* has been published. Articles in this issue of the *American Journal of Medical Quality* include:<br>• The Quality and Safety Track: **Training Future Physician Leaders** (Lisa M Vinci, Julie Oyler, and Vineet M Arora)<br>• The Path to **Quality in Outpatient Practice**: Meaningful Use, Patient-Centered Medical Homes, Financial Incentives, and Technical Assistance (Thomas P Meehan, Sr, Thomas P Meehan, Jr, Michele Kelvey-Albert, Thomas J Van Hoof, Steve Ruth, and Marcia K Petrillo)<br>• Measuring **Diabetes Care Performance** Using Electronic Health Record Data: The Impact of Diabetes Definitions on Performance Measure Outcomes (Annemarie Gregory Hirsch and Ann Scheck McAlearney)<br>• Decline in **ACEI/ARB Prescribing** as Heart Failure Core Metrics Improve During Computer-Based Clinical Decision Support (Pedro J Caraballo, James M Naessens, Mark J Klarich, Dorinda J Leutink, James A Peterson, Amy E Wagie, Dennis M Manning, and Qi Qian)<br>• Factors Influencing the Increasing **Disparity in LDL Cholesterol Control** Between White and Black Patients With Diabetes in a Context of Active Quality Improvement (Raymond Zhang, Ji Young Lee, Muriel Jean-Jacques, and Stephen D. Persell)<br>• Dependence of All-Cause Standardized In-Hospital Mortality on **Sepsis Mortality** Between 2005 and 2010 (Harrell Lester Reed, Sheila D Renton, and Mark D Hines)<br>• **Surgical Process Improvement**: Impact of a Standardized Care Model With Electronic Decision Support to Improve Compliance With SCIP Inf-9 (David J Cook, Jeffrey E Thompson, Rakesh Suri, and Sharon K Prinsen)<br>• The Effect of Interdisciplinary Team Rounds on **Urinary Catheter and Central Venous Catheter Days and Rates of Infection** (Navneet Arora, Killol Patel, Christian A Engell, and Jennifer A LaRosa)<br>• The **Patient-Centered Medical Neighborhood**: Transformation of Specialty Care (Christin Spatz, Patricia Bricker, and Robert Gabbay)<br>• **Surgical Safety Training** of World Health Organization Initiatives (Christopher R Davis, Anthony S Bates, Edward C Toll, Matthew Cole, Frank C T Smith, and Michael Stark)<br>• What Will It Take to Move the Needle on **Hospital Readmissions**? (R Neal Axon and Eric A Coleman)<br>• Implementation of Pharmacy to Dose: **Reducing Near Miss Medication Errors** (Cheryl E Vanderford, Katherine M McKinney, and J T Emmons)<br>• Measuring **Patient Safety in the Emergency Department**: The Spanish Experience (Santiago Tomas-Vecina, Manel R. Chanovas-Borrás, Fermí Roqueta-Egea, and Tomas Toranzo-Cepeda) |

*BMJ Quality and Safety*
August 2014, Vol 23, Issue 8

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| URL | http://qualitysafety.bmj.com/content/23/8 |
| 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:<br>• Editorial: The need for independent evaluations of **government-led health information technology initiatives** (Aziz Sheikh, Rifat Atun, D W Bates)<br>• Editorial: **Regulating and legislating safety**: the case for candour (Oliver Quick)<br>• Commentary: **From harm to hope and purposeful action**: what could we do after Francis? (Tricia Woodhead, Peter Lachman, James Mountford, Laura Botwinick, Carol Peden, Kevin Stewart)<br>• Viewpoint: 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)<br>• 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)<br>• The **Surgical Safety Checklist** and **Teamwork Coaching Tools**: a study of inter-rater reliability (Lyen C Huang, Dante Conley, Stu Lipsitz, Christopher C Wright, TW Diller, L Edmondson, W R Berry, S J Singer)<br>• More than a score: a qualitative study of **ancillary benefits of performance measurement** (Adam A Powell, Katie M White, Melissa R Partin, Krysten Halek, Sylvia J Hysong, Edwin Zarling, Susan R Kirsh, H E Bloomfield)<br>• Quality of care in systemic lupus erythematosus: the association between process and outcome measures in the **Lupus Outcomes Study** (Jinoos Yazdany, Laura Trupin, Gabriela Schmajuk, Patricia P Katz, E H Yelin)<br>• **Identifying patient safety problems during team rounds**: an ethnographic study (A Reema Lamba, Kelly Linn, Kathlyn E Fletcher)<br>• **Safety measurement and monitoring in healthcare**: a framework to guide clinical teams and healthcare organisations in maintaining safety (Charles Vincent, Susan Burnett, Jane Carthey)<br>• **Patient complaints in healthcare systems**: a systematic review and coding taxonomy (Tom W Reader, Alex Gillespie, Jane Roberts)<br>• A multidisciplinary, multifaceted improvement initiative to eliminate **mislabelled laboratory specimens** at a large tertiary care hospital (Edward G Seferian, Salima Jamal, Kathleen Clark, Mary Cirricione, Linda Burnes-Bolton, Mahul Amin, Neil Romanoff, Ellen Klapper) |

*BMJ Quality and Safety* online first articles

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| URL | http://qualitysafety.bmj.com/content/early/recent |
| Notes | *BMJ Quality and Safety* has published a number of 'online first' articles, including:<br>• Editorial: **After Mid Staffordshire**: from acknowledgement, through learning, to improvement (Graham P Martin, Mary Dixon-Woods)<br>• Editorial: **Interruptions and multi-tasking**: moving the research agenda in new directions (Johanna I Westbrook) |

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| | • 'It sounds like a great idea but…': a qualitative study of GPs' attitudes towards the development of a **national diabetes register** (Sheena M Mc Hugh, Monica O'Mullane, Ivan J Perry, Colin Bradley, On behalf of the National Diabetes Register Project (NDRP))<br>• The **WHO surgical safety checklist:** survey of patients' views (Stephanie Jane Russ, Shantanu Rout, Jochem Caris, Krishna Moorthy, Erik Mayer, Ara Darzi, Nick Sevdalis, Charles Vincent)<br>• The **morbidity and mortality conference** as an adverse event surveillance tool in a paediatric intensive care unit (Christina L Cifra, Kareen L Jones, Judith Ascenzi, Utpal S Bhalala, M M Bembea, J C Fackler, M R Miller) |

*International Journal for Quality in Health Care* online first articles

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| 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:<br>• Gender and performance of **community treatment assistants in Tanzania** (Alexander Jenson, Catherine Gracewello, Harran Mkocha, Debra Roter, Beatriz Munoz, and Sheila West)<br>• **Diagnostic error in children** presenting with acute medical illness to a community hospital (Catherine Warrick, Poonam Patel, Warren Hyer, Graham Neale, Nick Sevdalis, and David Inwald)<br>• Association of **weekend continuity of care** with hospital length of stay (Saul Blecker, Daniel Shine, Naeun Park, Keith Goldfeld, R. Scott Braithwaite, Martha J. Radford, and Marc N. Gourevitch) |

**Online resources**

*[UK] Safe staffing for nursing in adult inpatient wards in acute hospitals*
https://www.nice.org.uk/Guidance/SG1
The UK National Institute for Health and Care Excellence (NICE) has released their latest guidance, *NICE Safe staffing guideline [SG1]*.
This guideline covers safe staffing for nursing in adult inpatient wards in acute hospitals. It recommends a systematic approach at ward level to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week.
The guideline identifies organisational and managerial factors that are required to support safe staffing for nursing, and makes recommendations for monitoring and taking action if there are not enough nursing staff available to meet the nursing needs of patients on the ward.
The guidance committee concluded that **when each registered nurse is caring for more than 8 patients this is a signal to check that patients are not at risk of harm**. At this point senior management and nursing managers should closely monitor red flag events, analyse safe nursing indicator data and take action if required. No action may be required if patient needs are being adequately met.

*[USA] Fixing healthcare delivery*
http://www.coursera.org/course/fixinghealthcare
The (US) Institute for Healthcare Improvement (IHI) is collaborating with the University of Florida on a new massive open online course (MOOC). The "Fixing Healthcare Delivery" course is free of charge and is available via the Coursera education platform.

Starting 1 September 2014, the eight-week online course will cover five areas critical to improving the delivery of care: systems thinking; human factors design; teamwork; leadership; and mobilization.

*Accreditation: A magic wand*
http://www.isqua.org/education/resource-centre/accreditation-a-magic-wand-with-dr-bhupendra-kumar-rana
Webinar presentation by Dr. Bhupendra Kumar Rana (Joint Director of National Accreditation Board for Hospitals & Healthcare Providers, Quality Council of India). The webinar attempts to cover issues including defining accreditation, the benefits of accreditation, approaches to accreditation and the link with patient safety.
For information on the Commission's work on accreditation, including the National Safety and Quality Health Service Standards, see http://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/

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