AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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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 extended to 22 August 2014

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 has been extended until 22 August 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

Mortality measurement: The case in favour
Taylor R, Aylin P
London: Dr Foster Intelligence and Imperial College London; 2014.

URL	http://drfosterintelligence.co.uk/2014/07/15/measurement/
Notes	Report from the UK's Dr Foster Intelligence group restating the case for reporting risk-adjusted mortality measures. The authors argue that need to be various ways to measure and monitor healthcare and that no single measure can adequately summarise safety and quality of a healthcare organisation. They also rebut some of the criticisms that have been made of mortality measures and "advocate a **multidimensional approach to measuring healthcare** – including the use of risk-adjusted mortality measures – **as the best way of monitoring safety and improving quality**."

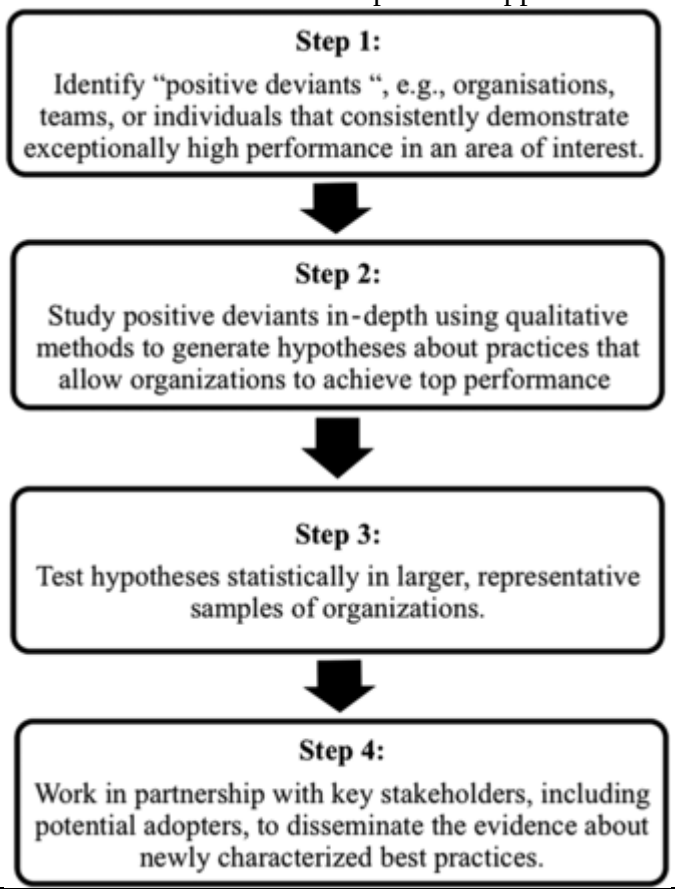
Journal articles

Antibiotic prescribing practice in residential aged care facilities — health care providers' perspectives
Lim CJ, Kwong MW-L, Stuart RL, Buising KL, Freidman ND, Bennett NJ, et al.
Medical Journal of Australia. 2014;201(2):101-5.

DOI	http://dx.doi.org/10.5694/mja13.00102
Notes	In the latest *MJA*, Lim and colleagues reported that **optimal antibiotic prescribing** in 12 high-level residential aged-care facilities in Victoria was **hampered by numerous workflow and culture-related barriers**. The study authors took a qualitative approach, using semi-structured interviews, focus groups and onsite observation to assess the main outcome measures: emergent themes on antibiotic prescribing practices in residential aged-care facilities. It also provided important insights to guide antimicrobial stewardship interventions in the residential aged-care setting, particularly highlighting the role of nurses**.** This study adds to what we already know about the factors leading to prescribing of antibiotics in residential aged care facilities; however this is perhaps one of the first to explore the views of individual health care professionals working in this setting about the challenges they experience surrounding optimal antibiotic prescribing.

For information on the Commission's work on healthcare associated infection, including antimicrobial stewardship, see http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Positive deviance: a different approach to achieving patient safety
Lawton R, Taylor N, Clay-Williams R, Braithwaite J
BMJ Quality & Safety. 2014 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2014-003115
Notes	Paper from UK and Australian researchers advocating for a more proactive and positive approach to patient safety by adopting the concept of **positive deviance**. Rather than focussing on negatives that lead to lapses in patient safety this approach looks to the **behaviours of successful teams and organisations**. This approach is built upon the premise that "solutions to common problems mostly exist within clinical communities … and that identifiable members of a community have tacit knowledge and wisdom that can be generalised" and that consequently "because the solutions have been generated within a community, they tend to be more readily accepted and feasible within existing resources, thus increasing the likelihood of success and, potentially, of adoption elsewhere." The authors also describe steps in the approach: 

High Levels Of Bed Occupancy Associated With Increased Inpatient And Thirty-Day Hospital Mortality In Denmark
Madsen F, Ladelund S, Linneberg A
Health Affairs. 2014;33(7):1236-44.

DOI	http://dx.doi.org/10.1377/hlthaff.2013.1303
Notes	As was the case with an item described in a recent issue of *On the Radar*, this Danish study reports finding that higher levels of bed occupancy were associated with mortality. The previous work suggested a 'tipping point'. For this study, all 2.65 million admissions to Danish hospitals' departments of medicine in the period 1995–2012 were analysed. The authors report finding that

	"**high bed occupancy rates were associated with a significant 9 percent increase in rates of in-hospital mortality and thirty-day mortality**, compared to low bed occupancy rates". Also significantly associated with **increased mortality** were being **admitted outside of normal working hours** or on a **weekend** or holiday.

Deafening silence? Time to reconsider whether organisations are silent or deaf when things go wrong
Jones A, Kelly D
BMJ Quality & Safety. 2014 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2013-002718
Notes	Following the items on medical/staff engagement in the last issue of *On the Radar* is this item suggesting a move beyond issues of whistle-blowing and organisational silence (or even wilful blindness). The authors "propose that a virtuous cycle is possible, whereby the introduction of systems that result in **better listening and valuing of employee concerns reinforces a culture of speaking up and**, in turn, **organizational learning**. Similarly, organizations that disregard employees concerns are destined not to learn, ultimately falling silent and failing." They go on to suggest that "Organisations should thus **demonstrably promote and value the importance of staff listening and speaking-out** across both vertical (eg, staff nurse speaking to matron) and horizontal (eg, clinical director speaking to clinical director) status boundaries as a positive response **reinforces to employees that they are safe to speak out, which in turn promotes regular critical upward feedback**."

Patient safety after partial and total knee replacement
Cobb JP
The Lancet. 2014 [epub].

DOI	http://dx.doi.org/10.1016/S0140-6736(14)60885-0
Notes	This paper stresses the need to focus on patient outcomes for joint replacement rather than device outcomes (as many joint registries apparently do). Cobb argues that such a focus "can lead to perverse results: a joint replacement with a problem that can be fixed, curing the pain and restoring the patient's quality of life, is a failure owing to its revision, whereas a painful joint replacement that cannot be revised, condemning the patient to a lifetime of stiffness and pain, is recorded as a success in registry terms." In light of such issues, Cobb argues that the data presented in a pair of papers that he is commenting upon in this article suggest that the lesser operation of partial or unicompartmental knee replacement (UKR) is a cost-effective option (despite the revision rate) and, furthermore, when "measured in terms of risk of perioperative death or serious morbidity, **UKR is unequivocally safer than TKR**" (total knee replacement). The implications are not trivial either, for if half of the eligible patients "were offered the more conservative procedure of UKR, the NHS could save an estimated £70 million every year immediately on operative costs alone, and …there would be 170 **fewer postoperative deaths annually, and many hundreds of fewer strokes, myocardial infarctions, and infections**."

Geographical variation in incidence of knee arthroscopy for patients with osteoarthritis: a population-based analysis of Victorian hospital separations data
Bohensky M, Barker A, Morello R, De Steiger RN, Gorelik A and Brand C.
Internal Medicine Journal. 2014; 44: 537-45

DOI	http://onlinelibrary.wiley.com/doi/10.1111/imj.12438/abstract
Notes	The burden of disease from degenerative conditions of the knee joint is apparently growing. Various treatment options exist, ranging from conservative management to surgical procedures. Arthroscopic debridement and chondroplasty of the knee joint are commonly used to manage these conditions. However, evidence suggests limited clinical benefit compared to conservative management in these patients. Arthroscopy is an invasive surgical procedure requiring anaesthesia. Compared to the conservative options, it entails higher levels of risk and is more costly. Investigating variation in the frequency and rates of these procedures is therefore of considerable interest. Using Victorian hospital admission data for 2008-09, this study examined variation in standardised rates of knee arthroscopy between populations living in the eight Victorian Health Service Regions (HSRs). A **2.5-fold difference** between the highest and lowest HSR rates was observed. The difference was **3.5-fold** for procedures with a diagnosis of **osteoarthritis**. Significantly higher rates were observed for non-metropolitan populations. The majority of admissions **(73%)** were in **private hospitals** (NB the study lists several limitations, which should be considered but are not described here). The Commission, in partnership with the AIHW, recently published a discussion paper titled *Exploring Healthcare Variation.* This examined variation in admission rates for a set of procedures, including knee arthroscopy, between populations living in Medicare Local catchments. National hospital morbidity data for 2010-11 were used. A **3.1-fold difference** in standardised admission rates for knee arthroscopy was observed among **Australian Medicare Local populations**. The difference was **2.6-fold** for **Victorian** populations (similar to the Victorian study). Non-metropolitan populations in Victoria had considerably higher rates. No such pattern was observed nationally. All five South Australian Medicare Locals were among the eight regions with the highest rates. The majority of admissions **(80%)** were in **private hospitals**. The results were not stratified by other diagnoses such as osteoarthritis. The comparison of this study with the discussion paper highlights the benefit of examining geographic healthcare variation at local as well as national level. The Commission is currently developing an *Australian Atlas of Healthcare Variation*. The Atlas will investigate a broader range of conditions, treatments and interventions across all healthcare settings. Submissions on the discussion paper will inform this work, and are still being accepted by email to medicalpracticevariation@safetyandquality.gov.au or by post to Healthcare variation, GPO Box 5480, Sydney NSW 2001

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • **Positive deviance**: a different approach to achieving patient safety (Rebecca Lawton, Natalie Taylor, Robyn Clay-Williams, Jeffrey Braithwaite)

	• A combined **teamwork training and work standardisation intervention in operating theatres**: controlled interrupted time series study (Lauren Morgan, Sharon P Pickering, Mohammed Hadi, Eleanor Robertson, Steve New, D Griffin, G Collins, O Rivero-Arias, K Catchpole, P McCulloch) • **Why Lean doesn't work** for everyone (Gary S Kaplan, Sarah H Patterson, Joan M Ching, C Craig Blackmore)

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: • Achieving a **climate for patient safety** by focusing on relationships (Milisa Manojlovich, M Kerr, B Davies, J Squires, R Mallick, and G L Rodger)

Online resources

[UK] Generic patient pathway quality standards
http://www.wmqrs.nhs.uk/download/511/Generic-pathway-QSs-V1-20140702_1405520731.pdf
The West Midlands Quality Review Service has developed these standards as part of their work in supporting regional NHS organisations in improving the quality of services. They are generic standards and are not specific to any patient pathway or type of service. They are, however, common Standards as shown by the development of evidence-based quality standards for a wide range of services.

[UK] Quality standards: care of adults with acquired brain injury
http://www.wmqrs.nhs.uk/download/512/WMQRS-QS-ABI-V1-20140702_1405520806.pdf
The West Midlands Quality Review Service has developed these standards in order to improve the quality of services for adults with acquired brain injury. The standards are suitable for use in self-assessment, monitoring by funders/commissioners and providers, and peer review visits. They describe what services should be aiming to provide and all services should be working towards meeting all applicable quality standards within the next two to five years.

[USA] Applying High Reliability Principles to Infection Prevention and Control in Long Term Care
http://www.jointcommission.org/HRipcLTC.aspx
The US Agency for Healthcare Research and Quality (AHRQ) and the Joint Commission have launched an e-learning module to reduce long term care infections using high reliability industry principles.
The 50-minute e-learning tool can help assisted living and nursing home staff prevent healthcare-associated infections. The online module teaches long-term care facilities to apply these principles to prevent infections and achieve high safety performance over extended periods of time.