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

Improvement collaboratives in health care. Evidence scan
De Silva D.
London: The Health Foundation; 2014.

URL	http://www.health.org.uk/publications/improvement-collaboratives-in-health-care/
Notes	This evidence scan report from the UK's Health Foundation draws together research about whether quality improvement collaboratives are effective. The scan suggests that **collaboratives are not always successful** but they are **more likely to be effective** if they: • **focus on who** should be included • consider the **topic focus** • consider **how to run** activities • provide **appropriate resources**.

Promoting Patient Safety Through Effective Health Information Technology Risk Management
Schneider EC, Ridgely MS, Meeker D, Hunter LE, Khodyakov DK, Rudin RS
Santa Monica: RAND Corporation; 2014. p. 77.

URL	http://psnet.ahrq.gov/resource.aspx?resourceID=28144
Notes	For this report the efforts of 11 hospitals and ambulatory practices to use an improvement strategy and tools developed to promote safe use of health IT and to diagnose, monitor, and mitigate health IT–related safety risks were evaluated. The authors suggest that tools such as the US Safety Assurance Factors for EHR Resilience (SAFER) Guides are needed to assist organisation in the safe use of health IT. They note that health care organisations need a better understanding of the safety risks posed by electronic health record (EHR) use to take full advantage of the SAFER Guides and suggest that there may be a need for additional tools and metrics (and further usability studies of existing tools and metrics) to better support the needs of health care organizations as they increasingly rely on health IT to improve the quality and safety of patient care.

Journal articles

Executive Summary: A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals: 2014 Updates
Yokoe DS, Anderson DJ, Berenholtz SM, Calfee DP, Dubberke ER, Ellingson KD, et al
Infection Control and Hospital Epidemiology. 2014;35(8):967-77.

DOI / URL	http://dx.doi.org/10.1086/677216 http://www.jstor.org/stable/10.1086/677216
Notes	This paper summarises the 2014 updates to the 2008 publication *A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals*.

	This update was created to provide acute care hospitals with **up-to-date, practical, expert guidance to assist in prioritizing and implementing their HAI prevention efforts**. They are the product of a collaborative effort led by the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), the American Hospital Association (AHA), the Association for Professionals in Infection Control and Epidemiology (APIC), and The Joint Commission, with major contributions from representatives of a number of organizations and societies with content expertise, including the Centers for Disease Control and Prevention (CDC), the Institute for Healthcare Improvement (IHI), the Pediatric Infectious Diseases Society (PIDS), the Society for Critical Care Medicine (SCCM), the Society for Hospital Medicine (SHM), and the Surgical Infection Society (SIS).

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

Morning handover of on-call issues: Opportunities for improvement
Devlin MK, Kozij NK, Kiss A, Richardson L, Wong BM
JAMA Internal Medicine. 2014 [epub].

DOI	http://dx.doi.org/10.1001/jamainternmed.2014.3033
Notes	Communication is also key to handover. This study examined morning handover practices in general internal medicine wards of 2 tertiary care academic medical centers in Toronto, Ontario, Canada, in 2012 and 2013 with regard to assessing the frequency of omissions of clinically important overnight issues and then identifying factors that influence the occurrence of such omissions. During the 26 days of observation, the observers identified 141 clinically important overnight issues of which the on-call trainee omitted 40.4% during morning handover and did not document any information in the patient's medical record for 85.8% of these issues. The authors suggest that training should be introduced to address this issues, along with dedicated time and a distraction-free environment, to improve handover of on-call issues.

For information on the Commission's work on clinical communications, including clinical handover, see http://www.safetyandquality.gov.au/our-work/clinical-communications/

A systematic review of teamwork in the intensive care unit: What do we know about teamwork, team tasks, and improvement strategies?
Dietz AS, Pronovost PJ, Mendez-Tellez PA, Wyskiel R, Marsteller JA, Thompson DA, et al
Journal of Critical Care. 2014.

DOI	http://dx.doi.org/10.1016/j.jcrc.2014.05.025
Notes	Paper presenting a systematic review on the question of teamwork in the intensive care unit (ICU). The review reports that while there has been activity in this area there remain definitional and theoretical issues to be determined. The authors report that the most **common team tasks** reported involved **strategy and goal formulation** and that the most widely implemented quality improvement **strategies** were **team training** and **structured protocols**. Unsurprisingly, as if often the case in such reviews, the key aspect of teamwork for many is **communication**.

Cardiopulmonary arrest and mortality trends, and their association with rapid response system expansion
Chen J, Ou L, Hillman KM, Flabouris A, Bellomo R, Hollis SJ, et al.
Medical Journal of Australia. 2014;201(3):166-70.

DOI	http://dx.doi.org/10.5694/mja14.00019
Notes	This Australian study sought to examine the changes in the incidence of in-hospital cardiopulmonary arrest (IHCA) and mortality associated with the introduction of rapid response systems (RRSs) by studying more than 9 million admissions in 82 public acute hospitals in New South Wales in the period 1 January 2002 ro 31 December 2009. The authors report finding that **RRS uptake increased from 32% in 2002 to 74% in 2009** and that increase was **associated with a 52% decrease in IHCA rate, a 55% decrease in IHCA-related mortality rate, a 23% decrease in hospital mortality rate and a 15% increase in survival to discharge after an IHCA**. The authors note that it was reduced IHCA incidence, rather than improved post-cardiac arrest survival, that was the main contributor to the reduction in IHCA mortality.

For information on the Commission's work on recognition and response to clinical deterioration, see http://www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/

Escalation of care and failure to rescue: A multicenter, multiprofessional qualitative study
Johnston M, Arora S, King D, Stroman L, Darzi A
Surgery. 2014;155(6):989-94.

DOI	http://dx.doi.org/10.1016/j.surg.2014.01.016
Notes	This UK study sought to examine the issue of escalation of care in surgery and to develop a conceptual framework of the influences on escalation of care in surgery allowing solutions to facilitate management of sick patients to be developed. Based on interviews with 41 participants (16 surgeons, 11 surgical PGY1s, six surgical nurses, four intensivists, and four critical care outreach team members) across three London hospitals they found that "A decision to escalate was based upon **five key themes: patient, individual, team, environmental, and organizational factors**. Most participants felt that supervision and escalation of care were problematic in their hospital, with **unclear escalation protocols** and **poor availability of senior surgical staff** the most common concerns. Mobile phones and direct conversation were identified to be more effective when escalating care than hospital pager systems. **Transparent escalation protocols, increased senior clinician supervision, and communication skills training were highlighted as strategies** to improve escalation of care."

Initiatives to reduce length of stay in acute hospital settings: a rapid synthesis of evidence relating to enhanced recovery programmes
Paton F, Chambers D, Wilson P, Eastwood A, Craig D, Fox D, et al
Health Services and Delivery Research. 2014;2(21).

DOI	http://dx.doi.org/10.3310/hsdr02210 http://www.journalslibrary.nihr.ac.uk/hsdr/volume-2/issue-21
Notes	This paper reports on an attempt to evaluate the clinical effectiveness and cost-effectiveness of enhanced recovery programmes for patients undergoing elective surgery in acute hospital settings in the UK.

	It aimed to identify and describe key factors associated with successful adoption, implementation and sustainability of enhanced recovery programmes in UK settings. It also summarises existing knowledge about patient experience of enhanced recovery programmes.
	The authors conclude that the evidence base to support widespread of implementation of **enhanced recovery programmes** as a means to achieving productivity gains and cost-savings is limited. The evidence base "does suggest possible benefits in terms of **reducing length of hospital stay by 0.5–3.5 days** compared with conventional care, **without compromising postoperative complications, readmissions or patient outcomes**.

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: • **Outcomes in patients with heart failure** treated in hospitals with varying admission rates: population-based cohort study (R Sacha Bhatia, Peter C Austin, Therese A Stukel, Michael J Schull, A Chong, J V Tu, D S Lee)

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: • **PACIC Instrument**: disentangling dimensions using published validation models (K. Iglesias, B. Burnand, and I. Peytremann-Bridevaux) • Exploring **patient safety culture in primary care** (Natasha J Verbakel, M van Melle, M Langelaan, T J M Verheij, C Wagner, and D L M Zwart) • Does adding an appended **oncology** module to the **Global Trigger Tool** increase its value? (Thea Otto Mattsson, Janne Lehmann Knudsen, Kim Brixen, and Jørn Herrstedt)

Online resources

Clinical Outcome Improvement and Strategic Organizational Management
http://www.isqua.org/education/resource-centre/clinical-outcome-improvement-and-strategic-organizational-management---english-version
Webinar presented by Professor Yuichi Imanaka (Executive Board Member, Japan Council for Quality Health Care and Professor of Healthcare Economics and Quality, Kyoto University Graduate School of Medicine) for ISQua covering how organisational factors contribute to clinical outcome improvements.

[USA] Integrated Care Pathway for Total Joint Arthroplasty
http://www.ihi.org/resources/Pages/Tools/IntegratedCarePathwayTJA.aspx
The [US] Institute for Healthcare Improvement, along with Premier Inc., conducted a collaborative research initiative to design a Care Pathway for total joint arthroplasty (TJA).
The Care Pathway, which includes safe, effective, efficient, and patient-centred TJA care processes, is now ready for testing to determine if its adoption is associated with measured improvements in TJA patient outcomes, experiences, and efficiency. The Pathway is designed for use by all members of the orthopaedic community who are responsible for the TJA process, including those at surgical practices, hospitals, and other care settings.

[Italy] Doing more does not mean doing better
http://www.slowmedicine.it/fare-di-piu-non-significa-fare-meglio/pratiche-a-rischio-di-inappropriatezza-in-italia.html
Italy has become the latest addition to the 'Choosing Wisely' trend with the launch of the "Doing more does not mean doing better" (Fare di più non significa fare meglio) campaign by Italy's Slow Medicine (www.slowmedicine.it). Slow Medicine is a movement of doctors, other health professionals, patients, and citizens that aims to promote measured, respectful, and equitable care.

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