



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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Shared Decision Making events

The Australian Commission on Safety and Quality in Health Care – in collaboration with partner organisations – is holding two free events on shared decision making. Both events feature international experts in the area: **Professor Richard Thomson** (Newcastle University, United Kingdom) and **Professor Dawn Stacey** (University of Ottawa, Canada)

The use of shared decision making and patient decision aids in practice: A workshop for clinicians, medical educators, carer and consumer advocates, health services and policy makers
Melbourne

This event is co-hosted by the Commission and the Department of Health, Victoria. The workshop will explore:

- International initiatives in promoting shared decision making and use of patient decision aids
- Research and evidence of effectiveness
- Implementation in acute health care situations
- Practical implications for health services to improve patient participation in health care decisions
- Key issues in the training of health professionals

Time: 8.30am–3.30pm
 Date: Monday 13 October 2014.
 Location: Department of Health, 50 Lonsdale St, Melbourne

Registration: Free
 Registration by 19 September is essential by RSVP to Andrew.Clarke@health.vic.gov.au

Shared Decision Making Symposium: Developing tools and skills for clinical practice
 Sydney

Co-hosted by the Australian Commission on Safety and Quality in Health Care and the University of Sydney’s Centre for Medical Psychology and Evidence-Based Decision Making (CeMPED) the symposium will include:

- Tools and skills for effective shared decision making
- Current implementation issues for clinical practice
- Presentations by International and Australian experts & panel discussion.

Time: 8.30am–1.00pm
 Date: Thursday, 16 October 2014.
 Location: Rydges World Square, 389 Pitt Street, Sydney.

Registration: Free and open to the public.
 Registration by 24 September is essential by RSVP to shannon.mckinn@sydney.edu.au

For further information, see <http://whatson.sydney.edu.au/events/published/shared-decision-making-symposium-developing-tools-and-skills-for-clinical-practice>

Reports

Geographic Variations in Health Care: What Do We Know and What Can Be Done to Improve Health System Performance?

OECD

OECD Health Policy Studies. Paris: OECD Publishing; 2014.

URL	http://dx.doi.org/10.1787/9789264216594-en
Notes	The Organisation for Economic Cooperation and Development report <i>Geographic Variations in Health Care: What Do We Know and What Can Be Done to Improve Health System Performance</i> examines variation in the rates of several common healthcare interventions between the thirteen participating countries (including Australia), and variation between geographic areas within these countries. The Australian results were provided by the Australian Commission on Safety and Quality in Health Care and the Australian Institute of Health and Welfare. Variation in Australia was measured according to where patients lived. The OECD report compares results from the 13 participating countries. Australia was observed to have a high knee replacement rate (more than 200 per 100,000 population), a high rate of caesarean section (more than 300 per 1,000 live births) and a relatively high hysterectomy rate (330 per 100,000 females) compared to other OECD countries in the report.
TRIM	D14-31739

For information on the Commission’s work on variation in health care, including the *Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study* discussion paper, see <http://www.safetyandquality.gov.au/our-work/variation-in-health-care/>

Variation in the Care of Surgical Conditions: Obesity

Reames BN, Birkmeyer NJ, Dimick JB, Goodney PR, Dzebisashvili N, Goodman DC, et al. Hanover, NH: The Dartmouth Institute for Health Policy and Clinical Practice; 2014.

URL	http://www.dartmouthatlas.org/downloads/reports/Obesity_report_09_16_14.pdf
Notes	<p>The Dartmouth Atlas group have been one of the major proponents of the importance of examining and understanding variation in health care. They have just released this, their latest report, looking at variation in the use of surgical treatments for obesity in the USA. One issue revealed is that Medicare beneficiaries are 27 times more likely to undergo bariatric surgery in Muskegon, Michigan than in San Francisco.</p> <p>Topics examined include the decision to use bariatric surgery, trends and regional variation in bariatric surgery rates, the quality of surgical care, and patient outcomes. The report also calls into question the feasibility of treating the obesity epidemic with surgery.</p> <p>This is the first of six reports into surgical variation in the USA the later reports examining surgical treatments for cerebral aneurysms, diabetes/peripheral artery disease, spinal stenosis, organ failure (transplantation) and prostate cancer.</p>
TRIM	D14-32396

Hospital Mortality Indicator (HMI) Review

Brand C, Landgren F, Staley C, Tropea J, Liew D, Bohensky M, & Gorelik A. Sydney: Australian Commission on Safety and Quality in Health Care; 2014

URL	http://www.safetyandquality.gov.au/wp-content/uploads/2014/09/Hospital-Mortality-Indicator-Literature-Review.pdf
Notes	<p>This literature review examines the utility and limitations of Hospital Mortality Indicators (HMI). The literature review includes comprehensive case studies from the United Kingdom, Canada and United States.</p> <p>The review provides an up-to-date picture of the work being undertaken to understand the composition, utilisation and utility of HMIs. The case studies contributed significantly to this review, noting variation between jurisdictions in specification of mortality models and the maturity of implementation. The report concluded that there was ongoing interest in improving technical specifications of HMIs with less focus on investigation and utilisation of these models.</p>

For information on the Commission’s work on hospital indicators, including hospital; mortality indicators, see <http://www.safetyandquality.gov.au/our-work/information-strategy/indicators/core-hospital-based-outcome-indicators/>

Comparing Lean and Quality Improvement. IHI White Paper

Scoville R, Little K

Cambridge, Massachusetts: Institute for Healthcare Improvement; 2014. p. 30.

URL	http://www.ihl.org/resources/Pages/IHIWhitePapers/ComparingLeanandQualityImprovement.aspx
Notes	Apparently the relationship between the Institute of Health Improvement’s (IHI) approach to quality improvement and the Lean methodology is unclear and has led to confusion about how to use or implement such approaches. The IHI has

	published this brief (30-page) white paper that provides a brief overview of the issues and some key definitions, followed by more detailed descriptions of Lean and the IHI approach to quality improvement. For each approach, the key conceptual foundations, the principles that lead the way to improved system performance, the project roadmaps typically followed and the tools that characterise their use are discussed. The authors also suggest ways that practitioners of both Lean and IHI-QI can use the principles and methods of the other to extend their capabilities. Fundamentally, the two methods are complementary ways of approaching improvement , it is not necessary to choose one over the other as a guide to action.
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A new settlement for health and social care: Final report
 Commission on the Future of Health and Social Care in England
 London. The King's Fund; 2014.

URL	http://www.kingsfund.org.uk/projects/commission-future-health-and-social-care-england
Notes	<p>This is the final report from the independent Commission on the Future of Health and Social Care in England. The commission presents the need for “a new settlement for health and social care to provide a simpler pathway through the current maze of entitlements” The Commission proposes redesigning care around the individual needs regardless of diagnosis, with a graduated increase in support as needs rise, particularly towards the end of life. The Commission has concluded that this vision for a health and care system fit for the 21st century is affordable and sustainable if a phased approach is taken and hard choices are taken about taxation. The changes can be summarised as:</p> <ul style="list-style-type: none"> • Commission social and health care together – a single budget • Create simpler pathways with more control for the individual • Increase provision of ‘free’ social care. <p>The increased cost for this health and social care is estimated to reach 12% of GDP – which is still less than comparable countries spend on healthcare alone.</p>

Journal articles

Emergency department patient safety incident characterization: an observational analysis of the findings of a standardized peer review process

Jepson ZK, Darling CE, Kotkowski KA, Bird SB, Arce MW, Volturo GA, et al
 BMC emergency medicine. 2014;14(1):20.

DOI	http://dx.doi.org/10.1186/1471-227X-14-20
Notes	<p>Crowding is just one issue for emergency departments (EDs) (see below). This paper reports on a study looking at the range of patient safety incidents in an ED. This was an observational study conducted in a large, urban, tertiary-care ED in the USA over a two-year period. All ED incident reports were analysed using a standardised, peer review process. Patient safety incidents (PSIs) were identified and analysed for contributing factors including systems failures and practitioner-based errors.</p> <p>In 24 months, 469 cases were investigated, with 152 PSIs identified. 188 systems failures and 96 practitioner-based errors were found to have contributed to the PSIs. In twelve cases, patient harm was determined to have resulted from PSIs. Systems</p>

	failures were identified in eleven of the twelve cases in which a PSI resulted in patient harm. These figures lead the authors to conclude that “Systems failures were almost twice as likely as practitioner-based errors to contribute to PSIs, and systems failures were present in the majority of cases resulting in patient harm. To effectively reduce PSIs , ED quality improvement initiatives should focus on systems failure reduction. ”
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The evolving literature on safety WalkRounds: emerging themes and practical messages

Singer SJ, Tucker AL

BMJ Quality & Safety. 2014 October 1, 2014;23(10):789-800.

DOI	http://dx.doi.org/10.1136/bmjqs-2014-003416
Notes	<p>Editorials tend to do little more than comment briefly on the paper(s) that they are related to in a given journal. This editorial, however, takes a much more expansive approach. The authors not only comment on the studies on walkrounds reported in this issue of <i>BMJ Quality and Safety</i>, but report on the development of the literature and state of the subject in recent years.</p> <p>In the editorial the authors describe the major themes and messages but also point out some of the limitations that the have also been found in the literature.</p> <p>The authors conclude “Safety rounds can lead to improved culture, but only when they are implemented authentically and with full commitment and ability to resolve frontline staff’s concerns. Half-hearted, insincere or ineffective safety rounds can backfire, eroding rather than improving safety culture and wasting time at all levels of the organisation. Organisations interested in implementing safety rounds are well advised to develop process improvement capabilities first, or to begin in one or two units, rather than tackling the entire organisation. Senior managers not inclined to invest the time and effort to solicit, really listen and address frontline staff’s concerns, may want to focus on other means to improve their organisation’s culture. Despite the term ‘walk rounds’, implementing safety rounds is no walk in the park; but then again, improving organisational culture never is.”</p>

BMJ Quality and Safety

October 2014, Vol. 23, Issue 10

URL	http://qualitysafety.bmj.com/content/23/10
Notes	<p>A new issue of <i>BMJ Quality and Safety</i> has been published. Many of the papers in this issue have been referred to in previous editions of <i>On the Radar</i> (when they were released online). Articles in this issue of <i>BMJ Quality and Safety</i> include:</p> <ul style="list-style-type: none"> • Editorial: The evolving literature on safety WalkRounds: emerging themes and practical messages (Sara J Singer, Anita L Tucker) • Moving improvement research closer to practice: the Researcher-in-Residence model (Martin Marshall, Christina Pagel, Catherine French, Martin Utley, D Allwood, N Fulop, C Pope, V Banks, A Goldmann) • Burnout in the NICU setting and its relation to safety culture (Jochen Profit, Paul J Sharek, Amber B Amspoker, Mark A Kowalkowski, Courtney C Nisbet, Eric J Thomas, Whitney A Chadwick, J Bryan Sexton) • Exposure to Leadership WalkRounds in neonatal intensive care units is associated with a better patient safety culture and less caregiver burnout (J Bryan Sexton, Paul J Sharek, Eric J Thomas, Jeffrey B Gould, C C Nisbet, A B Amspoker, M A Kowalkowski, R Schwendimann, J Profit)

	<ul style="list-style-type: none"> • ‘I think we should just listen and get out’: a qualitative exploration of views and experiences of Patient Safety Walkrounds (Leahora Rotteau, Kaveh G Shojania, Fiona Webster) • Adverse drug events and medication errors in Japanese paediatric inpatients: a retrospective cohort study (Mio Sakuma, Hiroyuki Ida, Tsukasa Nakamura, Yoshinori Ohta, Kaori Yamamoto, Susumu Seki, Kayoko Hiroi, Kiyoshi Kikuchi, K Nakayama, D W Bates, T Morimoto) • Tweets about hospital quality: a mixed methods study (F Greaves, A A Laverty, Daniel Ramirez Cano, K Moilanen, S Pulman, A Darzi, C Millett) • Development of a patient safety climate survey for Chinese hospitals: cross-national adaptation and psychometric evaluation (Junya Zhu, Liping Li, Hailei Zhao, Guangshu Han, Albert W Wu, Saul N Weingart) • 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) • Determinants of treatment plan implementation in multidisciplinary team meetings for patients with chronic diseases: a mixed-methods study (Rosalind Raine, Penny Xanthopoulou, Isla Wallace, C Nic a’ Bháird, A Lanceley, A Clarke, G Livingston, A Prentice, D Ardron, M Harris, M King, S Michie, J M Blazeby, N Austin-Parsons, S Gibbs, J Barber)
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BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	<p>BMJ Quality and Safety has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Personalised physician learning intervention to improve hypertension and lipid control: randomised trial comparing two methods of physician profiling (Patrick J O’Connor, David J Magid, JoAnn M Sperl-Hillen, David W Price, Stephen E Asche, William A Rush, Heidi L Ekstrom, David W Brand, Heather M Tavel, Olga V Godlevsky, P E Johnson, K L Margolis)

Online resources

[UK] Crowding in Emergency Departments

<http://secure.collemergencymed.ac.uk/code/document.asp?ID=6296>

The College of Emergency Medicine in the UK has issued this guidance with recommendations for dealing crowding in EDs (preferring to use ‘crowding’ rather than ‘overcrowding’ as “any degree of crowding harms patients”). The recommendations include:

1. Emergency Department capacity should be capable of meeting demand.
2. Non-Emergency Department staff should not ‘gatekeep’ access to the Emergency Department.
3. A patient who attends an Emergency Department is entitled to an assessment by a clinician.
4. Emergency Departments should have systems that can monitor the degree and impact of crowding.
5. Streaming patients does not help with Emergency Department crowding if the cause of crowding is inadequate hospital capacity.
6. Investigations should be ‘front loaded’ to reduce delay to disposition decisions.
7. Senior doctors of all specialities should be involved with rapid assessment and treatment.
8. Hospitals with Emergency Departments should have a hospital wide escalation policy for when the Emergency Department becomes crowded with locally agreed triggers.

[USA] *Effective Health Care Program reports*

<http://effectivehealthcare.ahrq.gov/>

The US Agency for Healthcare Research and Quality (AHRQ) has an Effective Health Care (EHC) Program. The EHC has released two final reports:

Vitamin D and Calcium: A Systematic Review of Health Outcomes (Update)

<http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=1953>

Chronic Urinary Retention: Comparative Effectiveness and Harms of Treatments.

<http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=1966>

Core Needle and Open Surgical Biopsy for Diagnosis of Breast Lesions

<http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=1960>

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