



On the Radar

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On the Radar

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Shared Decision Making Symposium: Developing tools and skills for clinical practice
Free live webcast on Thursday, 16 October 2014 (9.00am–1pm AEDT)

Shared decision making involves the integration of a patient's values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment, in order to come to appropriate health care decisions.

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 experts, Australian experts & panel discussion.

For information and details about how to access the webcast visit <http://www.safetyandquality.gov.au/our-work/shared-decision-making/shared-decision-making-symposium/>

Registration is not required, just visit the website on the day.

Not available to watch the live webcast? A recording of the symposium will be available the following day.

For further information about the symposium contact shannon.mckinn@sydney.edu.au

Reports

Reducing the risks of wrong-site surgery: Safety practices from The Joint Commission Center for Transforming Healthcare project

Health Research & Educational Trust and Joint Commission Center for Transforming Healthcare Chicago, IL: Health Research & Educational Trust; 2014. p. 26.

URL	http://www.hpoe.org/resources/hpoehretaha-guides/1668
Notes	As part of the (US) Joint Commission Center for Transforming Healthcare wrong-site surgery project, eight US hospitals and ambulatory surgery centres measured the risk of wrong-site surgery in their perioperative processes, pinpointed the contributing causes and developed specific solutions targeted to each one. As a result, the health care organisations significantly reduced the number of surgical cases with risks for wrong-site surgery in four main areas: scheduling, perioperative procedures, operating room preparations and organisational culture. This report describes the types of risks for wrong-site surgery, their root causes and targeted solutions.

Journal articles

Finding patients before they crash: the next major opportunity to improve patient safety

Bates DW, Zimlichman E

BMJ Quality & Safety. 2014 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2014-003499
Notes	In this editorial David Bates and Eyal Zimlichman discuss how technologies could be brought to bear to enhance the recognition of patient's physiological deterioration – finding them before they crash. The editorial reflects on a study in the <i>BMJ Quality and Safety</i> that examined the use of an electronic patient safety system along with use of electronic health records, mobile technologies and analytical approaches to identify deteriorating patients that was associated with marked reductions in in-hospital mortality. Bates and Zimlichman conclude “the use of more effective monitoring approaches promises to reduce mortality rates substantially for hospital patients . The most successful interventions will probably bring together a variety of technologies—electronic health records, sensors, mobile devices and analytics. But, to implement these interventions effectively in the complex environments in healthcare, we will have to pay careful attention to sociotechnical factors, as they can trump even the best technologies.”

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/>

Evidence-based practice is not synonymous with delivery of uniform health care

Djulfbegovic B, Guyatt GH

Journal of the American Medical Association. 2014; 312: 1293-4.

DOI	http://dx.doi.org/10.1001/jama.2014.10713
Notes	<p>This <i>JAMA</i> Viewpoint piece warns against ‘uniform’ health care apparently brought about by the promotion of evidence-based practice in response to clinical variation and rising healthcare costs.</p> <p>The central argument is that, for the majority of clinical interventions, the evidence is incomplete or uncertain. The trustworthiness of clinical guidelines is thrown into question, and with it, the notion of evidence-based care as it is informed by flawed protocols.</p> <p>This is a reiteration of the ‘cookie cutter’ argument and, in essence, a straw man argument. Firstly, the reduction in variation and cost reduction are not the overarching aim. Variation is necessary. It reflects the different health needs of populations and the diverse preferences of individual patients. It is variation not driven by these factors – unwarranted variation – that should be minimised.</p> <p>Regarding costs (and noting that this piece is written in the US context), while cheaper care may be a pleasant by-product, what funders really look for is value - better outcomes per unit cost – especially in the medium to long-term.</p> <p>Second, the notion of evidence-based care has moved on significantly, although as far back as the 19th century, Osler observed that “were it not for the great variability among individuals, medicine might as well be a science and not an art.”</p> <p>The goal of evidence-based care is not uniformity but appropriateness – ensuring that care is tailored to patients’ needs, preferences and their personal risk/utility function. While the authors acknowledge that “the right decision for one patient may be the wrong one for another”, they neglect to mention that the evidence needs to be discussed and debated in partnership with the informed patient.</p> <p>Shared decision making is a process of integrating the patient’s values and preferences into clinical decisions, and is recognised as a very useful way of incorporating evidence into the medical consultation. It is shown to ensure that health care decisions personalised, particularly where treatment options are preference- or supply-sensitive.</p> <p>The result of this type of evidence-based practice is not ‘uniform’ medicine, but appropriate care that can serve to (a) reduce unwarranted variation and (b) enhance the value, and return on investment in health care.</p>

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 variation in health care, see

<http://www.safetyandquality.gov.au/our-work/variation-in-health-care/>

The Cost of Opioid-Related Adverse Drug Events

Kane-Gill SL, Rubin EC, Smithburger PL, Buckley MS, Dasta JF

Journal of Pain and Palliative Care Pharmacotherapy. 2014;28(3):282-93.

DOI	http://dx.doi.org/10.3109/15360288.2014.938889
Notes	<p>Paper reporting on a review of the literature on the frequency and cost associated with different types of adverse drug events related to opioids. The literature indicates that there is “a substantial economic burden of opioid-related ADEs resulting in high hospital costs, prolonged hospital stays, and substantial health care</p>

	<p>resource usage. Nausea, vomiting, and constipation are frequent and increased costs occur in all types of pain (surgical, nonsurgical, cancer, non-cancer) in both inpatients and outpatients)". The authors report finding health care costs increased 7% to 47% for patients that experienced an opioid-related adverse event.</p> <p>As the authors notes, "Given the large economic burden of opioid-related ADEs, prevention rather than treatment may be the most effective strategy."</p>
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For information on the Commission’s work on medication safety, see www.safetyandquality.gov.au/our-work/medication-safety/

Deprescribing in older patients

First do no harm: a real need to deprescribe in older patients

Scott IA, Anderson K, Freeman CR, Stowasser DA

Med J Aust 2014; 201 (7): 390-392

The benefits and harms of deprescribing

Reeve E, Shakib S, Hendrix I, Roberts HS, Wiese MD

Med J Aust 2014; 201 (7): 386-389.

DOI	http://dx.doi.org/10.5694/mja14.00146 http://dx.doi.org/10.5694/mja13.00200
Notes	<p>Two articles in the <i>MJA</i> on the topic of ‘deprescribing’ – the deliberate withdrawal of medicines with the goal of reducing polypharmacy and avoiding potential patient harm.</p> <p>Scott et al quote statistics on the frequency of polypharmacy-related harm, particularly in the elderly, with 30% of hospitalisations in over 75 year olds being medicines-related, and one in four community-living older people hospitalised for medication-related problems over a 5-year period. Awareness is poor, with problems such as falls, delirium, lethargy and depression often unrecognised by clinicians as drug-related.</p> <p>Both papers advocate for careful management of deprescribing, including the selection of appropriate patients and management of tapering over a carefully monitored period of time by a generalist clinician. Scott et al suggest that deprescribing needs to be reframed as a mechanism for improving quality of life through decreased toxicity, requiring multiple strategies including shared decision-making, teamwork, and better understanding of appropriate discontinuation regimens Reeve et al discuss the evidence for deprescribing, finding a lack of clinical outcomes reported in what evidence does exist – most studies focus on reduction in use, rather than the impact on the patient. Nonetheless, a reduction in inappropriate medication use could be expected to reduce adverse-drug event related harms, as long as the clinical benefit is not lost. Careful selection and monitoring, they argue, should help overcome these problems.</p>

eGEMs

Volume 2, Issue 2 (2014)

URL	http://repository.academyhealth.org/egems/vol2/iss2/
Notes	A special issue of the e-journal <i>eGEMs</i> has been released with the theme ‘Sustaining the Effective Use of Health Care Data’. The issue highlights business models and strategies to support research and quality improvement in learning health systems, even after initial funding runs out.

<p><i>eGEMs</i> publishes innovative ideas and practices using electronic health data to generate evidence needed to improve the health of patients and populations. In this special issue leading experts in the field share successful efforts and ongoing challenges faced by researchers and clinicians working to improve health and health care.</p>
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Online resources

European Union Network for Patient Safety and Quality of Care

<http://www.pasq.eu/Home.aspx>

This site incorporates a wiki where European groups and individuals have uploaded details of their **Patient Safety and Quality of Care Good Practices** and **Safe Clinical Practices for Implementation**.

As the site notes, the Good Practices should be considered within the context in which they have been implemented and anyone wishing to adopt some of these practices, should consider their own context prior to implementing.

The Safe Clinical Practices (SCPs) described are being implemented in healthcare organisations in Europe. For each SCP a tool box has been developed. The four SCPS are:

- WHO Surgical Safety Checklist
- Medication Reconciliation
- Multimodal intervention to increase hand hygiene compliance
- Paediatric Early Warning Scores (PEWS).

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