AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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 Symposium: Developing tools and skills for clinical practice
Webcast/recording of event held on 16 October 2014.

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 included discussions on:

- 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 video from the webcast visit
http://www.safetyandquality.gov.au/our-work/shared-decision-making/shared-decision-making-symposium/

National Antimicrobial Prescribing Survey 2014
http://www.naps.vicniss.org.au/Default.aspx
Now open

Coinciding with Antibiotic Awareness Week (17–23 November), the Melbourne Health National Health and Medical Centre for Antimicrobial Stewardship is coordinating the National Antimicrobial Prescribing Survey (NAPS). The Survey went live on 10 October.

The Survey is supported by the Commission as effective antimicrobial stewardship (AMS) is a key plank of the Commission's national work to prevent and contain antimicrobial resistance (AMR). The NAPS results can also be used as evidence to support the AMS criteria of the National Safety and Quality Health Service (NSQHS) Standard 3: Preventing and Controlling Healthcare Associated Infections.

The Commission encourages acute health care services of all sizes, public and private, across the country, to participate in the Survey. For rural sites – which may not have specialist infectious diseases advice or an antimicrobial pharmacist – special assistance may be provided. For details on this assistance, refer to the *Communique on NAPS 2014 for Rural Health Service Providers*.

For more information on NAPS, please refer to the Commission's Communique:
Communique on NAPS 2014 (PDF 164 KB) (MS Word 186 KB)
Communique on NAPS 2014 for Rural Health Service Providers (PDF 165 KB) (MS Word 186 KB)

For information on the Commission's work on the antimicrobial resistance and antibiotic usage, please visit http://www.safetyandquality.gov.au/national-priorities/amr-and-au-surveillance-project/

Reports

Vital Signs 2014: The State of Safety and Quality in Australian Health Care
Australian Commission on Safety and Quality in Health Care
Sydney: ACSQHC; 2014.

URL	http://www.safetyandquality.gov.au/publications/vital-signs-2014-the-state-of-safety-and-quality-in-australian-health-care/
Notes	Professor Villis Marshall, Chair of the Australian Commission on Safety and Quality in Health Care, has launched *Vital Signs 2014: The State of Safety and Quality in Australian Health Care*. The report provides an overview of a series of key topics in relation to the safety and quality of Australia's health care system. Professor Marshall said "*Vital Signs 2014* is structured around three important questions that members of the public may ask about their health care. Will my care be safe? Will I get the right care? Will I be a partner in my care?" Each question is considered in its own section using examples of key health issues in Australia, such as healthcare associated infections, dementia and delirium, and health literacy. These sections are followed by two case studies, which focus on the quality of care in some important clinical areas. These case studies present a detailed description and analysis of key quality issues that affect outcomes for patients.

Variation in the Care of Surgical Conditions: Diabetes and Peripheral Arterial Disease. A Dartmouth Atlas of Health Care Series.
Goodney PR, Dzebisashvili N, Goodman DC, Bronner KK
Hanover, NH: The Dartmouth Institute for Health Policy and Clinical Practice; 2014.

URL	http://www.dartmouthatlas.org/downloads/reports/Diabetes_report_10_14_14.pdf
TRIM	D14-35785
Notes	This is the third in a series of six reports into surgical variation in the USA (the first two being on obesity and cerebral aneurysms and the future reports will cover surgical treatments for spinal stenosis, organ failure (transplantation) and prostate cancer). This report examines the significant racial and regional disparities in the care of patients with diabetes in the USA. The authors report finding that black patients are less likely to get routine preventive care than other patients and three times more likely to lose a leg to amputation.

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

Journal articles

The challenges in monitoring and preventing patient safety incidents for people with intellectual disabilities in NHS acute hospitals: evidence from a mixed-methods study
Tuffrey-Wijne I, Goulding L, Gordon V, Abraham E, Giatras N, Edwards C, et al.
BMC Health Services Research. 2014;14(1):432.

DOI	http://dx.doi.org/10.1186/1472-6963-14-432
Notes	The patient safety risks of patients can vary for many reasons. This paper examines some of the patient safety challenges that can arise for one particular vulnerable population, people with intellectual disabilities, in the acute hospital setting. Based on more than 1000 surveys and interviews, observation of patients, monitoring of incident reports and complaints over a 21-month period in 6 acute NHS trusts the authors found that that safety issues described "were mostly related to **delays** and **omissions of care**, in particular: inadequate provision of basic **nursing care**, **misdiagnosis**, **delayed investigations and treatment**, and **non-treatment decisions** and Do Not Attempt Cardiopulmonary Resuscitation orders. The authors also note that hospital staff "did not always readily identify patient safety issues or report them. Incident reports focused mostly around events causing immediate or potential physical harm, such as falls. Hospitals lacked effective systems for **identifying patients with intellectual disabilities** within their service, making monitoring safety incidents for this group difficult." They conclude that "The events leading to avoidable harm for patients with intellectual disabilities are not always recognised as safety incidents, and may be difficult to attribute as causal to the harm suffered. Acts of omission (failure to give care) are more difficult to recognise, capture and monitor than acts of commission (giving the wrong care). In order to improve patient safety for this group, the reasonable adjustments needed by individual patients should be identified, documented and monitored."

Cost-effectiveness of a quality improvement programme to reduce central line-associated bloodstream infections in intensive care units in the USA
Herzer KR, Niessen L, Constenla DO, Ward WJ, Pronovost PJ
BMJ Open. 2014 September 1, 2014;4(9).

DOI	http://dx.doi.org/10.1136/bmjopen-2014-006065
Notes	A not uncommon question raised about safety and/or quality interventions are whether they impose an additional cost for a health service or organisation. This may strike some people as a banal question as it might be thought that any reduction or avoidance of unnecessary morbidity or mortality was a good in itself. Notwithstanding this, this paper looks the cost-effectiveness of the otherwise successful 'Keystone ICU' project. This project. – now replicated in many countries – saw the development of a bundle of interventions that have successfully reduced the incidence of central line-associated bloodstreams infections (CLABSI) in intensive care units (ICUs). The results of this analysis reveal that the program "**reduces bloodstream infections and deaths at no additional cost**" . Indeed, beyond costing money "the programme's implementation has the **potential to substantially reduce morbidity, mortality and economic costs associated with central line-associated bloodstream infections**."

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

BMJ Quality and Safety
November 2014, Vol. 23, Issue 11

URL	http://qualitysafety.bmj.com/content/23/11
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: • Editorial: **Interruptions and multi-tasking**: moving the research agenda in new directions (Johanna I Westbrook) • **Positive deviance**: a different approach to achieving patient safety (Rebecca Lawton, Natalie Taylor, Robyn Clay-Williams, J Braithwaite) • Mitigating errors caused by **interruptions during medication verification and administration**: interventions in a simulated ambulatory chemotherapy setting (Varuna Prakash, Christine Koczmara, Pamela Savage, Katherine Trip, Janice Stewart, Tara McCurdie, Joseph A Cafazzo, Patricia Trbovich) • Clinician perspectives on considering **radiation exposure to patients** when ordering imaging tests: a qualitative study (Jenna F Kruger, Alice Hm Chen, Alex Rybkin, Kiren Leeds, Dominick L Frosch, L Elizabeth Goldman) • Parents' perspectives on **safety in neonatal intensive care**: a mixed-methods study (Audrey Lyndon, Carrie H Jacobson, Kelly M Fagan, Kirsten Wisner, Linda S Franck) • '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) • Assessing **distractors and teamwork during surgery**: developing an event-based method for direct observation (Julia C Seelandt, Franziska Tschan, S Keller, G Beldi, N Jenni, A Kurmann, D Candinas, N K Semmer)

	• 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) • The **WHO surgical safety checklist**: survey of patients' views (S J Russ, S Rout, J Caris, K Moorthy, E Mayer, A Darzi, N Sevdalis, C Vincent) • Evaluation of hospital factors associated with **hospital postoperative venous thromboembolism** imaging utilisation practices (Jeanette W Chung, Mila H Ju, C V Kinnier, E R Haut, D W Baker, K Y Bilimoria) • **Learning from mistakes** in clinical practice guidelines: the case of perioperative β-blockade (Mark D Neuman, Charles L Bosk, L A Fleisher)

International Journal for Quality in Health Care
Vol. 26, No. 5, October 2014

URL	http://intqhc.oxfordjournals.org/content/26/5?etoc
Notes	A new issue of *International Journal for Quality in Health Care* has been published. Many of the papers in this issue have been referred to in previous editions of On the Radar (when they released online). Articles in this issue of *International Journal for Quality in Health Care* include: • Towards a measurement instrument for **determinants of innovations** (Margot A H Fleuren, Theo G W M Paulussen, Paula Van Dommelen, and Stef Van Buuren) • International variation in the definition of **'main condition' in ICD-coded health data** (H. Quan, L Moskal, A J Forster, S Brien, R Walker, P S Romano, V Sundararajan, B Burnand, G Henriksson, O Steinum, S Droesler, H A Pincus, and W A Ghali) • Editor's choice: Trends in hospital performance in **acute myocardial infarction care**: a retrospective longitudinal study in Japan (Naoto Ukawa, Hiroshi Ikai, and Yuichi Imanaka) • Gender and performance of **community treatment assistants in Tanzania** (Alexander Jenson, Catherine Gracewello, Harran Mkocha, Debra Roter, Beatriz Munoz, and Sheila West) • 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) • **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) • Can **preventable adverse events** be predicted among **hospitalized older patients**? The development and validation of a predictive model (L Van De Steeg, M Langelaan, and C Wagner) • 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) • **Integrated care programmes** for adults with chronic conditions: a meta-review (Nahara Anani Martínez-González, Peter Berchtold, Klara Ullman, André Busato, and Matthias Egger)

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: • **Low value cardiac testing** and Choosing Wisely (R Sacha Bhatia, Wendy Levinson, Douglas S Lee) • **Designing quality improvement initiatives**: the action effect method, a structured approach to identifying and articulating programme theory (Julie E Reed, Christopher McNicholas, Thomas Woodcock, Laurel Issen, D Bell)

International Journal for Quality in Health Care online first articles

URL	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: • Systematic biases in **group decision-making**: implications for patient safety (Russell Mannion and Carl Thompson)

Online resources

[UK] NICE Evidence Updates
https://www.evidence.nhs.uk/about-evidence-services/bulletins-and-alerts/evidence-updates
The UK's National Institute for Health and Care Excellence (NICE) publishes updates on their Evidence Updates site. The latest update is on '**type 2 diabetes**'.
A new Evidence Update focuses on a summary of selected new evidence relevant to NICE public health guidance PH35 '**Preventing type 2 diabetes: population and community-level interventions**' (2011)
https://www.evidence.nhs.uk/evidence-update-66