AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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
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

The state of health care and adult social care in England 2013/14
Care Quality Commission
Newcastle: Care Quality Commission; 2014.

URL	http://www.cqc.org.uk/content/state-care-2013-14
Notes	The UK's Care Quality Commission has released their fifth 'State of care' report offering a view across 40,000 services in 2013/14 and arguing how **strong leadership** and a **positive culture** are the **key to safe care**. Key messages from the Care Quality Commission include: • The public should be at the heart of good care • Providers should accept where there are problems and use inspections to drive up quality • The wider health and care system needs to work together and help to put things right when services need to improve • The need to shine a light on poor care, highlight good and outstanding practice and encourage a learning culture. The Commission also note that: "Variation in basic safety is a serious problem, particularly: • a lack of effective safety processes. • the lack of a culture that truly learns from mistakes and near misses.

	Strong, effective leadership at all levels of an organisation is vital. In our new inspections of NHS trusts we have found that: • good leadership drives up quality and safety overall. • in more than 80% of cases, the rating for 'well-led' was the same as the trust's overall rating. Well-led organisations have strong and effective leadership, an open and supportive, values-driven culture and stable management. They are committed to ensuring safe, effective, caring and responsive care. CQC is calling time on unacceptable variation in the quality of care. In our report, we are challenging every health and care provider in England, and every commissioner and oversight body, to deliver the high standards of care that each person has a right to expect.”

Focus on Allied health professionals: Can we measure quality of care?
Quality Watch
London: The Health Foundation and the Nuffield Trust; 2014.

URL	http://www.qualitywatch.org.uk/focus-on/allied-health-professionals
Notes	QualityWatch is a major research program in the United Kingdom providing independent scrutiny on the quality of health and social care In the UK’s NHS (as in Australia) there is little systematic or national data available about how Allied Health Professionals (AHP) contribute to the quality of care. The report outlines the need for more data and information in order to understand the value that Allied Health Professionals deliver, particularly in care coordination and person centred care. • A set of observations from the analysis presented in the report outlines: • Recognition of AHP activity in the implementation of community information systems. • The development of ways to link basic administrative information with care records. • The development of ways to use information to quality-assure the care that AHPs deliver. • Continued development of AHP research. There are many echoes with the Australian context — the key messages will resonate with Allied Health clinicians and managers, professional associations and healthcare services. It is vital that the quality care aspects being delivered by this important group of health care professionals continue to be explored.

Journal articles

Overdiagnosis: How Our Compulsion for Diagnosis May Be Harming Children
Coon ER, Quinonez RA, Moyer VA, Schroeder AR
Pediatrics. 2014 [epub]

DOI	http://dx.doi.org/10.1542/peds.2014-1778
Notes	Adding to the literature on diagnosis, including over-diagnosis and misdiagnosis, while also contributing to debates about appropriate levels of care, comes this piece. The authors stress that “Overdiagnosis occurs when a true abnormality is discovered, but detection of that abnormality does not benefit the patient. It should be distinguished from misdiagnosis, in which the diagnosis is inaccurate, and it is not synonymous with overtreatment or overuse, in which excess medication or procedures are provided to patients for both correct and incorrect diagnoses.”

	The authors discuss why over-diagnosis occurs and how it may be harming children. They suggest that over-diagnosis may affect commonly diagnosed conditions such as attention-deficit/hyperactivity disorder, bacteraemia, food allergy, hyperbilirubinemia, obstructive sleep apnoea, and urinary tract infection.

Diagnostic error in children presenting with acute medical illness to a community hospital
Warrick C, Patel P, Hyer W, Neale G, Sevdalis N, Inwald D
International Journal for Quality in Health Care. 2014 October 1, 2014;26(5):538-46.

DOI	http://dx.doi.org/10.1093/intqhc/mzu066
Notes	Whereas the previous paper focused on over-diagnosis in young patients, this British paper looks at misdiagnosis or **diagnostic error** in children. The study sought to determine the incidence and aetiology of diagnostic errors in children presenting with acute medical illness to a community hospital in the UK. The study examined all the medical patients admitted to the paediatric ward and patients transferred from the Emergency Department to a different facility over a 90-day period. The authors report that "**Misdiagnoses** occurred in **5% of children** presenting with acute illness" and that these errors were "were multi-factorial in origin, commonly involving cognitive factors".

American Journal of Medical Quality
November 2014; 29 (6)

URL	http://ajm.sagepub.com/content/29/6?etoc
Notes	A new issue of the *American Journal of Medical Quality* has been published. Articles in this issue of the *American Journal of Medical Quality* include: • Collaborative **Practice Improvement for Childhood Obesity** in Rural Clinics: The Healthy Eating Active Living Telehealth Community of Practice (HEALTH COP) (Ulfat Shaikh, Jasmine Nettiksimmons, Jill G Joseph, Daniel Tancredi, and Patrick S Romano) • The Seamless Transfer of Care: A Pilot Study Assessing the Usability of an **Electronic Transfer of Care Communication Tool** (Maria Jose Santana, Jayna Holroyd-Leduc, William Ward Flemons, Maeve O'Beirne, Deborah White, Nancy Clayden, Alan J Forster, and William A Ghali) • Reduction of **Central Line–Associated Bloodstream Infections** in a Pediatric Hematology/Oncology Population (Matthew Z Wilson, Deana Deeter, Colleen Rafferty, Melanie M. Comito, and C S Hollenbeak) • Measuring Briefing and **Checklist Compliance in Surgery**: A Tool for Quality Improvement (Fabian M Johnston, Ana I Tergas, Jennifer L Bennett, Vicente Valero III, Candice K Morrissey, Amanda N Fader, Deborah B Hobson, Sallie J Weaver, Michael A Rosen, and E C Wick) • **Postadmission Sepsis** as a Screen for Quality Problems: A Case–Control Study (John S Hughes, Jon Eisenhandler, Norbert Goldfield, Patti G Weinberg, and Richard Averill) • Creating a **Physician-Led Quality Imperative** (Marcia F Nelson, Charles S Merriman, Peter T Magnusson, Kristapor V Thomassian, Alivia Strawn, and J Martin) • Effectiveness and Cost of Failure Mode and Effects Analysis Methodology to Reduce **Neurosurgical Site Infections** (Alexander R Hover, William W Sistrunk, Robert M Cavagnol, Alan Scarrow, Phillip J Finley, Audrey D Kroencke, and Judith L Walker) • Focus on **Transitions of Care**: Description and Evaluation of an

	Educational Intervention for Internal Medicine Residents (Hanan Aboumatar, Robert D Allison, Leonard Feldman, Kevin Woods, Patricia Thomas, and Charles Wiener) • Use of the Modified Early Warning Score and Serum Lactate to **Prevent Cardiopulmonary Arrest** in Hematology-Oncology Patients: A Quality Improvement Study (Robert S Young, Barbara H Gobel, Mark Schumacher, Jungwha Lee, Charlotta Weaver, and Sigmund Weitzman) • **Innovation and Transformation** in California's Safety Net Health Care Settings: An Inside Perspective (Courtney R Lyles, Veenu Aulakh, Wendy Jameson, Dean Schillinger, Hal Yee, and Urmimala Sarkar) • Developing, Implementing, and Evaluating a Multifaceted Quality Improvement Intervention to Promote **Sleep in an ICU** (Biren B Kamdar, Jessica Yang, Lauren M King, Karin J Neufeld, O Joseph Bienvenu, Annette M Rowden, Roy G Brower, Nancy A Collop, and D M Needham) • Is It Time to Change Directions of **Quality Measures**? (Thomas James III) • Halting the Revolving Door: How a Focus on Patient- and Community-Level Risks May Help Curb **Readmissions After Surgery** (Charles A. Odonkor, Pia Hurst, Naoki Kondo, Martin A Makary, and Peter J Pronovost)

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: • **Evaluating inpatient mortality**: a new electronic review process that gathers information from front-line providers (Audrey Provenzano, Shannon Rohan, Elmy Trevejo, Elisabeth Burdick, S Lipsitz, A Kachalia) • Analysing organisational context: case studies on the contribution of absorptive capacity theory to understanding **inter-organisational variation in performance improvement** (Gill Harvey, Pauline Jas, Kieran Walshe) • **Patients teaching patient safety**: the challenge of turning negative patient experiences into positive learning opportunities (Antonia S Stang, Brian M Wong)

Online resources

[USA] Quality Indicators™ Toolkit for Hospitals
http://www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html
The (US) Agency for Healthcare Research and Quality (AHRQ) has released an updated version of their Quality Indicators™ Toolkit for Hospitals (QI Toolkit). It is designed to assist acute care facilities improve inpatient quality performance.
Using this free QI Toolkit offers hospitals the opportunity to:

- Improve performance on two sets of AHRQ Quality Indicators, 18 Patient-Safety Indicators (PSIs) and 28 Inpatient Quality Indicators (IQIs).
- Measure hospital quality using available inpatient data to assess the quality of care, identify areas that need improvement, and track performance over time.
- Approach quality improvement work from various levels of readiness. Facilities can select any of the 33 tools available to meet their specific hospital quality needs.

- Take advantage of “Best Practices” for 14 PSIs, including information to determine where gaps exist and suggestions for hospitals regarding improvement, process steps, and additional resources.

[USA] Using Measurement for Quality Improvement
http://www.ahrq.gov/workingforquality/events.htm
The transcript and slides from this US National Quality Strategy webinar are now available.

[UK] Practical steps for boards: how to measure and monitor safety within your organisation
https://event.webcasts.com/starthere.jsp?ei=1045497&dm_i=4Y2,2W3AI,G85JNT,AH5L4,1
At 0930 UTC on 30 October 2014 (7pm Sydney, 8 pm Brisbane, Perth 5pm), the UK’s Health Foundation is hosting a webinar presented by Maxine Power (Director of Innovation and Improvement Science, Salford Royal NHS Foundation Trust) and Penny Pereira, (Assistant Director of Patient Safety, Health Foundation).
Maxine Power will explore the practical steps for boards to take to effectively measure and monitor quality and safety within their organisation. She will explain how healthcare boards can use intelligence from the past, the present and the future to understand the safety of their organisations.
Register at
https://event.webcasts.com/starthere.jsp?ei=1045497&dm_i=4Y2,2W3AI,G85JNT,AH5L4,1
