



On the Radar

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On the Radar

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Webcast: Medication Reconciliation Seminar

<http://www.blueshadowgroup.com.au/clients/ACSQHC/high5/index.html>

You are invited to attend a free live webcast on Friday, 14 November 2014 (9.15 – 4.00pm AEDT). The Medication Reconciliation Seminar, hosted by the Commission, aims to share the results from the Australian arm of the World Health Organization's (WHO) High 5s Project.

The program is divided into two sessions:

- The morning session will showcase the results from the WHO High 5s Ensuring Medication Accuracy at Transitions of Care project, the lessons learned and resources developed. The session will also provide a forum for discussing the challenges to implementing medication reconciliation in different health environments, including a discussion on using the High 5s Medication Reconciliation Standing Operating Protocol to meet relevant action items in the NSQHS Standard 4 - Medication Safety.
- The afternoon session will focus on moving from paper-based to electronic systems for medication reconciliation.

For more information and access to the webcast , see

<http://www.blueshadowgroup.com.au/clients/ACSQHC/high5/index.html>

Not available to watch the webcast live? A recording of the seminar will be available on the Commission's web site after the event.

Consultation: Guide for health service organisation boards implementing the National Safety and Quality Health Service Standards

<http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/consultation-guide-for-health-service-organisation-boards-implementing-the-national-safety-and-quality-health-service-nsqhs/>

Now open

The Commission is seeking feedback on the draft *Guide for health service organisation boards implementing the National Safety and Quality Health Service (NSQHS) Standards*.

The draft Guide has been developed to assist the boards of health service organisations and local health networks implementing the NSQHS Standards, with guidance provided for the 10 NSQHS Standards.

The Commission encourages board members, senior managers and directors of clinical governance of public hospitals and local health networks and private health service organisations, to provide feedback on the draft Guide.

Feedback is sought by close of business 19 December 2014, by post or email.

Any queries regarding this consultation process can be directed to NSQHSStandards@safetyandquality.gov.au or (02) 9126 3600.

Reports

Person-centred care made simple: What everyone should know about person-centred care

The Health Foundation

London: The Health Foundation; 2014 October 2014. 40 p.

URL	http://personcentredcare.health.org.uk/resources/person-centred-care-made-simple
TRIM	D14-38244
Notes	The (UK) Health Foundation has added to their output on patient-centred care with this guide. The guide seeks to provide a quick overview of person-centred care. It offers a clear explanation of the principles of person-centred care, why it is important, how it has developed, and provides some examples to help those considering putting person-centred care into practice.

For information on the Commission's work on patient and consumer centred care, see

<http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/>

Improving the delivery of adult diabetes care through integration

Diabetes UK

London: Diabetes UK; 2014.

URL	http://www.diabetes.org.uk/Professionals/Service-improvement/Integrated-diabetes-care/
Notes	Diabetes UK has published this describing how diabetes care can be improved to achieve better outcomes for people with diabetes. The challenge for funders and providers at the local level is to make the system work to support that. The report brings together information about what the various aspects of good diabetes care should look like. The report also provides shares examples of what is being done in parts of England to make the system work for people with diabetes and clinicians.

Journal articles

A personal reflection on staff experiences after critical incidents

Knott C

Medical Journal of Australia. 2014;201(9):550-1.

Sometimes a doctor can't help but kill a patient

Hitchcock K

The Monthly. November 2014.

DOI / URL	http://dx.doi.org/10.5694/mja14.00681 (Knott) http://www.themonthly.com.au/issue/2014/november/1414760400/karen-hitchcock/medicine (Hitchcock)
Notes	<p>A pair of items offering a personal perspective on what it is like to be a 'second victim' – as an individual or as part of the healthcare team involved in a serious adverse event. In both these instances the author was involved in a case where a patient died. Indeed, Hitchcock's opening line reads "A few weeks ago I killed a patient." Given the contemporary interest in issues of euthanasia the reader may expect a story along those lines. But this is not the case. Hitchcock and Knott both reflect on the experience of being a clinician where the care they deliver contributes to the worst possible outcome.</p> <p>Knott confirms that much of the experience is accurately captured in the literature and that much can be done for the patient's family and the 'second victims'. However, that final term does not sit comfortably, as Knott insists "I do not believe I am a second victim. Rather, I am a member of a responsible team. We have learned and helped others by conceptually placing the bereaved family at the centre of our own recovery. This long and challenging process demonstrates the power and importance of patient-centred quality and safety initiatives."</p> <p>Knott goes on to argue that health care organisations need to be 'high-reliability organisations' (HROs). HROs have an organisational performance that "is often matched by an ability to expand capacity in a crisis. This is achieved through planning for variability in human performance by accepting the possibility of failure. HROs have evolved multiple redundant preventive and adaptive systems that integrate safety, quality and workplace learning." He is also sanguine enough to recognise that "critical incidents will still occur".</p>

Integrated care programmes for adults with chronic conditions: a meta-review

Martínez-González NA, Berchtold P, Ullman K, Busato A, Egger M

International Journal for Quality in Health Care. 2014 October 1, 2014;26(5):561-70.

DOI	http://dx.doi.org/10.1093/intqhc/mzu071
Notes	<p>This meta-review of systematic reviews and meta-analyses of integrated care programmes in chronically ill patients identified 27 systematic reviews. Conditions covered included chronic heart failure (CHF; 12 reviews), diabetes mellitus (DM; seven reviews), chronic obstructive pulmonary disease (COPD; seven reviews) and asthma (five reviews).</p> <p>The authors report that "A majority of the reviews found beneficial effects of integration, including reduced hospital admissions and re-admissions (in CHF and DM), improved adherence to treatment guidelines (DM, COPD and asthma) or quality of life (DM). Few reviews showed reductions in costs."</p>

Association of weekend continuity of care with hospital length of stay

Blecker S, Shine D, Park N, Goldfeld K, Braithwaite RS, Radford MJ, et al.

International Journal for Quality and Safety in Health Care. 2014 2014-10-01 00:00:00;26(5):530-7.

DOI	http://dx.doi.org/10.1093/intqhc/mzu065
Notes	Paper reporting on a study covering 33391 patients undertaken in a single 'academic medical center' (teaching hospital) to examine the association of continuity of care with length of stay, likelihood of weekend discharge, in-hospital mortality and 30-day readmission. From their observations the authors suggest that “Increased weekend continuity of care is associated with reduced length of stay. Improvement in weekend cross-coverage and patient handoffs may be useful to improve clinical outcomes.”

Increases in Emergency Department Occupancy Are Associated With Adverse 30-day Outcomes

McCusker J, Vadeboncoeur A, Lévesque J-F, Ciampi A, Belzile E

Academic Emergency Medicine. 2014;21(10):1092-100.

DOI	http://dx.doi.org/10.1111/acem.12480
Notes	<p>This Canadian paper used administrative data covering a cohort of 677,475 patients visiting one of 42 hospital emergency departments (EDs) in 2005 to examine the relationship of ED occupancy (crowding) with patient outcomes.</p> <p>The authors report finding that “After adjustment for ED and patient characteristics, a 10% increase in ED bed relative occupancy ratio was associated with 3% increases in death and hospital admission at a return visit. A 10% increase in ED waiting room crowding was associated with a small decrease in return visits. There was a stronger association between bed crowding and mortality among larger EDs.”</p> <p>As the authors conclude, “In Quebec EDs, increases in bed occupancy are associated with an increase in the rates of 30-day adverse outcomes, even after adjustment for patient and ED characteristics. The results raise important concerns about the quality of care during periods of ED crowding.”</p> <p>In some ways this echoes Knott’s call for health care organisation to be high-reliability organisations that can grow their capacity (broadly defined) when under pressure.</p>

Systematic derivation of an Australian standard for Tall Man lettering to distinguish similar drug names

Emmerton L, Rizk MFS, Bedford G, Lalor D

Journal of Evaluation in Clinical Practice. 2014 [epub].

DOI	http://dx.doi.org/10.1111/jep.12247
Notes	Paper describing the systematic processes undertaken for identifying confusable drug names and the derivation of a risk-based, standardised approach for the production of a national list of Tall Man lettering conventions for those drugs. This process has led to a standard now endorsed for use in clinical settings in Australia.

For information on the Australian National Tall Man Lettering, see

<http://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-of-medicines/national-tall-man-lettering/>

Changes in Medical Errors after Implementation of a Handoff Program

Starmer AJ, Spector ND, Srivastava R, West DC, Rosenbluth G, Allen AD, et al.

New England Journal of Medicine. 2014;371(19):1803-12.

DOI	http://dx.doi.org/10.1056/NEJMsa1405556
Notes	Paper describing a prospective intervention study of a resident handoff-improvement program in nine US hospitals, measuring rates of medical errors, preventable adverse events, and miscommunications, as well as resident workflow. Covering 10,740 patient admissions, the medical error rate decreased by 23% from the pre-intervention period to the post-intervention period (24.5 vs. 18.8 per 100 admissions), and the rate of preventable adverse events decreased by 30% (4.7 vs. 3.3 events per 100 admissions). The rate of non-preventable adverse events did not change significantly (3.0 and 2.8 events per 100 admissions). The authors conclude that the implementation of the handoff program was associated with reductions in medical errors and in preventable adverse events and with improvements in communication, without a negative effect on workflow.

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

Quality improvement in practice: improving diabetes care and patient outcomes in Aboriginal Community Controlled Health Services

Stoneman A, Atkinson D, Davey M, Marley JV

BMC Health Services Research. 2014;14:481.

DOI	http://dx.doi.org/10.1186/1472-6963-14-481
Notes	Paper describing how a continuous quality improvement approach has enhanced diabetes care (and patient outcomes) in Aboriginal Community Controlled Health Services (ACCHSs) in the remote Kimberley region of north Western Australia. The study included retrospective audit of records for 348 Aboriginal and Torres Strait Islander primary care patients aged ≥ 15 years with a confirmed diagnosis of type 2 diabetes mellitus at four Kimberley ACCHSs. The main outcome measures included diabetes care related activities, clinical outcome measures and factors influencing good diabetes related care and effective CQI. The authors report that features that facilitated good care included “clearly defined staff roles for diabetes management, support and involvement of Aboriginal Health Workers, efficient recall systems, and well-coordinated allied health services . Effective CQI features included seamless and timely data collection, local ownership of the process, openness to admitting deficiencies and willingness to embrace change.” It was concluded that “Well-designed health care delivery and CQI systems, with a strong sense of ownership over diabetes management led to increased service delivery rates and improved clinical outcome measures in ACCHSs.”

The connection between evidence-based medicine and shared decision making

Hoffmann TC, Montori VM, Del Mar C

Journal of the American Medical Association. 2014;312(13):1295-6.

DOI	http://dx.doi.org/10.1001/jama.2014.10186
Notes	In this paper, Hoffman and colleagues suggest that the “pinnacle of good patient care” lies at the intersection of evidence-based medicine (EBM) and shared decision making (SDM). The interdependency of EBM and SDM is explored: without SDM there can be “evidence tyranny” and clinicians may erroneously

	<p>guess the preferences of the patient; and without EBM, the patient cannot construct evidence-informed preferences and decision making.</p> <p>The authors argue that the connection between EBM and SDM can be realised through:</p> <ul style="list-style-type: none"> • routinely incorporating SDM into EBM training within medical education; • incorporating SDM into clinical practice guidelines; and • strongly recommending SDM in guidelines when options are closely matched, uncertainty in the evidence impairs the determination of a clearly superior approach or when the balance of benefits and risks depends on patient action or preferences. <p>The Commission is currently working with key clinical colleges to develop an online training module in risk communication and is a major sponsor of the 7th International Shared Decision Making Conference and the 4th International Society for Evidence-Based Health Care Conference to be held in Sydney on 19–22 July 2014. Further information about the Commission’s work in SDM can be found at: http://www.safetyandquality.gov.au/our-work/shared-decision-making/</p>
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Recognising and responding to the acutely deteriorating patient

Rapid response system

Hillman KM, Chen J, Jones D.

Medical Journal of Australia 2014;201(9):519-521.

Incidents resulting from staff leaving normal duties to attend medical emergency team calls

Concord Medical Emergency Team (MET) Incidents Study Investigators.

Medical Journal of Australia 2014;201(9):528-531.

Factors influencing escalation of care by junior medical officers

Rotella JA, Yu W, Ferguson J, Jones D.

Anaesthesia and Intensive Care 2014;42(6):723-9.

DOI	<p>http://dx.doi.org/10.5694/mja14.01088 (Hillman et al)</p> <p>http://dx.doi.org/10.5694/mja14.00647 (Concord MET investigators)</p> <p>http://www.aaic.net.au/Document/?D=20140162 (Rotella et al)</p>
Notes	<p>What are rapid response systems and what strategies help them succeed? In a succinct summary of essential ‘need to knows’, Hillman et al describe the critical features, purpose and benefits of a rapid response system. More importantly they provide ‘real world’ strategies for maximising the impact of a hospital rapid response system noting that “implementing an organisation-wide system such as an RRS involves challenging the way clinicians interact, bypassing entrenched hierarchies and constructing a system centred on patient needs” and requires more than calling criteria and a rapid response.</p> <p>How do MET calls affect routine provision of care? In the same issue of MJA, the potential adverse consequences of superimposing MET team responsibilities on other duties are explored in an incident monitoring study. Investigators catalogued incidents occurring in patients as a result of staff attending MET calls for other patients in a large NSW hospital. The study found no major harm to patients but significant disruption to normal routines— which could theoretically impact on the quality of care.</p>

	<p>In the 18 week study period there were 19 MET calls per 1000 admissions and an average 1.1 incidents per MET call. A mean of 8 staff members were recorded at each MET call, with incidents arising in 213.7 incidents per 1000 MET staff attendances. The majority (99.5%) of incidents had 'minimum' consequences. Less than 1% of incidents collected were reported on the institution's usual incident reporting system.</p> <p>What influences JMOs' escalation of care?</p> <p>This small, self-report study of junior medical officers (n=50) found that only 30% of JMOs agreed that they had not escalated care because of failing to recognise clinical deterioration. In an apparent contradiction, 64% agreed that they had not escalated care of a patient previously because they did not seem sick enough. Workload, time of day and fear of criticism did not seem to prevent escalation of care, but 36% were reluctant to escalate if it meant waking a senior consultant. A lack of knowledge about the patient's clinical condition or limitations of therapy made escalation more likely. Approximately equal numbers of JMOs stated they would escalate if a patient was dying as those who would not.</p>
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For information on the Commission's work on recognising and responding to clinical deterioration, see www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/

Australian Health Review
Vol. 38, No. 5. 2014

URL	http://www.publish.csiro.au/nid/271/issue/7059.htm
Notes	<p>A new issue of <i>Australian Health Review</i> has been published. Articles in this issue of <i>Australian Health Review</i> include:</p> <ul style="list-style-type: none"> • Capricornia Allied Health Partnership (CAHP): a case study of an innovative model of care addressing chronic disease through a regional student-assisted clinic (Kerrie-anne Frakes, Sharon Brownie, Lauren Davies, Janelle B Thomas, Mary-Ellen Miller and Zephania Tyack) • An evaluation of the quality of evidence underpinning diabetes management models: a review of the literature (Deborah Schofield, Michelle M Cunich and Lucio Naccarella) • Effectiveness of 'rehabilitation in the home' service (Sneha Bharadwaj and David Bruce) • Physiotherapy-led arthroplasty review clinic: a preliminary outcomes analysis (Kate E Large, Carolyn J Page, Kim Brock, Michelle M Dowsey and Peter F M Choong) • Hospitals caring for rural Aboriginal patients: holding response and denial (Judith Dwyer, Eileen Willis and Janet Kelly) • Implementing a working together model for Aboriginal patients with acute coronary syndrome: an Aboriginal Hospital Liaison Officer and a specialist cardiac nurse working together to improve hospital care (Karen Daws, Amanda Punch, Michelle Winters, Sonia Posenelli, John Willis, Andrew MacIsaac, Muhammad Aziz Rahman and Linda Worrall-Carter) • Antimicrobial stewardship activities: a survey of Queensland hospitals (Minyon L Avent, Lisa Hall, Louise Davis, Michelle Allen, Jason A Roberts, S Unwin, K A McIntosh, K Thursky, K Busing and D L Paterson)

	<ul style="list-style-type: none"> • Aiming to be NEAT: safely improving and sustaining access to emergency care in a tertiary referral hospital (Clair M Sullivan, Andrew Staib, Judy Flores, Leena Aggarwal, A Scanlon, J H Martin and I A Scott) • Staff perceptions of primary healthcare service change: influences on staff satisfaction (Rachel Tham, Penny Buykx, Leigh Kinsman, Bernadette Ward, John S. Humphreys, Adel Asaid, Kathy Tuohey and Rohan Jenner) • Reflecting on the tensions faced by a community-based multicultural health navigator service (Saras Henderson and Elizabeth Kendall) • The use of social media as a 'leadership behaviour' in medicine (Harris Eyre, Malcolm Forbes and Gemma Robertson)
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BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	<p><i>BMJ Quality and Safety</i> has published a number of 'online first' articles, including:</p> <ul style="list-style-type: none"> • Effectiveness of facilitated introduction of a standard operating procedure into routine processes in the operating theatre: a controlled interrupted time series (Lauren Morgan, Steve New, Eleanor Robertson, Gary Collins, Oliver Rivero-Arias, Ken Catchpole, Sharon P Pickering, Mohammed Hadi, Damian Griffin, Peter McCulloch) • Do patient-reported outcomes offer a more sensitive method for comparing the outcomes of consultants than mortality? A multilevel analysis of routine data (Mira Varaganam, Andrew Hutchings, Nick Black) • Project JOINTS: What factors affect bundle adoption in a voluntary quality improvement campaign? (Dmitry Khodyakov, M Susan Ridgely, Christina Huang, Katherine O DeBartolo, M E Sorbero, E C Schneider) • Am I my brother's keeper? A survey of 10 healthcare professions in the Netherlands about experiences with impaired and incompetent colleagues (Jan Willem Weenink, Gert P Westert, Lisette Schoonhoven, Hub Wollersheim, Rudolf B Kool)

Online resources

Medical Devices Safety Update

Volume 2, Number 6, November 2014

<http://www.tga.gov.au/publication-issue/medical-devices-safety-update-volume-2-number-6-november-2014>

The Therapeutic Goods Administration (TGA) has released the latest edition of its medical device safety bulletin. Topics covered in this issue include:

- Urogynaecological surgical mesh implants review – highlights the importance of appropriate patient selection, surgeon experience and the need for fully informed patient consent.
- National Joint Replacement Registry data offers insight into orthopaedic implants
- Warning – incidents relating to use of walking frames as wheelchairs
- Recent safety alerts.

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