AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

# On the Radar

Issue 202
1 December 2014

*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.

Access to particular documents may depend on whether they are Open Access or not, and/or your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

*On the Radar* is available online, via email or as a PDF document from
http://www.safetyandquality.gov.au/publications-resources/on-the-radar/

If you would like to receive *On the Radar* via email, you can subscribe on our website http://www.safetyandquality.gov.au/ or by emailing us at mail@safetyandquality.gov.au.
You can also send feedback and comments to mail@safetyandquality.gov.au.

For information about the Commission and its programs and publications, please visit
http://www.safetyandquality.gov.au
You can also follow us on Twitter @ACSQHC.

**On the Radar**
Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson, Alice Bhasale

**Reports**

*An inquiry into Patient Centred Care in the 21st Century: Implications for general practice and primary care*
Royal College of General Practitioners
London: Royal College of General Practitioners; 2014.

| | |
|---|---|
| URL | http://www.rcgp.org.uk/policy/rcgp-policy-areas/inquiry-into-patient-centred-care-in-the-21st-century.aspx |
| TRIM | TRIM D14-41647 |
| Notes | The UK's Royal College of General Practitioners commissioned an independent panel to lead an inquiry into patient centred care in the 21st century - with the aim of identifying cost effective solutions to the medical, social and financial challenges posed by rising levels of multi-morbidity.<br>The inquiry has concluded that clinicians must work with patients in a very different way, providing personalised care and empowering patients to play an active role in managing their health. The report also calls for a seismic shift in the way that general practice is delivered, so that practices come together as federations or networks and work with a range of other services to deliver coordinated and proactive care in the community. |

*Improving quality in general practice.* Evidence scan
De Silva D, Bamber J
London: The Health Foundation; 2014.

| | |
|---|---|
| URL | http://www.health.org.uk/publications/improving-quality-in-general-practice/ |
| TRIM | D14-41379 |
| Notes | This 'evidence scan' from the UK's Health Foundation examines explores how quality in general practice may be defined. It summarises the empirical evidence on what the public think of general practice and the features they value, and on tested interventions to improve the quality of general practice care. |

*The reconfiguration of clinical services: What is the evidence?*
Imison C, Sonola L, Honeyman M, Ross S
London: The King's Fund; 2014.

| | |
|---|---|
| URL | http://www.kingsfund.org.uk/publications/reconfiguration-clinical-services |
| Notes | The King's Fund in the UK has published this paper with the intention of helping those planning and implementing major clinical service reconfigurations ensure that change is as evidence-based as possible. It investigates the five key drivers – quality, workforce, cost, access and technology – across 13 clinical service areas (whole of trust, community services, mental health inpatient services, accident and emergency (A&E) and urgent care services, acute medical services, acute surgical services, elective surgical care, trauma services, stroke care, specialist vascular surgery, maternity services, neonatal services, and paediatric services.), summarising the research evidence and professional guidance available in each. |

**Journal articles**

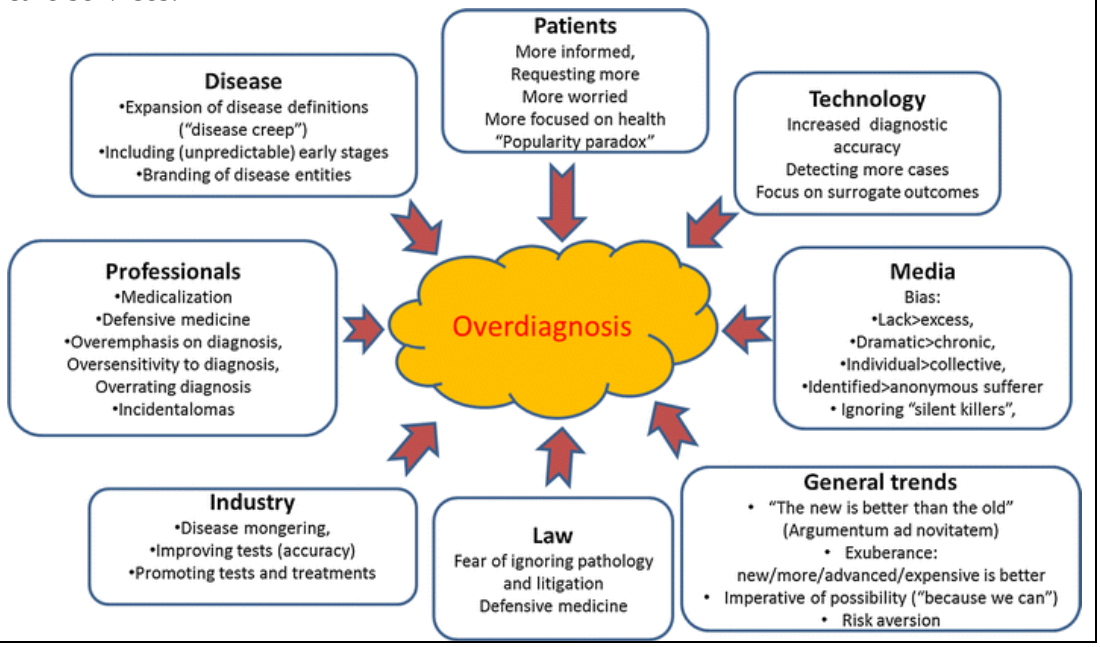
*Australia-wide point prevalence survey of the use and appropriateness of antimicrobial prescribing for children in hospital*
Osowicki J, Gwee A, Noronha J, Palasanthrina P, McCullan B, Britton PN, et al
Medical Journal of Australia. 2014;201(11):1-6.

| | |
|---|---|
| DOI | http://dx.doi.org/10.5694/mja13.00154 |
| Notes | Despite the importance of information about the appropriateness of antimicrobial prescribing for effective antimicrobial stewardship there are few studies providing relevant Australian data. This study of paediatric prescribing coincides with the report of a national point prevalence study published by the Commission. Both have similar findings – much prescribing is appropriate, but there is still room for improvement, especially for surgical antibiotic prophylaxis where guideline-compliant treatment was generally less likely. Osowicki and colleagues report that across 8 paediatric hospitals, 82% of prescriptions were deemed appropriate overall. However, 35% of antimicrobial prescriptions for surgical patients were considered inappropriate, mostly due to inappropriate duration of treatment. Similarly the Commission report notes that across 151 hospitals nationally, 41.5% of surgical prophylaxis prescriptions were for longer than 24 hours, substantially more than the best-practice target of less than 5%. 70% of all antibiotic prescriptions were considered appropriate. |

For information on the Commission's work on antimicrobials, including antibiotic stewardship, see http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

The Commission has recently launched a new *Clinical Care Standard for Antimicrobial Stewardship.* This is available at http://www.safetyandquality.gov.au/our-work/clinical-care-standards/antimicrobial-stewardship-clinical-care-standard/

*Diagnosing overdiagnosis: conceptual challenges and suggested solutions*
Hofmann B
European Journal of Epidemiology. 2014 2014/09/01;29(9):599-604.

| | |
|---|---|
| DOI | http://dx.doi.org/10.1007/s10654-014-9920-5 |
| Notes | Commentary piece discussing the challenges of over-diagnosis.<br>Apparently, one of these is the lack of an agree definition. This leads to a lack of clarity as to how prevalent over-diagnosis is.<br>Some of the other challenges are accepted. These include "unnecessary diagnosis (including anxiety and reduced quality of life), unnecessary treatment (including harms and adverse side effects), allocation of scarce resources (including opportunity cost), professional integrity, and potential reduced trust in the health care services."<br>  |

*Patient safety goals for the proposed Federal Health Information Technology Safety Center*
Sittig DF, Classen DC, Singh H
Journal of the American Medical Informatics Association. 2014 [epub].

| | |
|---|---|
| DOI | http://dx.doi.org/10.1136/amiajnl-2014-002988 |
| Notes | With the creation of a US national Health Information Technology (HIT) Safety Center anticipated this piece has been written to provide some recommendations for the activities such an entity could undertake. The authors suggest the following goals:<br>(1) facilitate creation of a nationwide 'post-marketing' surveillance system to monitor HIT related safety events;<br>(2) develop methods and governance structures to support investigation of major HIT related safety events;<br>(3) create the infrastructure and methods needed to carry out random assessments of HIT related safety in complex HCOs; and<br>(4) advocate for HIT safety with government and private entities. |

*Application of the WHO surgical safety checklist outside the operating theatre: medicine can learn from surgery*
Braham DL, Richardson AL, Malik IS
Clinical Medicine. 2014 October 1, 2014;14(5):468-74.

| | |
|---|---|
| DOI | http://dx.doi.org/10.7861/clinmedicine.14-5-468 |
| Notes | Another example of the WHO surgical safety checklist has been adapted for implementation. This example describes how it was implemented in the British cardiac catheterisation laboratory and the impact of this intervention. |

*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:<br>• Driven to distraction: a prospective controlled study of a **simulated ward round experience** to improve patient safety teaching for medical students (Ian Thomas, Laura Nicol, Luke Regan, Jennifer Cleland, Drieka Maliepaard, Lindsay Clark, Kenneth Walker, John Duncan) |

**Online resources**

*[UK] Fit and proper persons requirement and the duty of candour for NHS bodies*
http://www.cqc.org.uk/content/fit-and-proper-persons-requirement-and-duty-candour-nhs-bodies
The UK's Care Quality Commission has released two regulations that come into force this week for NHS bodies.
The fit and proper persons requirement outlines what providers should do to make clear that directors are responsible for the overall quality and safety of care.
The duty of candour explains what they should do to make sure they are open and honest with people when something goes wrong with their care and treatment.

*[UK] Consultant outcome data*
http://www.nhs.uk/Service-Search/performance/Consultants
The My NHS website now includes clinical outcomes data for 5000 consultant surgeons.
The consultant outcome data published shows the results of consultants' practice for a range of specialties – medical treatments and surgical procedures.
The data shows how many times a consultant has performed a particular procedure and, in many instances, includes other quality measures such as length of hospital stay, re-admission rate, complication rate, adverse events and mortality rates.
Publication of the data means consultants' performance can be compared openly for a given specialty to help spread best practice and identify issues.

*Why hospital-wide mortality ratios should be avoided*
http://isqua.org/education/webinars/november-2014-webinar-with-nick-black
Webinar presented by Professor Nick Black (Professor of Health Services Research, London School of Hygiene & Tropical Medicine) contributing to the vigorous debate around hospital quality. Many countries have chosen to use hospital-wide mortality ratios, which have the attraction of simplicity and providing a single measure. However, these measures are contentious.
An approach based on in-depth case record review is also explored together with other methods for assessing the quality of hospital care.

*[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 the following final report:

- *Pharmacokinetic/Pharmacodynamic Measures for Guiding Antibiotic Treatment for Hospital-Acquired Pneumonia* http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayProduct&productID=2008

---