



On the Radar

Issue 204
15 December 2014

This issue of *On the Radar* is the last one for this year. The next issue is expected to be available on 12 January 2015.

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, Eliza McEwin, Alice Bhasale

Books

How to Make Telehealth Work: Defining Telehealth Processes and Procedures
Wade V
Adelaide: Unicare e-health; 2014.

URL	http://www.e-unicare.com.au/wp-content/uploads/2014/10/unicare_ebook_edition_2.pdf
Notes	This is the second edition of this book whose purpose is to describe and discuss how to make telehealth work. It includes descriptions of the clinical processes and procedures needed to effectively set up and operate telehealth services. The four sections are: Part 1 an introduction to telehealth and how it is being implemented in Australia Part 2 discusses the change management issues Part 3 contains a list of clinical disciplines and the specific issues for introducing telehealth in each area. Part 4 contains conclusions and recommendations for practice.

Reports

Managing quality in community health care services

Foot C, Sonola L, Bennett L, Fitzsimons B, Raleigh V, Gregory S

London: The King's Fund; 2014 December 2014. 47 p.

URL	http://www.kingsfund.org.uk/publications/managing-quality-community-health-care-services
Notes	<p>The UK's King's Fund has published this report that presents findings from a small-scale study into how quality is managed in community services. It explores how community care providers define and measure quality and recommends important next steps to support better measurement and management of quality. The recommendations to local service leaders include:</p> <ul style="list-style-type: none"> • Taking the initiative to improve how quality is measured and monitored • Taking advantage of opportunities to compare and learn from others • Developing provider-led initiatives to benchmark data and develop shared indicators across the sector • Prioritising the engagement of community services staff in quality, motivating them to take responsibility for accurate reporting and supporting them with tools and skills in quality improvement and leadership for quality.

Patient Perspectives - Exploring aspects of integration for hospital patients. Volume 1, Adult Admitted Patients. NSW Public Hospitals 2013

Bureau of Health Information

Sydney: BHI; 2014. p. 64.

URL	http://www.bhi.nsw.gov.au/publications/nsw_patient_survey_reports/patient_perspectives_exploring_aspects_of_integration_for_hospital_patients
Notes	<p>The Bureau of Health Information in New South Wales has released its latest report, <i>Patient Perspectives: Exploring aspects of integration for hospital patients</i>. Using a thematic approach to integrated care, the report looks at three dimensions of integrated care:</p> <ul style="list-style-type: none"> • Dimension 1: Care that is seamless, effective and efficient • Dimension 2: Care that responds to all of a person's health needs • Dimension 3: Care provided in partnership with the individual, their carers and family. <p>Based on more than 35,000 responses to questions asked in the NSW Adult Admitted Patient Survey for 2013, this report compares results across hospitals, local health districts and internationally. The survey shows that most patients rate NSW hospitals well on aspects of integration of care, including self-management support and provision of information.</p> <p>Along with the report, the BHI has also made the associated data available through their interactive portal Healthcare Observer.</p>

Journal articles

A qualitative study of senior hospital managers' views on current and innovative strategies to improve hand hygiene

McInnes E, Phillips R, Middleton S, Gould D.

BMC Infectious Diseases. 2014 Nov 18;14(1):611.

DOI	http://dx.doi.org/10.1186/s12879-014-0611-3
Notes	<p>This study provided insights from the perspective of senior managers on their hospital's hand hygiene strategies. These insights saw need in two main areas: first, the need for visible and 'on the ground' organisational support and leadership including role modelling; and second, the need for tailoring the five moments of hand hygiene to specific roles and settings, including interactions with non-clinical staff that take into account the patient's entire hospital journey. The researchers undertook individual semi-structured face-to-face interviews of 13 senior – clinical and non-clinical – managers at a 350 bed tertiary referral hospital in Sydney. While these insights may not be representative of all senior managers at this hospital or at other hospitals, and may not be generaliseable, seven key themes emerged. These were:</p> <ol style="list-style-type: none"> I. Culture change starts with the leaders II. Refresh and renew the message III. Connect the five moments to the whole patient journey IV. Actionable audit result V. Empower patients VI. Reconceptualising non-compliance VII. Start using the hammer. <p>Future research is needed on the perspective of frontline hospital staff views of their hospital's hand hygiene strategies.</p>

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

The Impact of Time at Work and Time Off From Work on Rule Compliance: The Case of Hand Hygiene in Health Care

Dai H, Milkman KL, Hofmann DA, Staats BR

Journal of Applied Psychology. 2014 [epub].

DOI	http://dx.doi.org/10.1037/a0038067
Notes	<p>The results of this American study show that a day at work can take its toll: immediate and continuous work demands led to reduced hand hygiene compliance over the course of a work day. This result adds to previous research that showed reduced hand hygiene compliance over longer intervals (weeks, months and years). The researchers used longitudinal field observations of more than 4000 health care workers in 35 different hospitals experiencing more than 13.7 million hand hygiene opportunities. They found that hand hygiene compliance rates declined on average about 9 percentage points from the beginning to the end of a typical 12 hour work day. Increased work intensity increased the decline whereas longer breaks between work days increased hand hygiene compliance. Based on these results, the authors estimated 7500 unnecessary infections per year at an annual cost of about \$150 million USD across the study hospitals. Further research is needed to work out how to reduce the effects of work demands on hand hygiene compliance.</p>

Computerized Dose Range Checking Using Hard and Soft Stop Alerts Reduces Prescribing Errors in a Pediatric Intensive Care Unit

Balasuriya L, Vyles D, Bakerman P, Holton V, Vaidya V, Garcia-Filion P, et al.

Journal of Patient Safety. [epub].

DOI	http://dx.doi.org/10.1097/PTS.0000000000000132
Notes	There are continuing efforts to make electronic medication systems safer. This paper describes how an enhanced dose range checking (DRC) system was developed and implemented incorporating "soft" and "hard" alerts was designed and implemented to evaluate prescription error rates in a paediatric intensive care unit and paediatric cardiovascular intensive care unit in a US hospital. The authors report that “Before go-live, alerts were often clinically irrelevant. After go-live, there was a statistically significant decrease in orders that were submitted unmodified [65.7% of alert instances compared with 90%] and an increase in the number of orders that were reduced [24.7% of alerts compared with 10%] or cancelled [9.5% of alerts compared with zero]”

For information on the Commission’s work on safety in e-health, see

<http://www.safetyandquality.gov.au/our-work/safety-in-e-health/>

Laboratory Medicine Handoff Gaps Experienced by Primary Care Practices: A Report from the Shared Networks of Collaborative Ambulatory Practices and Partners (SNOCAP)

West DR, James KA, Fernald DH, Zelic C, Smith ML, Raab SS

The Journal of the American Board of Family Medicine. 2014 November 1, 2014;27(6):796-803.

DOI	http://dx.doi.org/10.3122/jabfm.2014.06.140015
Notes	Paper reporting on a survey conducted to assess perceptions of clinicians, staff, and management personnel of gaps in information handover between primary care practices and laboratories working in 21 primary care practices in the US state of Colorado. The authors report “the results highlight the lack of standardization and definition of roles in handoffs in primary care laboratory practices for test ordering, monitoring, and receiving and reporting test results.” Despite many practices having integrated electronic medical records the need for a back-up tracking system to ensure important test results were not lost was reported.

‘Connecting the dots’: leveraging visual analytics to make sense of patient safety event reports

Ratwani RM, Fong A

Journal of the American Medical Informatics Association. 2014 [epub].

DOI	http://dx.doi.org/10.1136/amiajnl-2014-002963
Notes	Having generated or collected data it is necessary to turn that into meaningful information. This commentary piece describes the development of “intuitive visualization dashboards to facilitate data exploration and trend analysis” for a health system. The authors describe the development of a system level dashboard (representing data from multiple hospitals) and a hospital level dashboard. The dashboards apparently allow users to directly manipulate the data, provide coordinated displays in different formats, and allow users to quickly zoom in on specific variables of interest.

Heartfelt Standard

Chew, D.

MJA Insight 8 December 2014

URL	https://www.mja.com.au/insight/2014/46/derek-chew-heartfelt-standard
Notes	The Commission has recently launched the first two Standards in its program of Clinical Care Standards. This editorial describes the <i>Acute Coronary Syndromes Clinical Care Standard</i> as follows “by translating key aspects of the ACS evidence base into nationally agreed standards of practice, this Clinical Care Standard will help form the foundation of how Australian ACS care is practised and evaluated in years to come.”

For information on the Clinical Care Standards launched by the Commission, see

<http://www.safetyandquality.gov.au/CCS>

Mobile physician reporting of clinically significant events-a novel way to improve handoff communication and supervision of resident on call activities

Nabors C, Peterson SJ, Aronow WS, Sule S, Mumtaz A, Shah T, et al.

Journal of Patient Safety. 2014; 10(4):211-7.

DOI	http://dx.doi.org/10.1097/PTS.0b013e31829952ff
Notes	This paper reports on a study that suggests making reporting of events easier – in this case by using a mobile device – can enhance the level of reporting. Such a system makes the collection and collation of information easier and more rapid.

BMJ Quality and Safety

January 2015, Vol. 24, Issue 1

URL	http://qualitysafety.bmj.com/content/24/1
Notes	<p>A new issue of <i>BMJ Quality and Safety</i> has been published. Many of the papers in this issue have been referred to in previous editions of <i>On the Radar</i> (when they were released online). Articles in this issue of <i>BMJ Quality and Safety</i> include:</p> <ul style="list-style-type: none">• Editorial: Finding patients before they crash: the next major opportunity to improve patient safety (David W Bates, Eyal Zimlichman)• Editorial: Patients teaching patient safety: the challenge of turning negative patient experiences into positive learning opportunities (Antonia S Stang, Brian M Wong)• Viewpoint: The systems approach to medicine: controversy and misconceptions (Sidney W A Dekker, Nancy G Leveson)• Impact of introducing an electronic physiological surveillance system on hospital mortality (Paul E Schmidt, Paul Meredith, David R Prytherch, Duncan Watson, Valerie Watson, Roger M Killen, Peter Greengross, Mohammed A Mohammed, Gary B Smith)• Patients as teachers: a randomised controlled trial on the use of personal stories of harm to raise awareness of patient safety for doctors in training (Vikram Jha, Hannah Buckley, Rhian Gabe, Mona Kanaan, Rebecca Lawton, C Melville, N Quinton, J Symons, Z Thompson, I Watt, J Wright)• 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)• 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)

	<ul style="list-style-type: none"> • 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) • 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) • Clinical user experiences of observation and response charts: focus group findings of using a new format chart incorporating a track and trigger system (Doug Elliott, Emily Allen, Lin Perry, Margaret Fry, Christine Duffield, Robyn Gallagher, Rick Iedema, Sharon McKinley, M Roche) • Key characteristics of successful quality improvement curricula in physician education: a realist review (A C Jones, S A Shipman, G Ogrinc)
--	--

International Journal for Quality in Health Care

Vol. 26, No. 6, December 2014

URL	http://intqhc.oxfordjournals.org/content/26/6?etoc
Notes	<p>A new issue of the <i>International Journal for Quality in Health Care</i> 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 the <i>International Journal for Quality in Health Care</i> include:</p> <ul style="list-style-type: none"> • Influence of adverse drug events on morbidity and mortality in intensive care units: the JADE study (Yoshinori Ohta, Mio Sakuma, Kaoru Koike, David W. Bates, and Takeshi Morimoto) • Achieving a climate for patient safety by focusing on relationships (Milisa Manojlovich, Mickey Kerr, Barbara Davies, Janet Squires, Ranjeeta Mallick, and Ginette L Rodger) • Exploring patient safety culture in primary care (Natasha J Verbakel, Marije Van Melle, Maaïke Langelaan, Theo J M Verheij, Cordula Wagner, and Dorien L M Zwart) • The use of data from national and other large-scale user experience surveys in local quality work: a systematic review (Mona Haugum, Kirsten Danielsen, Hilde Hestad Iversen, and Oyvind Bjertnaes) • Systematic biases in group decision-making: implications for patient safety (Russell Mannion and Carl Thompson) • Improving rates of cotrimoxazole prophylaxis in resource-limited settings: implementation of a quality improvement approach (J Bardfield, B Agins, M Palumbo, A L Wei, J Morris, B Marston, FOR THE COTRIMOXAZOLE QI GROUP)

Health Affairs

1 December 2014; Vol. 33, No. 12

URL	http://content.healthaffairs.org/content/33/12.toc
Notes	<p>A new issue of <i>Health Affairs</i>, with the theme of Children's Health, has been published. Articles in this issue of <i>Health Affairs</i> include:</p> <ul style="list-style-type: none"> • Editorial: Caring For Children (Alan R Weil) • The Rise In Chronic Conditions Among Infants, Children, And Youth Can Be Met With Continued Health System Innovations (James M Perrin, L Elizabeth Anderson, and Jeanne Van Cleave)

	<ul style="list-style-type: none"> • Adverse Childhood Experiences: Assessing The Impact On Health And School Engagement And The Mitigating Role Of Resilience (Christina D Bethell, Paul Newacheck, Eva Hawes, and Neal Halfon) • North Carolina Physician-Based Preventive Oral Health Services Improve Access And Use Among Young Medicaid Enrollees (Ashley M Kranz, Jessica Lee, Kimon Divaris, A Diane Baker, and William Vann, Jr.) • Behavioral Health Care For Children: The Massachusetts Child Psychiatry Access Project (John H Straus and Barry Sarvet) • Lessons For Providers And Hospitals From Philadelphia's Obstetric Services Closures And Consolidations, 1997–2012 (Scott A Lorch, Ashley E Martin, Richa Ranade, Sindhu K Srinivas, and David Grande) • Introduction Of Performance-Based Financing In Burundi Was Associated With Improvements In Care And Quality (Igna Bonfrer, Robert Soeters, E Van de Poel, O Basenya, G Longin, F van de Looij, and E van Doorslaer) • The Best Chance At Life (Jessica Bylander) • Inequities In Health Care Needs For Children With Medical Complexity (Dennis Z Kuo, Anthony Goudie, Eyal Cohen, Amy Houtrow, Rishi Agrawal, Adam C Carle, and Nora Wells) • CASE STUDY: Accelerating Efforts To Prevent Childhood Obesity: Spreading, Scaling, And Sustaining Healthy Eating And Physical Activity (Debbie I Chang, Allison Gertel-Rosenberg, and Kim Snyder) • Integrating Racial/Ethnic Equity Into Policy Assessments To Improve Child Health (Pamela K. Joshi, Kimberly Geronimo, Bethany Romano, Alison Earle, Lindsay Rosenfeld, Erin F. Hardy, and Dolores Acevedo-Garcia) • International Survey Of Older Adults Finds Shortcomings In Access, Coordination, And Patient-Centered Care (Robin Osborn, Donald Moulds, David Squires, Michelle M. Doty, and Chloe Anderson)
--	--

Healthcare Infection
Volume 19(4) 2014

URL	http://www.publish.csiro.au/nid/241/issue/7117.htm
Notes	<p>A new issue of <i>Healthcare Infection</i> has been published. Articles in this issue of <i>Healthcare Infection</i> include:</p> <ul style="list-style-type: none"> • Improvements in process with a multimodal campaign to reduce urinary tract infections in hospitalised Australian patients (Deborah Rhodes, Jacqueline Kennon, Stacey Aitchison, Kerrie Watson, Linda Hornby, Gillian Land, P Bass, S McLellan, S Karki, A C Cheng and L J Worth) • <i>Clostridium difficile</i>-associated disease: how much do we really know? A single institution study (H S Roth, C T Parker, R J Wale and S K Warrier) • Changes in healthcare-associated infections after the introduction of a national hand hygiene initiative (Adrian G Barnett, Katie Page, Megan Campbell, D Brain, E Martin, S Winters, L Hall, D Paterson and N Graves) • Prior room occupancy increases risk of methicillin-resistant <i>Staphylococcus aureus</i> acquisition (Brett G Mitchell, Wilhelmine Digney and John K Ferguson) • Approaches to surveillance of <i>Staphylococcus aureus</i> bacteraemia and <i>Clostridium difficile</i> infection in Australian states and territories (Elizabeth Hanley and Cate Quoye)

International Journal for Quality in Health Care online first articles

URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
Notes	<p><i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none">• The impact of varying patient populations on the in-control performance of the risk-adjusted CUSUM chart (Wenmeng Tian, Hongyue Sun, Xiang Zhang, and William H Woodall)• Fidelity of implementation to a care team redesign and improved outcomes of diabetes care (Sherry M Grace, Jeremy Rich, William Chin, and Hector P Rodriguez)

Online resources

[UK] 2014 Reith Lectures – Dr Atul Gawande

<http://www.bbc.co.uk/programmes/b00729d9>

The BBC’s Reith Lecture series is an annual event. American surgeon and writer Dr Atul Gawande is giving four lectures in the 2014 lectures:

1. *Why Do Doctors Fail?* – Gawande explores the nature of fallibility and suggests that preventing avoidable mistakes is a key challenge for the future of medicine.
<http://www.bbc.co.uk/programmes/b04bsgvm>
2. *The Century of the System* – Gawande argues that better systems can transform global healthcare by radically reducing the chance of mistakes and increasing the chance of successful outcomes.
<http://www.bbc.co.uk/programmes/b04sv1s5>
3. *The Problem of Hubris* – Gawande calls for a new approach to the two great unfixable problems in life and healthcare - ageing and death
<http://www.bbc.co.uk/programmes/b04tjdlj>
4. *The Idea of Wellbeing* – Gawande argues that medicine must shift from a focus on health and survival to a focus on wellbeing - on protecting, insofar as possible, people’s abilities to pursue their highest priorities in life.
<http://www.bbc.co.uk/programmes/b04v380z>

[UK] *Intrapartum care: care of healthy women and their babies during childbirth*

<http://www.nice.org.uk/guidance/CG190>

The UK’s National Institute for Health and Care Excellence (NICE) has published an updated guideline *Intrapartum care: care of healthy women and their babies during childbirth*.

It offers evidence-based advice on the care of women and their babies during labour and immediately after the birth. It covers healthy women with uncomplicated pregnancies entering labour at low risk of developing intrapartum complications.

New recommendations have been added in a number of areas, including choosing place of birth, care during the latent first stage of labour, transfer of care, fetal assessment and monitoring during labour (particularly cardiotocography compared with intermittent auscultation) and management of the third stage of labour.

What works

<http://www.kpmg.com/GLOBAL/EN/ISSUESANDINSIGHTS/ARTICLESPUBLICATIONS/WHAT-WORKS/Pages/default.aspx>

The global consultancy business KPMG is developing a series of publications under the *What works* umbrella. According to the website “What Works is a series of thought leadership reports that address some of the most pressing healthcare challenges that the world faces today.” The first area in the What Works series is *Creating new value with patients carers and communities*.

Disclaimer

On the Radar is an information resource of the Australian Commission on Safety and Quality in Health Care. The Commission is not responsible for the content of, nor does it endorse, any articles or sites listed. The Commission accepts no liability for the information or advice provided by these external links. Links are provided on the basis that users make their own decisions about the accuracy, currency and reliability of the information contained therein. Any opinions expressed are not necessarily those of the Australian Commission on Safety and Quality in Health Care.