



## On the Radar

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### On the Radar

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### **Consultation: draft Guidance for clinicians and managers responsible for defining scope of practice at the appointment and reappointment of credentialed practitioners**

<http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/current-consultations/#Consultation:-Draft-Guidance-for-clinicians-and-managers-responsible-for-defining-scope-of-practice-at-the-appointment-and-reappointment-of-credentialed-practitioners>

*Now open*

The Commission is seeking feedback on the draft *Guidance for clinicians and managers responsible for defining scope of practice at the appointment and reappointment of credentialed practitioners*.

The National Safety and Quality Health Service (NSQHS) Standards require health service organisations to ‘implement a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce’. This resource has been developed to provide practical guidance for managers and clinicians responsible for defining scope of practice as part of a credentialing process.

The Commission encourages executives of health service organisations, managers and clinicians responsible for defining scope of practice and others with an interest in the area to provide feedback on the draft resource. Feedback is sought by close of business 15 April 2015, by email or post.

Any queries regarding this consultation process can be directed to [NSQHStandards@safetyandquality.gov.au](mailto:NSQHStandards@safetyandquality.gov.au) or (02) 9126 3595.

## Reports

*Improving experiences of care: Our shared understanding and ambition*

National Quality Board

London: National Quality Board; 2015. p. 92.

URL	<a href="http://www.england.nhs.uk/wp-content/uploads/2015/01/improving-experiences-of-care.pdf">http://www.england.nhs.uk/wp-content/uploads/2015/01/improving-experiences-of-care.pdf</a>
Notes	<p>The UK's National Quality Board (NQB) – with support from other partners — has published this document setting out a common way for the national health and care organisations that comprise the NQB to talk about people's experiences of care and their roles in improving them.</p> <p>The document describes the ambition for improving people's experiences of care, and also includes examples of good practice and resources, to support organisations and individuals in improving experiences of care.</p> <p><i>Improving experiences of care: Our shared understanding and ambition</i> is intended for all individuals and organisations within, or with an interest in, the health system. It also aims to provide people who use services with an understanding of what they can expect from their experiences of care.</p>

## Journal articles

*Creating a high-reliability health care system: improving performance on core processes of care at Johns Hopkins Medicine*

Pronovost PJ, Armstrong CM, Demski R, Callender T, Winner L, Miller MR, et al

Academic Medicine. 2015 Feb;90(2):165-72.

DOI	<a href="http://dx.doi.org/10.1097/acm.0000000000000610">http://dx.doi.org/10.1097/acm.0000000000000610</a>
Notes	<p>Paper describing the approach taken at Johns Hopkins to develop “an infrastructure to manage quality and safety efforts throughout a complex health care system”. The authors describe how these changes contributed to “improved performance on core measures for acute myocardial infarction, heart failure, pneumonia, surgical care, and children's asthma”.</p> <p>In the paper the authors discuss the new governance structure that sought to establish health care system-wide oversight and hospital accountability for quality and safety efforts. A patient safety and quality institute was formed (the Armstrong Institute for Patient Safety and Quality) as they sought to improve performance at two teaching hospitals and three community hospitals</p> <p>Starting in March 2012 the initiative aimed to achieve <math>\geq 96\%</math> compliance on seven inpatient process-of-care core measures. The primary outcome measure was the percentage of patients at each hospital who received the recommended process of care. The authors compared health system and hospital performance before (2011) and after (2012, 2013) the initiative. The health system achieved <math>\geq 96\%</math> compliance on six of the seven targeted measures by 2013.</p> <p>The authors argue that, <b>to improve quality and safety, health care systems should establish a system-wide governance structure and accountability process. They also should define and communicate goals and measures and build an infrastructure to support peer learning.</b></p>

*Hospital organisation, management, and structure for prevention of health-care-associated infection: a systematic review and expert consensus*

Zingg W, Holmes A, Dettenkofer M, Goetting T, Secci F, Clack L, et al  
The Lancet Infectious Diseases.15(2):212-24.

DOI	<a href="http://dx.doi.org/10.1016/S1473-3099(14)70854-0">http://dx.doi.org/10.1016/S1473-3099(14)70854-0</a>
Notes	<p>The authors of this systematic review published in Lancet Infectious Diseases, drew on 92 studies to identify crucial elements in preventing healthcare associated infections in hospitals. The review identified ten key components:</p> <ul style="list-style-type: none"> <li>• <b>organisation</b> of infection control at the hospital level</li> <li>• <b>bed occupancy, staffing, workload</b>, and employment of pool or agency nurses</li> <li>• availability of and ease of access to <b>materials and equipment</b> and optimum ergonomics</li> <li>• appropriate use of <b>guidelines</b></li> <li>• <b>education and training</b></li> <li>• <b>auditing</b></li> <li>• <b>surveillance and feedback</b></li> <li>• multimodal and multidisciplinary <b>prevention programmes</b> that include behavioural change</li> <li>• engagement of <b>champions</b></li> <li>• positive <b>organisational culture</b>.</li> </ul> <p>As the authors conclude, “These components comprise manageable and widely applicable ways to reduce health-care-associated infections and improve patients’ safety.”</p>

For information on the Commission’s work on healthcare associated infections, see [www.safetyandquality.gov.au/our-work/healthcare-associated-infection/](http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/)

*Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions: controlled longitudinal study*

Harrison MJ, Dusheiko M, Sutton M, Gravelle H, Doran T, Roland M.  
BMJ. 2014 2014-11-11 23:31:20;349.

DOI	<a href="http://dx.doi.org/10.1136/bmj.g6423">http://dx.doi.org/10.1136/bmj.g6423</a>
Notes	<p>This article in the <i>BMJ</i>, describes the impact of the Quality and Outcomes Framework (QOF) in England on emergency hospital admissions for ambulatory care sensitive conditions (ACSCs).</p> <p>This controlled longitudinal study examined the populations registered with each of 6975 family practices in England between 1998/99 and 2010/11.</p> <p>The QOF is national primary care pay for performance scheme. This study found that “the introduction of a major national <b>pay for performance scheme</b> for primary care in England was associated with a <b>decrease in emergency admissions for incentivised conditions</b> compared with conditions that were not incentivised.”</p> <p>The authors speculate that “The decrease seems larger than would be expected from the changes in the process measures that were incentivised, suggesting that the pay for performance scheme may have had impacts on quality of care beyond the directly incentivised activities.”</p> <p>Clearly it would be important that the appropriate things are incentivised, perverse incentives are not introduced and that the improvements are maintained, if not sustained.</p>

*Patient Safety skills in primary care: a national survey of GP educators*  
 Ahmed M, Arora S, McKay J, Long S, Vincent C, Kelly M, et al.  
 BMC Family Practice. 2014 Dec 17;15(1):206.

DOI	<a href="http://dx.doi.org/10.1186/s12875-014-0206-5">http://dx.doi.org/10.1186/s12875-014-0206-5</a>
Notes	<p>This UK study sought to determine the views of General Practice Educational Supervisors (GPES) regarding the qualities and attributes of a safe General Practitioner (GP) and the perceived trainability of these ‘safety skills’. From the survey the GPES considered that the <b>skills/attributes most important</b> to being a safe GP were <b>honesty</b> (93%), <b>technical clinical skills</b> (89%) and <b>conscientiousness</b> (89%). That deemed least important/relevant to being a safe GP was leadership (36%). The most trainable safety skills/attributes were apparently technical skills (93%), situation awareness (75%) and anticipation/preparedness (71%). The least trainable were honesty (35%), humility (33%) and patient awareness/empathy (30%). Additional safety skills identified as relevant to primary care included <b>patient advocacy</b>, <b>negotiation skills</b>, <b>accountability/ownership</b> and <b>clinical intuition</b>.</p> <p>It is suggested that from these it is now necessary to “develop and implement training in these skills to ensure that current and future GPs possess the necessary competencies to engage and lead in safety improvement efforts.”</p>

*Creating Value In Health By Understanding And Overcoming Resistance To De-Innovation*  
 Ubel PA, Asch DA  
 Health Affairs. 2015 February 1, 2015;34(2):239-44.

DOI	<a href="http://dx.doi.org/10.1377/hlthaff.2014.0983">http://dx.doi.org/10.1377/hlthaff.2014.0983</a>
Notes	<p>Innovation, and the dissemination of evidence in health care in general, is known to be a slow process. This opinion piece discusses the issue of de-innovation – “eliminating entrenched and often costly practices that previously made sense but that, because of new evidence or competing approaches, have lost their value”. In the context of improving the efficiency, value and sustainability of healthcare systems, this piece provides a very useful discussion on the entrenched psychological biases that make the process of de-innovation even more difficult, and slower, than innovation. An important consideration is that one is not the mirror image of the other, predominantly because the stakes (and stakeholders) may be quite different for each. Drawing on behavioural science and economics, the challenges to de-innovation are discussed, using a range of examples including PSA screening, sleep testing and ‘indication creep’ for the (now withdrawn) COX-2 inhibitor rofecoxib (Vioxx). Psychological phenomena such as confirmation bias, the availability heuristic, cognitive dissonance, the endowment effect and loss aversion, which, incidentally, may also explain why payment reform (such as pay for performance) may not have the effect predicted by orthodox economic theory. A very timely, and useful piece.</p>

For more information about the Commission’s work on reducing unwarranted variation and improving appropriateness of care, see <http://www.safetyandquality.gov.au/our-work/variation-in-health-care/> and <http://www.safetyandquality.gov.au/our-work/shared-decision-making/>

*The Iatref study: medical errors are associated with symptoms of depression in ICU staff but not burnout or safety culture*

Garrouste-Orgeas M, Perrin M, Soufir L, Vesin A, Blot F, Maxime V, et al.

Intensive Care Medicine. 2015 2015/02/01;41(2):273-84.

DOI	<a href="http://dx.doi.org/10.1007/s00134-014-3601-4">http://dx.doi.org/10.1007/s00134-014-3601-4</a>
Notes	<p>This French study sought to examine whether burnout, symptoms of depression and safety culture affected the frequency of medical errors and adverse events in 31 French intensive care units (ICUs). This prospective, observational study was conducted from August 2009 to December 2011 and 1,534 of the eligible 1,988 staff participated.</p> <p>The authors report that medical error and adverse event rates were 804.5/1,000 and 167.4/1,000 patient-days, respectively. They found that depression symptoms were an independent risk factor for medical errors. While burnout was not associated with medical errors and that the safety culture score had a limited influence on medical errors. Other independent risk factors for medical errors or adverse events were related to ICU organisation (40 % of ICU staff off work on the previous day), staff (specific safety training) and patients (workload). One-on-one training of junior physicians during duties and existence of a hospital risk-management unit were associated with lower risks.</p> <p>The ‘Take home message’ that the authors offer is that “A safety culture, as measured in our study using the Safety Attitudes Questionnaire, had a limited influence on medical errors. <b>Depression-related symptoms in staff members significantly increased the risk of medical errors</b>, whereas burnout syndrome did not.”</p>

*Implementing a Standardized Safe Surgery Program Reduces Serious Reportable Events*

Loftus T, Dahl D, Ohare B, Power K, Toledo-Katsenes Y, Hutchison R, et al

Journal of the American College of Surgeons. 2015;220(1):12-7.e3.

DOI	<a href="http://dx.doi.org/10.1016/j.jamcollsurg.2014.09.018">http://dx.doi.org/10.1016/j.jamcollsurg.2014.09.018</a>
Notes	<p>Paper recounting how a US health system implemented a surgical safety program. The study tracked serious reportable event (SRE) rates (retained surgical item, wrong site, wrong patient, and wrong procedure) before and after implementation of a standardised safe surgery program over a total of 683,193 cases in 4 years. The program was associated with a 52% reduction in SREs with the rate before implementation 0.075/1,000 cases and after implementation 0.037/1,000 cases. The authors conclude that “an effectively implemented <b>standardized safe surgery program</b> results in a <b>significant reduction in SREs</b>” They also note that “<b>Robotic cases</b> are at <b>high risk</b> for an SRE” as they reported being “7 times more likely to incur an SRE”.</p> <p>The apparent success of this program is attributed to having a planning process that involved human factors engineering approaches as well as having a continuing implementation and reinforcement program.</p>

*Intercepting Wrong-Patient Orders in a Computerized Provider Order Entry System*  
 Green RA, Hripcsak G, Salmasian H, Lazar EJ, Bostwick SB, Bakken SR, et al  
 Annals of Emergency Medicine. (0).

DOI	<a href="http://dx.doi.org/10.1016/j.annemergmed.2014.11.017">http://dx.doi.org/10.1016/j.annemergmed.2014.11.017</a>
Notes	Computerised medication systems are intended eliminate or at least ameliorate some medication errors. However, as with the introduction of any innovation, technology or change, there is the possibility of permitting new errors. This paper reports on the insertion of patient verification dialog into a computerised provider order entry (CPOE) system. The dialog forced providers to confirm the patient's identity after a mandatory 2.5-second delay at the start of an order. The study found that <b>wrong-patient orders</b> were <b>reduced by 30%</b> immediately after implementation and after 2, the rate of wrong-patient orders remained 24.8% less than before intervention. Thus an intervention that added a couple of seconds to an order dropped the rate of wrong-patients substantially.

For information on the Commission’s work on medication safety, including electronic medication management see [www.safetyandquality.gov.au/our-work/medication-safety/](http://www.safetyandquality.gov.au/our-work/medication-safety/)

*At Risk Care Plans: A Way to Reduce Readmissions and Adverse Events*  
 Bahle J, Majercik C, Ludwick R, Bukosky H, Frase D  
 J Nurs Care Qual. 2014 Dec 10.

DOI	<a href="http://dx.doi.org/10.1097/NCQ.000000000000106">http://dx.doi.org/10.1097/NCQ.000000000000106</a>
Notes	Falls are a significant cause of harm in healthcare facilities. This paper describes one hospital’s development and implementation of a program that identified patients with a risk of falling and a targeted care plan that included enhancing care coordination, teamwork, and communication of care needs. The authors argue that these interventions have “dramatically reduced hospital readmissions, costs, and adverse events for high-risk adult inpatients” in their community hospital. Falls assessments and associated programs are relatively common in some hospital systems in recognition of the scale of the problems that falls can pose.

For information on the Commission’s work on falls prevention, including the falls prevention guidelines see <http://www.safetyandquality.gov.au/our-work/falls-prevention/>

*BMJ Quality and Safety*  
 March 2015, Vol. 24, Issue 3

URL	<a href="http://qualitysafety.bmj.com/content/24/3">http://qualitysafety.bmj.com/content/24/3</a>
Notes	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: <ul style="list-style-type: none"> <li>• Editorial: <b>Assessing patient safety competencies</b> using Objective Structured Clinical Exams: a new twist on an old tool (Lynfa Stroud, Arpana R Vidyarthi)</li> <li>• Editorial: <b>Parent-activated medical emergency teams</b>: a parent's perspective (James Titcombe)</li> <li>• Editorial: <b>New SQUIRE publication guidelines</b>: supporting nuanced reporting and reflection on complex interventions (Louise Davies, Greg Ogrinc)</li> <li>• Editorial: <b>But I told you she was ill! The role of families in preventing avoidable harm in children</b> (Damian Roland)</li> </ul>



	<ul style="list-style-type: none"> <li>• Development and testing of an objective structured clinical exam (OSCE) to <b>assess socio-cultural dimensions of patient safety competency</b> (Liane R Ginsburg, Deborah Tregunno, Peter G Norton, Sydney Smee, Ingrid de Vries, Stefanie S Sebok, E G VanDenKerkhof, M Luctkar-Flude, J Medves)</li> <li>• Do <b>patient-reported outcomes</b> offer a more sensitive method for comparing the outcomes of consultants than mortality? A multilevel analysis of routine data (Mira Varagunam, Andrew Hutchings, Nick Black)</li> <li>• Developing and evaluating the success of a <b>family activated medical emergency team</b>: a quality improvement report (Patrick W Brady, Julie Zix, Richard Brill, Derek S Wheeler, Kristie Griffith, Mary Jo Giaccone, Kathy Dressman, Uma Kotagal, Stephen Muething, Ken Tegtmeier)</li> <li>• <b>Clinically led performance management</b> in secondary healthcare: evaluating the attitudes of medical and non-clinical managers (Timothy M Trebble, Maureen Paul, Peter M Hockey, Nicola Heyworth, Rachael Humphrey, Timothy Powell, Nicholas Clarke)</li> <li>• <b>Influenza vaccination</b> rates for <b>hospitalised patients</b>: a multiyear quality improvement effort (Emily Suzanne Cohen, Greg Ogrinc, Tom Taylor, Christine Brown, James Geiling)</li> <li>• Demystifying <b>theory</b> and its <b>use in improvement</b> (Frank Davidoff, Mary Dixon-Woods, Laura Leviton, Susan Michie)</li> </ul>
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*BMJ Quality and Safety* online first articles

URL	<a href="http://qualitysafety.bmj.com/content/early/recent">http://qualitysafety.bmj.com/content/early/recent</a>
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• The <b>quality of hospital work environments</b> and <b>missed nursing care</b> is linked to <b>heart failure readmissions</b>: a cross-sectional study of US hospitals (J Margo Brooks Carthon, Karen B Lasater, Douglas M Sloane, Ann Kutney-Lee)</li> </ul>

*International Journal for Quality in Health Care* online first articles

URL	<a href="http://intqhc.oxfordjournals.org/content/early/recent?papetoc">http://intqhc.oxfordjournals.org/content/early/recent?papetoc</a>
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"> <li>• Joint influence of <b>patient-assessed chronic illness care</b> and <b>patient activation</b> on glycaemic control in <b>type 2 diabetes</b> (Eindra Aung, Maria Donald, Gail M. Williams, Joseph R. Coll, and Suhail A R Doi)</li> </ul>

**Online resources**

*[WHO] Health literacy toolkit for low- and middle-income countries*

[http://www.searo.who.int/entity/healthpromotion/documents/hl\\_toolkit/en/](http://www.searo.who.int/entity/healthpromotion/documents/hl_toolkit/en/)

The World Health Organization (WHO) Regional Office for South-East Asia has released this series of information sheets introducing health literacy, its relevance to public policy, and the ways it can be used to inform the promotion of good health, the prevention and management of communicable and non-communicable diseases, and the reduction of health inequities. It provides information and links to further resources to assist organizations and governments to incorporate health literacy responses into practice, service delivery systems, and policy.

For information on the Commission’s work on health literacy, see

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

[USA] *The Digital Health Revolution*

<http://www.commonwealthfund.org/digital-health-revolution/>

The [US] Commonwealth Fund has published this ‘multimedia essay’ that looks at how digital technologies may yet change the way healthcare is delivered and experienced. In many other aspects of our lives technology has fundamentally altered the way we live (think of how you deal with your banking or how you communicate with other people and how much these have changed over the last 10 years), but in health this change has been much patchier with many of our interactions little changed. In this ‘essay’, the authors examine how digital technologies may change healthcare, including their potential to help achieve five important goals:

- helping patients become more engaged in their own care
- closing communication gaps
- identifying patients' needs and tailoring services to meet them
- enabling consumers to get care in convenient, cost-effective ways
- improving decision-making by consumers and providers.

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