



## On the Radar

Issue 212

2 March 2015

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### On the Radar

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### Reports

*Staff engagement: Six building blocks for harnessing the creativity and enthusiasm of NHS staff*  
Collins B

London: The King's Fund; 2015. p. 24.

URL	<a href="http://www.kingsfund.org.uk/publications/staff-engagement">http://www.kingsfund.org.uk/publications/staff-engagement</a>
Notes	<p>The King's Fund website notes "There is now an overwhelming body of evidence to show that <b>engaged staff deliver better health care</b>. Trusts with more engaged staff tend to have <b>lower levels of patient mortality</b>, make <b>better use of resources</b>, and have <b>stronger financial performance</b> and <b>higher patient satisfaction</b>, with more patients reporting that they were treated with dignity and respect. This paper encourages boards and other leaders to focus on staff engagement and suggests a number of questions boards can ask to assess their organisation's level of staff engagement."</p> <p>The 'six building blocks' are:</p> <ol style="list-style-type: none"> <li>1. Develop a compelling, shared strategic direction</li> <li>2. Build collective and distributed leadership</li> <li>3. Adopt supportive and inclusive leadership styles</li> <li>4. Give staff the tools to lead service transformation</li> <li>5. Establish a culture based on integrity and trust</li> <li>6. Place staff engagement firmly on the board agenda.</li> </ol>

## Journal articles

*Underlying reasons associated with hospital readmission following surgery in the United States.*

Merkow RP, Ju MH, Chung JW, Hall BL, Cohen ME, Williams MV, et al.

Journal of the American Medical Association. 2015;313(5):483-95.

DOI	<a href="http://dx.doi.org/10.1001/jama.2014.18614">http://dx.doi.org/10.1001/jama.2014.18614</a>
Notes	<p>This study examined readmission among 498 875 operations of patients at 346 US hospitals participating in the National Surgical Quality Improvement Program (NSQIP) between January 1, 2012, and December 31, 2012. Readmission rates and reasons were assessed for all surgical procedures and for 6 representative operations: bariatric procedures, colectomy or proctectomy, hysterectomy, total hip or knee arthroplasty, ventral hernia repair, and lower extremity vascular bypass.</p> <p>The authors report that the <b>unplanned readmission rate</b> for the 498 875 operations was <b>5.7%</b>. For the individual procedures, the readmission rate ranged from 3.8% for hysterectomy to 14.9% for lower extremity vascular bypass. The <b>most common reason for unplanned readmission</b> was <b>surgical site infection (SSI)</b> overall (19.5%).</p> <p>The authors also report that “Only 2.3% of patients were readmitted for the same complication they had experienced during their index hospitalization. Only 3.3% of patients readmitted for SSIs had experienced an SSI during their index hospitalization. There was no time pattern for readmission, and early (<math>\leq 7</math> days postdischarge) and late (<math>&gt; 7</math> days postdischarge) readmissions were associated with the same 3 most common reasons: SSI, ileus or obstruction, and bleeding.”</p> <p>Among the conclusions they draw is that “readmissions after surgery are a measure of postdischarge complications”.</p>

*Association of hospital participation in a quality reporting program with surgical outcomes and expenditures for Medicare beneficiaries*

Osborne NH, Nicholas LH, Ryan AM, Thumma JR, Dimick JB

Journal of the American Medical Association. 2015;313(5):496-504.

DOI	<a href="http://dx.doi.org/10.1001/jama.2015.25">http://dx.doi.org/10.1001/jama.2015.25</a>
Notes	<p>Paper reporting on a study using 9 years of (US) Medicare data to examine differences in surgical outcomes between hospitals participating in the National Surgical Quality Improvement Program (NSQIP) and non-participating hospitals. The data set covered 1 226 479 patients undergoing general and vascular surgery at 263 hospitals participating in NSQIP and 526 non-participating hospitals. The study looked at thirty-day mortality, serious complications, re-operation, and readmission within 30 days.</p> <p>While they report finding no statistically significant improvements in the selected outcomes at 1, 2, or 3 years after (vs before) enrolment in NSQIP, the authors also concluded that “hospitals had progressively better surgical outcomes but enrollment in a national quality reporting program was not associated with the improved outcomes or lower Medicare payments among surgical patients. Feedback on outcomes alone may not be sufficient to improve surgical outcomes.”</p> <p>In a <a href="#">related editorial</a> in the same issue of <i>JAMA</i>, Don Berwick notes that “The most likely explanation ... is that end-results information, although necessary for improvement, is not sufficient, and that the skills necessary to make effective changes in processes and cultures do not yet pervade US hospitals, to say the least.”</p> <p>He continues, noting that “<b>measurement, alone, is not enough for improvement.</b> As an African proverb says, ‘Weighing a pig does not make the pig fatter.’”</p>

*An overview of the use and implementation of checklists in surgical specialities – A systematic review*

Patel J, Ahmed K, Guru KA, Khan F, Marsh H, Shamim Khan M, et al  
International Journal of Surgery. 2014;12(12):1317-23.

*Point prevalence of surgical checklist use in Europe: relationship with hospital mortality*

Jammer I, Ahmad T, Aldecoa C, Kourenti D, Goranović T, Grigoras I, et al.  
British Journal of Anaesthesia. 2015 [epub].

DOI	Patel et al <a href="http://dx.doi.org/10.1016/j.ijso.2014.10.031">http://dx.doi.org/10.1016/j.ijso.2014.10.031</a> Jammer et al <a href="http://dx.doi.org/10.1093/bja/aeu460">http://dx.doi.org/10.1093/bja/aeu460</a>
Notes	A pair of papers looking at the uptake of the surgical checklists, one by a systematic review, the other a point prevalence study. The systematic review examined English language literature and focused on 16 studies. From their review the authors conclude that “ <b>Surgical checklists have been shown to significantly improve patient outcomes subsequent to surgery</b> , and therefore their use is being widely encouraged and accepted. Continual feedback could be given to maintain high checklist compliance, and thus high patient safety.” The point prevalence study was a retrospective analysis of data describing surgical checklist use from a 7 day cohort study of surgical outcomes in 28 European nations (European Surgical Outcomes Study, EuSOS) that covered 45,591 patients from 426 hospitals. A surgical checklist was used with 67.5% of patients, with marked variation across countries (from 0 to 99.6% of patients). The authors report that “Reported use of a <b>checklist</b> was <b>associated with lower mortality</b> . This observation may represent a protective effect of the surgical checklist itself, or alternatively, may be an indirect indicator of the quality of perioperative care.”

*Clinical safety of England's national programme for IT: A retrospective analysis of all reported safety events 2005 to 2011*

Magrabi F, Baker M, Sinha I, Ong M-S, Harrison S, Kidd MR, et al.  
International Journal of Medical Informatics. 2015;84(3):198-206.

DOI	<a href="http://dx.doi.org/10.1016/j.ijmedinf.2014.12.003">http://dx.doi.org/10.1016/j.ijmedinf.2014.12.003</a>
Notes	This paper from a group of Australian researchers discusses their retrospective analysis of 850 safety events between September 2005 and November 2011 that were identified in England's national programme for IT (NPfIT). Of the 850 events, 68% (n = 574) described potentially hazardous circumstances, 24% (n = 205) had an observable impact on care delivery, 4% (n = 36) were a near miss, and 3% (n = 22) were associated with patient harm, including three deaths (0-35%).” Most events reflected technical failure, but those incidents involving human errors had a higher chance of causing harm to patients. Technical failures affecting 10 or more patients accounted for nearly 25% of events and were more likely to impact care delivery. The authors conclude that these events “reinforce that the use of IT does create hazardous circumstances and can lead to patient harm or death. Large-scale patient safety events have the potential to affect many patients and clinicians, and this suggests that addressing them should be a priority for all major IT implementations..”

For information on the Commission’s work on safety in e-health, see  
<http://www.safetyandquality.gov.au/our-work/safety-in-e-health/>

*Trust, temporality and systems: how do patients understand patient safety in primary care? A qualitative study*

Rhodes P, Campbell S, Sanders C

Health Expectations. 2015 [epub].

DOI	<a href="http://dx.doi.org/10.1111/hex.12342">http://dx.doi.org/10.1111/hex.12342</a>
Notes	Paper reporting on a study involving general practice patients in northern England and their understandings of safety in primary care. The 38 patients interviewed attended 19 practices in varying settings. For these patients the focus was not on systems that ensure safety but rather the importance of individual trust, interactions and relationships. Issues such as prompt investigations and referrals were identified by patients, whereas none of the patients interviewed identified unnecessary care as a concern.

*Reducing unacceptable missed doses: pharmacy assistant-supported medicine administration*

Baqir W, Jones K, Horsley W, Barrett S, Fisher D, Copeland R, et al

International Journal of Pharmacy Practice. 2015.

DOI	<a href="http://dx.doi.org/10.1111/ijpp.12172">http://dx.doi.org/10.1111/ijpp.12172</a>
Notes	One form of medication error is missed or omitted doses. This paper reports on an intervention where pharmacy assistants supported nurses doing medication rounds. The study involved three study groups ((A) intervention group (PA-supported medicine administration); (B) intra-ward control group; and (C) inter-ward control group) with data collected over 2 weeks (December 2011 and February 2012) covering 778 patients. Over the course of the 2 weeks, unacceptable omitted medication doses were observed in 18.5% of patients on the control ward, versus only 1.1% of patients on the wards with pharmacy assistant support. These results led the authors to conclude that “PA-supported medication rounds can significantly reduce the rate of omitted doses”.

For information on the Commission’s work on medication safety, see

<http://www.safetyandquality.gov.au/our-work/medication-safety/>

*Root cause analysis to support infection control in healthcare premises*

Venier AG

Journal of Hospital Infection [epub].

DOI	<a href="http://dx.doi.org/10.1016/j.jhin.2014.12.003">http://dx.doi.org/10.1016/j.jhin.2014.12.003</a>
Notes	Root cause analysis (RCA) is quite routinely used when investigating adverse events. This commentary suggests infection control teams may be able to use RCA in addressing healthcare associated infections.

For information on the Commission’s work on healthcare associated infection, see

[www.safetyandquality.gov.au/our-work/healthcare-associated-infection/](http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/)

*International Journal for Quality in Health Care*

Vol. 27, No. 1, February 2015

URL	<a href="http://intqhc.oxfordjournals.org/content/27/1?etoc">http://intqhc.oxfordjournals.org/content/27/1?etoc</a>
Notes	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 <i>On the Radar</i> (when they released online). Articles in this issue of the <i>International Journal for Quality in Health Care</i> include:

	<ul style="list-style-type: none"> <li>• Editor's choice: What are <b>incident reports</b> telling us? A comparative study at two Australian hospitals of <b>medication errors</b> identified at audit, detected by staff and reported to an incident system (Johanna I Westbrook, Ling Li, Elin C Lehnбом, Melissa T Baysari, Jeffrey Braithwaite, Rosemary Burke, Chris Conn, and Richard O Day)</li> <li>• Editor's choice: Improving the identification and management of <b>chronic kidney disease</b> in primary care: lessons from a staged <b>improvement collaborative</b> (Gill Harvey, Kathryn Oliver, John Humphreys, Katy Rothwell, and Janet Hegarty)</li> <li>• <b>Patient experiences of inpatient hospital care</b>: a department matter and a hospital matter (Maarten W Krol, Dolf De Boer, Herman Sixma, Lucas Van Der Hoek, Jany J D J M Rademakers, and Diana M Delnoij)</li> <li>• The association between <b>patient-reported incidents</b> in hospitals and estimated rates of <b>patient harm</b> (Oyvind Bjertnaes, Ellen Tvetter Deilkås, Kjersti Eeg Skudal, Hilde Hestad Iversen, and Anne Mette Bjerkan)</li> <li>• The impact of varying patient populations on the in-control performance of the <b>risk-adjusted CUSUM chart</b> (Wenmeng Tian, Hongyue Sun, Xiang Zhang, and William H Woodall)</li> <li>• <b>Organizational culture</b> affecting quality of care: guideline adherence in <b>perioperative antibiotic use</b> (Naoto Ukawa, Masayuki Tanaka, Toshitaka Morishima, and Yuichi Imanaka)</li> <li>• Quality and extent of <b>informed consent</b> for invasive procedures: a pilot study at the institutional level in Turkey (H Hanzade Dogan, Elif Işik, Ezgi Vural, Hayriye Vehid, and Mayer Brezis)</li> <li>• Frequency of <b>ambulatory care adverse events</b> in Latin American countries: the AMBEAS/PAHO cohort study (Dolors Montserrat-Capella, Manuel Suárez, Lidia Ortiz, José Joaquín Mira, Hernando Gaitán Duarte, Ludovic Reveiz, on behalf of the AMBEAS Group)</li> <li>• Fidelity of implementation to a <b>care team redesign</b> and improved outcomes of <b>diabetes care</b> (Sherry M Grace, Jeremy Rich, William Chin, and Hector P Rodriguez)</li> <li>• Multicentre study to develop a medication safety package for decreasing inpatient harm from <b>omission of time-critical medications</b> (Linda V Graudins, Catherine Ingram, B T Smith, W J Ewing, and M Vandevreede)</li> </ul>
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*Australian Journal of Primary Health*

Volume 21(1) 2015

URL	<a href="http://www.publish.csiro.au/nid/262/issue/7499.htm">http://www.publish.csiro.au/nid/262/issue/7499.htm</a>
Notes	<p>A new issue of the <i>Australian Journal of Primary Health</i> has been published. Articles in this issue of <i>Australian Journal of Primary Health</i> include:</p> <ul style="list-style-type: none"> <li>• Impact of <b>community participation in primary health care</b>: what is the evidence? (Jessamy Bath and John Wakerman)</li> <li>• <b>Quality improvement initiatives</b> in a case management service: case study (Deborah J. Davies)</li> <li>• <b>Medicine use and safety</b> while breastfeeding: investigating the perspectives of community pharmacists in Australia (Martine de Ponti, Kay Stewart, Lisa H Amir and Safeera Y Hussainy)</li> <li>• Barriers and enablers to good <b>communication and information-sharing</b> practices in care planning for chronic condition management (Sharon Lawn, Toni Delany, Linda Sweet, Malcolm Battersby and Timothy Skinner)</li> </ul>



	<ul style="list-style-type: none"> <li>• <b>Self-management</b> of chronic conditions in a rural and remote context (Adem Sav, Michelle A King, Fiona Kelly, Sara S McMillan, Elizabeth Kendall, Jennifer A Whitty and Amanda J Wheeler)</li> <li>• <b>Improving communication</b> between health-care professionals and patients with limited English proficiency in the general practice setting (Melanie Attard, Alexa McArthur, Dagmara Riitano, Edoardo Aromataris, Chris Bollen and Alan Pearson)</li> <li>• Farmers' contact with health care services prior to <b>suicide</b>: evidence for the <b>role of general practitioners</b> as an intervention point (Katerina Kavalidou, Samara McPhedran and Diego De Leo)</li> <li>• Audit of <b>referral pathways</b> in the diagnosis of lung cancer: a pilot study (Geraldine Largey, Samantha Chakraborty, Tracey Tobias, Peter Briggs and Danielle Mazza)</li> </ul>
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*American Journal of Medical Quality*  
 March/April 2015; 30 (2)

URL	<a href="http://ajm.sagepub.com/content/30/2?etoc">http://ajm.sagepub.com/content/30/2?etoc</a>
Notes	<p>A new issue of the <i>American Journal of Medical Quality</i> has been published. Articles in this issue of the <i>American Journal of Medical Quality</i> include:</p> <ul style="list-style-type: none"> <li>• Impact of Including <b>Readmissions</b> for Qualifying Events in the <b>Patient Safety Indicators</b> (Sheryl M Davies, Olga Saynina, Laurence C Baker, and Kathryn M McDonald)</li> <li>• Face-to-Face <b>Handoff</b>: Improving Transfer to the Pediatric Intensive Care Unit <b>After Cardiac Surgery</b> (Jeffrey Vergales, Nancy Addison, Analise Vendittelli, E Nicholson, D J Carver, C Stemland, T Hoke, and J Gangemi)</li> <li>• Barriers to and Facilitators of <b>Interprofessional-Interdepartmental Interventions</b>: Unearthing Departmental <b>Culture</b> (Barret Michalec, Natalie Reinhold, Robert Dressler, L Laskowski-Jones, L Adarve, and D Elliott)</li> <li>• <b>Primary Care Access Barriers</b> as Reported by Nonurgent Emergency Department Users: Implications for the US Primary Care Infrastructure (Jennifer L Hefner, Randy Wexler, and Ann Scheck McAlearney)</li> <li>• Designing a <b>Quality Improvement Program With Electronic Health Records</b>: New York City's Health eQuits (Damon Duquaine, Shannon M Farley, Rachel Sacks, Jenna Mandel-Ricci, Sheryl L Silfen, and S C Shih)</li> <li>• Impact of Audit and Feedback and Pay-for-Performance Interventions on Pediatric Hospitalist <b>Discharge Communication</b> With Primary Care Providers (Javier Tejedor-Sojo, Tracy Creek, and Traci Leong)</li> <li>• Patient-Reported <b>Reasons for Emergency Department Visits</b> in the Urban Medicaid Population (Lin Wang, Nikolay Tchopcev, Kara Kuntz-Melcavage, Michelle Hawkins, and Regina Richardson)</li> <li>• First Time <b>Rounding Experiences</b> for Nonclinicians: The Cleveland Clinic Experience (Laura R Greenwald, Amy S Nowacki, and James K. Stoller)</li> <li>• Variability in <b>Anesthetic Care</b> for Total Knee Arthroplasty: An Analysis From the Anesthesia Quality Institute (Peter M Fleischut, Jonathan M Eskreis-Winkler, Licia K Gaber-Baylis, Gregory P Giambrone, Susan L Faggiani, Richard P Dutton, and Stavros G Memtsoudis)</li> <li>• Association Between <b>Patient Satisfaction and Outcomes</b> in Kidney Transplant (Rajagopal Srinivas, Kenneth D Chavin, Prabhakar K Baliga, Titte Srinivas, and David J Taber)</li> </ul>

	<ul style="list-style-type: none"> <li>• Are <b>Clinical Practice Guidelines</b> for Cataract and Glaucoma Trustworthy? (Benjamin K Young, Connie M Wu, Annie M Wu, Curtis E Margo, and Paul B Greenberg)</li> <li>• Compliance Does Not Mean Quality: An In-Depth Analysis of the <b>Safe Surgery Checklist</b> at a Tertiary Care Health Facility (Tahrin Mahmood, Faizal Haji, Rita Damignani, Darius Bagli, Adam Dubrowski, Julian Manzone, Judy Truong, Robert Martin, and Maria Mylopoulos)</li> <li>• Impact of a <b>Pharmacy Education Program on Chronic Kidney Disease Patients</b> With Complications in an Outpatient Clinic at Police General Hospital (Dhakrit Rungkitwattanakul, Weerachai Chaijamorn, Roongrudee Meesomboon, A Sangwiroon, J Kongrod, P Nurukkae, and S Poollua)</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>• Editorial: <b>Electronic health records and patient safety</b>: should we be discouraged? (Thomas H Payne)</li> <li>• <b>Human factors and ergonomics and quality improvement science</b>: integrating approaches for safety in healthcare (Sue Hignett, Emma Leanne Jones, Duncan Miller, Laurie Wolf, Chetna Modi, Muhammad Waseem Shahzad, Peter Buckle, Jaydip Banerjee, Ken Catchpole)</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>• <b>Interoperability</b> after deployment: persistent challenges and regional strategies in Denmark (Patrick Kierkegaard)</li> </ul>

### Online resources

#### *Assessment Methodologies - Achieving Accreditation*

<http://www.isqua.org/education/webinars/february-2015-webinar-with-stephen-clark>

Webinar presented by Dr Stephen Clark (Group Chief Executive: Quality Innovation Performance Ltd and Australian General Practice Accreditation Ltd) discussing assessment methodologies to achieve accreditation. In the webinar he discusses Australia's healthcare system and what's happening there in terms of health reform. He also discusses the importance of standards in primary care and the benefits of accreditation.

For more information on the Commission's work on accreditation and the National Safety and Quality Health Service Standards, see <http://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/>

#### *[WHO] WHO calls for worldwide use of "smart" syringes*

<http://www.who.int/mediacentre/news/releases/2015/injection-safety/en/>

The World Health Organization is calling for the adoption of ‘smart’ syringes (which use various mechanisms to prevent multiple use of the syringes) to prevent needle reuse and has also called for reduced use of injections in general.

It is claimed that up to 1.7 million people were infected with hepatitis B, up to 315,000 with hepatitis C, and as many as 33,800 with HIV through an unsafe injection in 2010. The WHO encourages countries to transition to exclusive use of ‘smart’ syringes by 2020.

*[UK] NICE Guidelines and Quality Standards*

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

The UK’s National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest updates are:

- NICE Guideline NG2 **Bladder cancer**: diagnosis and management of bladder cancer  
<https://www.nice.org.uk/guidance/ng2>
- NICE Guideline NG3 **Diabetes in pregnancy**: management of diabetes and its complications from preconception to the postnatal period  
<https://www.nice.org.uk/guidance/ng3>
- NICE Guideline CG61 **Irritable bowel syndrome** in adults: diagnosis and management of irritable bowel syndrome in primary care <https://www.nice.org.uk/guidance/cg61>
- NICE Quality Standard QS80 **Psychosis and schizophrenia in adults**  
<http://www.nice.org.uk/guidance/QS80>

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