



On the Radar

Issue 218
13 April 2015

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On the Radar

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Reports

Evaluation: what to consider. Commonly asked questions about how to approach evaluation of quality improvement in health care

The Health Foundation

London: The Health Foundation; 2015.


URL	http://www.health.org.uk/publications/evaluation-what-to-consider/
TRIM	D15-9342
Notes	<p>The UK's Health Foundation has produced this 'practical guide' to aid those engaged in health care quality improvement in understanding, designing and undertaking evaluation of quality improvements. The guide is intended to assist those new to evaluation by suggesting methodological and practical considerations and providing resources to support further learning.</p> <p>Ten questions covered in the guide:</p> <ol style="list-style-type: none"> 1. Why do an evaluation? 2. What are the different types of evaluation? 3. What are the design considerations for an evaluation? 4. What are we comparing our intervention with? 5. How does evaluation differ from other forms of measurement? 6. What practical issues should we consider? 7. When should we start and finish an evaluation?

	<p>8. How do we cope with changes in the intervention when the evaluation is underway?</p> <p>9. Should we do the evaluation ourselves or commission an external team?</p> <p>10. How do we communicate evaluation findings?</p> <p>The guide is not prescriptive or step-by-step as people and organisations will have very diverse evaluation needs. Instead, it aims to stimulate thinking and support planning.</p>
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Using communications approaches to spread improvement

Randall S

London: The Health Foundation; 2015.

URL	http://www.health.org.uk/publications/using-communications-approaches-to-spread-improvement/
TRIM	D15-9343
Notes	<p>The guide—from the UK’s Health Foundation—is intended for those actively engaged in health care improvement work. It includes:</p> <ul style="list-style-type: none"> • key concepts in spreading ideas • evidence on what is known about what works to spread improvement • practical suggestions for planning your communications, engaging the right people, sustaining interest in the work and celebrating and sharing achievements. 

Partnering to Improve Quality and Safety: A Framework for Working with Patient and Family Advisors

Health Research & Educational Trust

Chicago, IL: Health Research & Educational Trust; 2015. p. 21.

URL	http://www.hpoe.org/resources/hpoehtaha-guides/1828
TRIM	D15-9344
Notes	<p>The Symposium for Leaders in Healthcare Quality has developed this guide to help hospitals and care systems build and sustain partnerships with patient and family advisors, specifically to improve quality and safety. This guide presents a framework for a way to engage patients, engaging them as advisors on quality and patient safety initiatives.</p> <p><i>FIGURE 1. FRAMEWORK FOR HOSPITALS PARTNERING WITH PATIENT AND FAMILY ADVISORS</i></p> <pre> graph TD A[RECRUIT] --> B[PREPARE THE ADVISORS] B --> C[CREATE A CULTURE OF ENGAGEMENT] C --> D[IMPLEMENT IMPROVEMENT INITIATIVES AND MEASURE IMPACT] D --> E[SUSTAIN THE RELATIONSHIPS] </pre> <ul style="list-style-type: none"> RECRUIT <ul style="list-style-type: none"> • Identify patient and family advisors with knowledge of or experience with the topic at hand. PREPARE THE ADVISORS <ul style="list-style-type: none"> • Provide education and training in the basics of quality improvement. • Offer coaching on how to use storytelling to promote change. CREATE A CULTURE OF ENGAGEMENT <ul style="list-style-type: none"> • Explain the role of patient and family advisors and how they will contribute to the project. • Model a culture of partnership. • Encourage questions and feedback from staff. IMPLEMENT IMPROVEMENT INITIATIVES AND MEASURE IMPACT <ul style="list-style-type: none"> • Engage patient and family advisors in improvement initiatives including PDSA cycles and projects facilitated by patient safety and quality committees. • Measure the impact on patient satisfaction, quality, safety, and health outcomes. SUSTAIN THE RELATIONSHIPS <ul style="list-style-type: none"> • Maintain open channels of communication. • Update patient and family advisors on new developments with the project. • Share information on additional opportunities to participate in improvement projects.

Journal articles

Effectiveness of interventions designed to reduce the use of imaging for low-back pain: a systematic review

Jenkins HJ, Hancock MJ, French SD, Maher CG, Engel RM, Magnussen JS.

Canadian Medical Association Journal. 2015 April 7, 2015;187(6):401-8.

DOI	https://dx.doi.org/10.1503/cmaj.141183
Notes	<p>Paper reporting on a systematic review examining the effectiveness of interventions aimed at reducing the use of imaging for low-back pain. Imaging for lower-back pain is performed at a relatively high rate and there are concerns that it is unnecessary, inappropriate and can expose patients to harm.</p> <p>From an initial identification of 8500 studies, the review examined 54 in detail with 7 being retained for the review.</p> <p>The review found that “Clinical decision support in a hospital setting and targeted reminders [of appropriate indications for imaging] to primary care doctors were effective interventions in reducing the use of imaging for low-back pain. These are potentially low-cost interventions that would substantially decrease medical expenditures associated with the management of low-back pain.”</p>

A Collaborative Learning Network Approach to Improvement: The CUSP Learning Network
 Weaver SJ, Lofthus J, Sawyer M, Greer L, Opett K, Reynolds C, et al
 Joint Commission Journal on Quality and Patient Safety. 2015;41(4):147-59.

URL	https://www.ingentaconnect.com/content/jcaho/jcjq/2015/00000041/00000004/art00001
Notes	Being a learning organisation is considered a marker of an organisation with a positive safety and quality culture. This paper reports on a network that engages multiple organisations in order to share experiences and learnings. The Comprehensive Unit-based Safety Program (CUSP) Learning Network is meant to facilitate peer-to-peer learning and coaching approaches of CUSP to improve organisational safety culture, patient safety, and care quality across the network's member organisations. The article describes the mentorship and network learning aspects of the collaborative, along with descriptions of the implementation process and barriers faced at each institution.

Initiatives to Identify and Mitigate Medication Errors in England

Cousins D, Gerrett D, Richards N, Jadeja M

Drug Safety. 2015 [epub].

DOI	https://dx.doi.org/10.1007/s40264-015-0270-3
Notes	This commentary piece also describes an initiative designed to facilitate sharing of information and learning. In this case it discusses a UK initiative to implement requirements for collecting and sharing incident data about medication errors and to create opportunities for system feedback while enabling learning from errors at the local level. The authors describe that initiative as facilitating the “implementation of new requirements for medication error reporting and reduce the need for duplicate data entry by frontline staff. The initiative is also intended ...to improve learning at the local level by clarifying medication safety roles and identifying key safety contacts to allow better communication between local and national levels. Finally, the partnership has established a new National Medication Safety Network to provide a forum for discussing potential and recognised safety issues, and for identifying trends and actions to improve the safe use of medicines.”

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

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

Unfinished nursing care, missed care, and implicitly rationed care: State of the science review

Jones TL, Hamilton P, Murry N

International Journal of Nursing Studies. 2015 [epub].

DOI	https://dx.doi.org/10.1016/j.ijnurstu.2015.02.012
Notes	This paper reports on a literature review of ‘unfinished care’ (including missed care, implicitly rationed care; and care left undone). The authors report that from their review: <ul style="list-style-type: none"> • Predictors of unfinished care included perceived team interactions, adequacy of resources, safety climate, and nurse staffing. • Unfinished care is a predictor of decreased nurse-reported care quality, decreased patient satisfaction; increased adverse events; increased turnover; decreased job and occupational satisfaction; and increased intent to leave.

The dynamics of quality: a national panel study of evidence-based standards

Hardcastle AC, Mounce LTA, Richards SH, Bachmann MO, Clark A, Henley WE, et al
Health Services and Delivery Research. 2015;3(11).

DOI	https://dx.doi.org/10.3310/hsdr03110
Notes	<p>This study involved interviewing 16,773 patients in four waves (5,114 were interviewed in all four waves) as part of the English Longitudinal Study of Ageing in 2004–5, 2006–7, 2008–9 and 2010–11. The study sought to assess changes over 6 years in the receipt of effective health-care interventions for older patients with cardiovascular disease, depression, diabetes or osteoarthritis. The study sought to ascertain the percentage of indicated health care received by eligible participants for 19 quality indicators.</p> <p>The authors report that they “found that many people were still not receiving the care they needed, with little change over 6 years. The percentage of good care received for osteoarthritis was only 32%, compared with 83% for cardiovascular disease, 65% for depression and 76% for diabetes. There were no types of people who consistently missed out on care, although people with cognitive impairment received worse care for diabetes. Poorer people with specific illness burden may be less likely than wealthier people to receive a diagnosis, but people with a diagnosis were generally equally likely to get good-quality care.”</p>

Patients' Perspectives of Surgical Safety: Do They Feel Safe?

Dixon JL, Tillman MM, Wehbe-Janek H, Song J, Papaconstantinou HT
The Ochsner Journal. 2015 [epub].

DOI	http://www.ochsnerjournal.org/doi/abs/10.1043/TOJ-14-0086
Notes	<p>Paper reporting on a survey of 102 patients in a Texas hospital examining patients' views on surgical safety. The authors report that “Current surgical safety practice is perceived positively by our patients; however, patients still identify physician-patient interactions, relationships, and trust as the most positive factors influencing their perception of the safety environment.” Factors such as checklists, time-outs, etc. may be influencing surgical safety but do not appear to loom large in patients' perspective.</p> <p>The authors also noted that patients undergoing their first surgery and wealthier patients showed “a significant decrease in specific safety perceptions”.</p>

Health Affairs

April 2015; Vol. 34, No. 4

URL	http://content.healthaffairs.org/content/34/4?etoc
Notes	<p>A new issue of <i>Health Affairs</i> has been published with the theme ‘Cost & Quality Of Cancer Care’. Articles in this issue of <i>Health Affairs</i> include:</p> <ul style="list-style-type: none"> • The Cost And Quality Of Cancer Care (Alan R. Weil) • Quality-Adjusted Cost Of Care: A Meaningful Way To Measure Growth In Innovation Cost Versus The Value Of Health Gains(Darius Lakdawalla, Jason Shafrin, C Lucarelli, S Nicholson, Z M Khan, and T J Philipson) • Cancer Mortality Reductions Were Greatest Among Countries Where Cancer Care Spending Rose The Most, 1995–2007 (Warren Stevens, T J Philipson, Z M Khan, J P MacEwan, M T Linthicum, and D P Goldman) • National Expenditure For False-Positive Mammograms And Breast Cancer Overdiagnoses Estimated At \$4 Billion A Year (Mei-Sing Ong and Kenneth D. Mandl)

	<ul style="list-style-type: none"> • For Uninsured Cancer Patients, Outpatient Charges Can Be Costly, Putting Treatments Out Of Reach (Stacie B Dusetzina, Ethan Basch, and Nancy L Keating) • Older Women With Localized Breast Cancer: Costs And Survival Rates Increased Across Two Time Periods (Aaron J Feinstein, Jessica Long, Pamela R Soulos, Xiaomei Ma, Jeph Herrin, Kevin D Frick, Anees B Chagpar, Harlan M Krumholz, James B Yu, Joseph S Ross, and C P Gross) • Wide Variation In Payments For Medicare Beneficiary Oncology Services Suggests Room For Practice-Level Improvement (Jeffrey D Clough, Kavita Patel, Gerald F Riley, Rahul Rajkumar, Patrick H Conway, and P B Bach) • Early Diffusion Of Gene Expression Profiling In Breast Cancer Patients Associated With Areas Of High Income Inequality (Ninez A Ponce, Michelle Ko, Su-Ying Liang, Joanne Armstrong, Michele Toscano, Catherine Chanfreau-Coffinier, and Jennifer S Haas) • Michigan’s Fee-For-Value Physician Incentive Program Reduces Spending And Improves Quality In Primary Care (Christy Harris Lemak, Tammie A Nahra, Genna R Cohen, N D Erb, M L Paustian, D Share, and R A Hirth) • Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs (Jingping Xing, Candace Goehring, and David Mancuso) • Making Multipayer Reform Work: What Can Be Learned From Medical Home Initiatives (Mary Takach, Charles Townley, Rachel Yalowich, and Sarah Kinsler) • Large Performance Incentives Had The Greatest Impact On Providers Whose Quality Metrics Were Lowest At Baseline (Jessica Greene, Judith H • Efficacy And Safety Concerns Are Important Reasons Why The FDA Requires Multiple Reviews Before Approval Of New Drugs (Joseph S Ross, Kristina Dzara, and Nicholas S Downing)
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Journal of Health Services Research & Policy
 April 2015; Vol. 20, No. 2

URL	http://hsr.sagepub.com/content/20/2?etoc
Notes	<p>A new issue of the <i>Journal of Health Services Research & Policy</i> has been published. Articles in this issue of the <i>Journal of Health Services Research & Policy</i> include:</p> <ul style="list-style-type: none"> • Editorial: To do the service no harm: the dangers of quality assessment (Nick Black) • Scope for energy improvement for hospital imaging services in the USA (Amin Esmaeili, Janet M Twomey, Michael R Overcash, Seyed A Soltani, Charles McGuire, and Kamran Ali) • Development of key indicators of hospital resilience: a modified Delphi study (Shuang Zhong, Michele Clark, Xiang-Yu Hou, Yuli Zang, and Gerard FitzGerald) • Development and validation of a predictive model for all-cause hospital readmissions in Winnipeg, Canada (Yang Cui, Colleen Metge, Xibiao Ye, Michael Moffatt, Luis Oppenheimer, and Evelyn L Forget) • Impact of case-mix on comparisons of patient-reported experience in NHS acute hospital trusts in England (Veena Raleigh, Steve Sizmur, Yang Tian, and James Thompson)

	<ul style="list-style-type: none"> • Impact of ‘high-profile’ public reporting on utilization and quality of maternity care in England: a difference-in-difference analysis (Anthony A Lavery, Mauro Laudicella, Peter C Smith, and Christopher Millett) • In place of fear: aligning health care planning with system objectives to achieve financial sustainability (Stephen Birch, Gail Tomblin Murphy, Adrian MacKenzie, and Jackie Cumming) • Comparing end-of-life practices in different policy contexts: a scoping review (Antoine Boivin, Isabelle Marcoux, Geneviève Garnon, Pascale Lehoux, Nicholas Mays, Marie-Claude Prémont, Yi-Sheng Chao, Evert van Leeuwen, and Raynald Pineault)
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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"> • The PRONE score: an algorithm for predicting doctors’ risks of formal patient complaints using routinely collected administrative data (Matthew J Spittal, Marie M Bismark, David M Studdert)

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 business case for pediatric asthma quality improvement in low-income populations: examining a provider-based pay-for-reporting intervention (Kristin L Reiter, Kristin Andrews Lemos, Charlotte E. Williams, Dominick Esposito, and Sandra B Greene) • To recommend the local primary health-care centre or not: what importance do patients attach to initial contact quality, staff continuity and responsive staff encounters? (Birgitta Abrahamsson, Marie-Louise U Berg, Göran Jutengren, and Annikki Jonsson)

Online resources

Hospital User’s Manual: Penetrating the General Public with Patient Safety

<http://isqua.org/education/webinars/march-2015-webinar-with-heon-jae-jeong>

Webinar presented by Heon-Jae Jeong (Director of International Affairs for the Korean Society for Patient Safety) discussing the power of engaging patients effectively to promote safety. The webinar draws on his book *Hospital User’s Manual: 33 Safety Rules for Patients* and also covers strategies to bring all the stakeholders together in improving patient safety: patients, their family, healthcare organizations and legislature.

[UK] Toolkit to support NHS commissioners to reduce poor experience of in-patient care

<http://www.england.nhs.uk/2015/04/07/inpatient-toolkit/>

NHS England has developed this toolkit to support NHS commissioners/funders to work collaboratively with patients, carers and provider organisations to reduce poor experiences of inpatient care. It has three core elements: a data tool to help identify priority areas to focus on in order to improve inpatient experience; case examples to illustrate improvement work undertaken by organisations; and signposting to relevant improvement tools.

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