AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

Issue 219
20 April 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

Journal articles

Car parking is a clinical quality issue
Gilbert D
BMJ. 2015;350.

DOI	http://dx.doi.org/10.1136/bmj.h1312
Notes	A title that is perhaps designed/destined to elicit a derisory snort from a proportion of readers? David Gilbert's piece in the *BMJ* points out how many aspects of the 'patient experience' can come together to affect the patient and how they experience (and respond to) their care.

Developing person-centred analysis of harm in a paediatric hospital: a quality improvement report
Lachman P, Linkson L, Evans T, Clausen H, Hothi D
BMJ Quality & Safety. 2015 May 1, 2015;24(5):337-44.

DOI	http://dx.doi.org/10.1136/bmjqs-2014-003795
Notes	Study reporting on how a prominent children's hospital developed, implemented and evolved a tool enabling patients and families to report harm. The authors discuss the process and experience and state that "testing and introduction of a self-reporting, real-time bedside tool has led to **active engagement** with families and patients and **raised situation awareness**". They also "believe that this will lead to improved and safer care in the longer term."

For information on the Commission's work on patient and consumer centred care, see http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Measuring Quality of Pediatric Care: Where We've Been and Where We're Going
Schuster MA
Pediatrics. 2015 April 1, 2015;135(4):748-51.

DOI	http://dx.doi.org/10.1542/peds.2014-3082
Notes	This paper is the text of an address following the receipt of an award for paediatric research. In the address Mark Schuster briefly reviewed the history of quality measurement in paediatrics. He concluded by describing how paediatric quality measurement "will consist of if we get it right: • Quality measures will be appropriate and designed for children… Indicators will be balanced across key dimensions, such as preventive, acute, and chronic care, as well as transitions. They will also cover both process and outcome measures, including patient experience measures, along with structure measures, where relevant. • …a national consensus-approved set of core measures… • Measurement will be routine and …automated • All measures and their specifications will be publicly available so… Similarly, the results of quality measurement will be made available to consumers so that they can make informed choices. • Measurement will cover issues that patients and families care about… He concludes by stating that "**Quality measurement only matters if it's leading to better health care for children and their families**, and ultimately to better health. When we get past the details of benchmarks and pay-for-performance and casemix adjustment, that's what it is all about: doing a better job for children."

Survival curves to support quality improvement in hospitals with excess 30-day mortality after acute myocardial infarction, cerebral stroke and hip fracture: a before–after study
Kristoffersen DT, Helgeland J, Waage HP, Thalamus J, Clemens D, Lindman AS, et al
BMJ Open. 2015;5(3).

DOI	http://dx.doi.org/10.1136/bmjopen-2014-006741
Notes	Thirty day mortality attracts a deal of attention for various reasons. This Norwegian study discusses how analyses of these data can help guide quality improvement. After annual public reporting for 30-day in-and-out-of-hospital mortality (30D) for three medical conditions was started in Norway in 2011, 12 of 61 hospitals had statistically significant lower/higher mortality compared with the hospital mean. Three hospitals with significantly higher mortality requested detailed analyses for quality improvement purposes. This study discusses how survival curves helped identify points in the clinical pathways for targeting improvements. The authors report that for the three hospitals, "crude 30D declined and they were non-outliers for risk-adjusted 30D for 2013." It could be argued that this is exactly the role for many indicators and other measures – that they are the start of a process of investigation, analysis and improvement and not an end in themselves.

Incidence of "never events" among weekend admissions versus weekday admissions to US hospitals: national analysis
Attenello FJ, Wen T, Cen SY, Ng A, Kim-Tenser M, Sanossian N, et al.
BMJ. 2015;350.

DOI	http://dx.doi.org/10.1136/bmj.h1460
Notes	Adding to the literature on after-hours and the weekend effect is this US study that examined discharge data on 351 million patients discharged from US hospitals in the period 2002–2010. The study examined the association between weekend admission to hospital and 11 hospital acquired conditions deemed 'never events'. Nineteen percent of the admissions were on a weekend and "**hospital acquired conditions** occurred at an overall frequency of **4.1%** (**5.7%** among **weekend admissions** versus 3.7% among weekday admissions)." The conclusion that "**Weekend admission** to hospital is associated with an **increased likelihood** of **hospital acquired condition**, **cost**, and **length of stay**" mirrors that of previous studies.

BMJ Quality and Safety
May 2015, Vol. 24, Issue 5

URL	http://qualitysafety.bmj.com/content/24/5
Notes	A new issue of *BMJ Quality and Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality and Safety* include: • Editorial: **Disclosure after large-scale events**: the price of honesty? (Philip C Hébert) • Intended and unintended effects of **large-scale adverse event disclosure**: a controlled before-after analysis of five large-scale notifications (Todd H Wagner, Thomas Taylor, Elizabeth Cowgill, Steven M Asch, Pon Su, Barbara Bokhour, Janet Durfee, R A Martinello, E Maguire, A R Elwy) • Fix and forget or fix and report: a qualitative study of tensions at the front line of **incident reporting** (Tanya Anne Hewitt, Samia Chreim) • **Pay-for-performance** policy and **data-driven decision making** within nursing homes: a qualitative study (Kathleen Abrahamson, Edward Miech, Heather Wood Davila, Christine Mueller, Valerie Cooke, Greg Arling) • What to expect when you're **evaluating healthcare improvement**: a concordat approach to managing collaboration and uncomfortable realities (Liz Brewster, Emma-Louise Aveling, Graham Martin, Carolyn Tarrant, Mary Dixon-Woods, The Safer Clinical Systems Phase 2 Core Group Collaboration & Writing Committee) • How to study **improvement interventions**: a brief overview of possible study types (Margareth Crisóstomo Portela, Peter J Pronovost, Thomas Woodcock, Pam Carter, Mary Dixon-Woods) • Developing **person-centred analysis of harm** in a paediatric hospital: a quality improvement report (Peter Lachman, Lynette Linkson, Trish Evans, Henning Clausen, Daljit Hothi)

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: • Introducing **consultant outpatient clinics** to community settings to improve access to paediatrics: an observational impact study (Hugh McLeod, Gemma Heath, Elaine Cameron, Geoff Debelle, Carole Cummins) • Preventing **device-associated infections** in US hospitals: national surveys from 2005 to 2013 (Sarah L Krein, Karen E Fowler, David Ratz, Jennifer Meddings, Sanjay Saint) • Can **staff and patient perspectives** on hospital safety **predict harm-free care**? An analysis of staff and patient survey data and routinely collected outcomes (Rebecca Lawton, Jane Kathryn O'Hara, Laura Sheard, Caroline Reynolds, Kim Cocks, Gerry Armitage, John Wright)

International Journal for Quality in Health Care online first articles

URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • What affects local **community hospitals' survival** in turbulent times? (Hung-Che Chiang and Shiow-Ing Wang) • Technological aspects of **hospital communication challenges**: an observational study (Ilinca Popovici, Plinio P. Morita, Diane Doran, Stephen Lapinsky, Dante Morra, Ashleigh Shier, R Wu, and J A Cafazzo)

Online resources

[USA] Pathways to Safer Opioid Use
http://health.gov/hcq/training.asp#pathways
The United States Department of Health and Human Services (HHS) recently published their National Action Plan for Adverse Drug Event Prevention (ADE Action Plan). The Plan targets opioids as a significant contributor to ADEs.
This new, interactive training, "Pathways to Safer Opioid Use," teaches health care providers how to implement opioid-related recommendations from the ADE Action Plan, and patient-centred strategies to communicate the safe use of opioids in managing chronic pain.
By completing the training, participants will understand how to:

- Apply health literacy strategies to help patients understand and act on information to prevent opioid-related ADEs
- Identify individual risk factors, opioid medications, and interactions that place individuals with chronic pain at increased risk for opioid-related ADEs
- Recognise the importance of a multidisciplinary, team-based approach to treating patients with chronic pain
- Demonstrate the ability to combine the principles of the Health Literate Care Model and the biopsychosocial model of chronic pain management through case study examples.

[USA] Contemporary View of Medication-Related Harm. A New Paradigm
http://www.nccmerp.org/sites/default/files/nccmerp_fact_sheet_2015-02-v91.pdf
The US National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) has produced this factsheet that seeks to clarify the terminology around medication-related harm. The factsheet also provides a decision tree to distinguish whether an incident is an adverse drug reaction, adverse drug event, or medication error and determine if it was preventable. The NCCMERP proposes new terminology to clarify the terms and the relationships among them and encourages consistent adoption across the medication safety community"

- "Preventable ADE" is harm caused by the use of a drug as a result of an error. These events warrant examination by the provider to determine why it happened.
- "Non-Preventable ADE" is drug-induced harm occurring with appropriate use of medication. While these are currently non-preventable, future studies may reveal ways in which they can be prevented.

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.