AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Consultation on a resource for community health services applying the NSQHS Standards
The Australian Commission on Safety and Quality in Health Care has developed a draft *NSQHS Standards Guide for Community Health Services*. The Commission is seeking feedback on this resource that has been developed to help community health services using the National Safety and Quality Health Service (NSQHS) Standards.
The draft Guide for community health services describes how the NSQHS Standards can be applied in community health services and suggests strategies to meet the NSQHS Standards. It also includes examples of evidence that community health services can use to demonstrate they are meeting the NSQHS Standards.
The guide was developed primarily for community health services that are in a Local Health Network or are part of a private hospital ownership group. However, it may be useful for other community health services using the NSQHS Standards.
Feedback is sought by **24 July 2015**.
Find out about the consultation process and download the draft Guide at
http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/current-consultations

Reports

Responding to the threat of antimicrobial resistance: Australia's first national antimicrobial resistance strategy 2015–2019
Australian Government, Department of Health, Department of Agriculture
Canberra 2015.

URL	http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-amr.htm
Notes	The Australian Government has released the first National Antimicrobial Resistance Strategy to guide the response to the threat of antibiotic misuse and resistance. The strategy was developed in partnership with industry and government (including the Australian Commission on Safety and Quality in Healthcare), and should guide action by governments, health professionals, veterinarians, farmers and communities to reduce the emergence of resistant bacteria. The Strategy "calls on all stakeholders to support a collaborative effort to change those practices that have contributed to the development of resistance and implement new initiatives to reduce inappropriate antibiotic usage and resistance."

Managing Two Worlds Together (Stage 3): Improving Aboriginal Patient Journeys
Lowitja Institute
Melbourne 2015.

URL	https://www.lowitja.org.au/lowitja-publishing
Notes	The Lowitja Institute have released a series of reports from the **Improving Aboriginal Patient Journeys** (IAPJ) study, which is Stage 3 of the Managing Two Worlds Together project. The reports released include: • *Managing Two Worlds Together (Stage 3): Improving Aboriginal Patient Journeys – Study Report* (J Kelly, J Dwyer, B Pekarsky, T Mackean, E Willis, C de Crespigny, S Perkins, K O'Donnell, R King, L Mackean, A Brown, M Lawrence & K Dixon) • *Managing Two Worlds Together (Stage 3): Improving Aboriginal Patient Journeys – **Rural and Remote Sites Case Studies*** (J Kelly, J Wiseman, S Mazzone, D Miller, J Newham, B Ryan, K Thomas & L Martinez) • *Managing Two Worlds Together (Stage 3): Improving Aboriginal Patient Journeys – **Cardiac Case Studies*** (J Kelly, M Ramage, D Perry, J Tinsley, H Auckram, W Corkhill, S Wyatt, N McCabe) • *Managing Two Worlds Together (Stage 3): Improving Aboriginal Patient Journeys – **City Sites Case Studies*** (J Kelly, N McCabe, W McInnes, M Kirkbride, A Graham, D Rigney & A Nori) • *Managing Two Worlds Together (Stage 3): Improving Aboriginal Patient Journeys – **Maternity Case Studies*** (J Kelly, P Medway, D Miller, L Catt & M Lawrence) • *Managing Two Worlds Together (Stage 3): Improving Aboriginal Patient Journeys – **Renal Case Studies*** (J Kelly, K Herman, G Martin, C T East, C Russell & S Brown) • *Managing Two Worlds Together (Stage 3): Improving Aboriginal Patient Journeys – Workbook* (J Kelly, J Dwyer, B Pekarsky, T Mackean, N McCabe, J Wiseman, C de Crespigny & K O'Donnell)

Journal articles

Patient and carer identified factors which contribute to safety incidents in primary care: a qualitative study
Hernan AL, Giles SJ, Fuller J, Johnson JK, Walker C, Dunbar JA
BMJ Quality & Safety. 2015 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2015-004049
Notes	Paper reporting on an Australian qualitative study examining patient and carer perceptions around of factors affecting safety in primary care. The authors identified 13 factors that contribute to safety incidents in primary care. These included **communication**, **access**, **patient factors**, external **policy context**, **dignity and respect**, **primary–secondary care interface**, **continuity of care**, task **performance**, **task characteristics**, **consultation time**, **safety culture**, **team factors** and the **physical environment**.

Teamwork, communication and safety climate: a systematic review of interventions to improve surgical culture
Sacks GD, Shannon EM, Dawes AJ, Rollo JC, Nguyen DK, Russell MM, et al
BMJ Quality & Safety 2015 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2014-003764
Notes	An article about a systematic review of culture-improvement interventions and the impact of these on surgical culture. The article notes the importance of flexible standardisation and that organisations would benefit from developing individualised programmes based on proven domains such as teamwork, communication and considering their local environment. The evidence shows that culture-improvement appears to be associated with positive effects, including better patient outcomes and enhanced healthcare efficiency.

Association of a bundled intervention with surgical site infections among patients undergoing cardiac, hip, or knee surgery
Schweizer ML, Chiang H-Y, Septimus E, Moody J, Braun B, Hafner J, et al
Journal of the American Medical Association. 2015;313(21):2162-71.

DOI	http://dx.doi.org/10.1001/jama.2015.5387
Notes	This paper reports on how the implementation of a pre-operative infection prevention 'bundle' was associated with a significant reduction in serious *S. aureus* surgical site infections. The study covered 42,534 cardiac operations and hip and knee replacements performed in 20 hospitals in nine US states. The bundle included screening for *S. aureus*, decolonising patients, and administering perioperative antibiotics according to an evidence-based protocol. Rates of *S. aureus* surgical site infections (SSI) were seen to fall substantially among patients in the groups that fully adhered to the bundle..

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

"Never Events" and the Quest to Reduce Preventable Harm
Austin JM, Pronovost PJ
Joint Commission Journal on Quality and Patient Safety. 2015;41(6):279-88.

URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2015/00000041/00000006/art00006
Notes	Over the years sentinel events, 'never' events and the like (including the corollary 'always' events) have received a fair degree of attention (and criticism). This commentary piece rehearses the history and changes to the concept and use of never events. The authors go on to offer some recommendations, including standardising definitions and measures, increasing transparency and reporting and collaborative approaches to error prevention.

An Approach to Assessing Patient Safety in Hospitals in Low-Income Countries
Lindfield R, Knight A, Bwonya D
PLoS ONE. 2015;10(4):e0121628.

DOI	http://dx.doi.org/10.1371/journal.pone.0121628
Notes	Successful methods for addressing safety issues in low-resource settings are of interest to those in better resourced settings, particularly when the mantra of 'doing more with less' is so prevalent. This study was based on observations of patient safety practices in the eye care units of two Ugandan hospitals. The observations were grouped into four themes: the **team**, the **environment**, **patient-centred** care and the **process**. In the two cases, areas for improvement identified were staff-patient communication, the presence and use of protocols and a focus on consistent practice.

A Trigger Tool to Detect Harm in Pediatric Inpatient Settings
Stockwell DC, Bisarya H, Classen DC, Kirkendall ES, Landrigan CP, Lemon V, et al
Pediatrics. 2015 June 1, 2015;135(6):1036-42.

DOI	http://dx.doi.org/10.1542/peds.2014-2152
Notes	Further to a number of recent items on paediatric patient safety is this paper describing the use of a trigger tool for children in hospital. This particular study examined 600 patient charts in 6 academic children's hospitals with a novel paediatric trigger tool. From the review, the authors report "240 harmful events ("harms") were identified, resulting in a rate of **40 harms per 100 patients admitted** and **54.9 harms per 1000 patient days** across the 6 hospitals. At least 1 harm was identified in 146 patients (24.3% of patients). Of the 240 total events, 108 (**45.0%**) were assessed to have been potentially or definitely **preventable**. The most common patient harms were **intravenous catheter infiltrations/burns**, **respiratory distress**, **constipation**, **pain**, and **surgical complications**."

A systematic review to identify the factors that affect failure to rescue and escalation of care in surgery
Johnston MJ, Arora S, King D, Bouras G, Almoudaris AM, Davis R, et al
Surgery. 2015;157(4):752-63.

DOI	http://dx.doi.org/10.1016/j.surg.2014.10.017
Notes	Paper reporting a systematic review exploring factors linking 'failure to rescue' and escalation of care in surgery. The authors report that "factors that contribute to the avoidance of preventable harm include the recognition and communication of serious deterioration to implement definitive treatment", noting that causes of delayed escalation included hierarchy and failures in communication.

For information on the Commission's work on recognising and responding to clinical deterioration, see www.safetyandquality.gov.au/our-work/recognising-and-responding-to-clinical-deterioration/

Diagnostic Errors that Lead to Inappropriate Antimicrobial Use
Filice GA, Drekonja DM, Thurn JR, Hamann GM, Masoud BT, Johnson JR
Infection Control & Hospital Epidemiology. 2015 [epub].

DOI	http://dx.doi.org/10.1017/ice.2015.113
Notes	Paper reporting on a US retrospective cohort study conducted in a Veterans Affairs hospital that examined 500 patients with an antimicrobial course. The study sought to identify if the diagnoses that led to the selection of an antimicrobial were accurate and appropriate. From the reviews, the authors report that "diagnoses were correct in 291 cases (58%), **incorrect** in 156 cases (**31%**), and of indeterminate accuracy in 22 cases (4%). In the remaining 31 cases (6%), the diagnosis was a sign or symptom rather than a syndrome or disease." Further, when the diagnosis was correct, 181 of 292 courses (62%) were appropriate, compared with only 10 of 208 (5%) when the diagnosis was incorrect or indeterminate. The authors concluded that "Diagnostic accuracy is important for optimal inpatient antimicrobial use. Antimicrobial stewardship strategies should help providers avoid diagnostic errors and know when antimicrobial therapy can be withheld safely."

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

Long-term impact of a chronic disease management program on hospital utilization and cost in an Australian population with heart disease or diabetes
Hamar GB, Rula EY, Coberley C, Pope JE, Larkin S
BMC Health Services Research. 2015;15(1):174.

DOI	http://dx.doi.org/10.1186/s12913-015-0834-z
Notes	Paper reporting on a chronic disease management program implemented by an Australia private health insurance company. The program offered individual support via telephone nurse outreach and online tools for self-management, behaviour change and well-being to eligible members of the insurance fund. This study sought to evaluate the longitudinal value of the in reducing hospital utilization and costs over 4 years using a matched cohort study involving 4,948 members with heart disease or diabetes and 28,520 non-participants. The paper reports that over the 4 year period, program participation saw significant "reductions in hospital admissions (-11.4%, $P < 0.0001$), readmissions (-36.7%, $P < 0.0001$), and bed days (-17.2%, $P < 0.0001$). The effect size increased over time for admissions and bed days. The relative odds of any admission and readmission over the 4 years were 27% and 45% lower, respectively, in the treatment group. Cumulative program savings from reduced hospital claims was $3,549 over 4-years; savings values for each program year were significant and increased with time."

International Journal for Quality in Health Care
Vol. 27, No. 3, June 2015

URL	http://intqhc.oxfordjournals.org/content/27/3?etoc
Notes	A new issue of the *International Journal for Quality in Health Care* 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 *International Journal for Quality in Health Care* include: • Editorial: What are the leading **keywords of IJQHC** in last 3 years? (Usman Iqbal, Hsuan-Chia Yang, and Yu-Chuan Jack Li) • Editor's choice: Compliance with **hospital accreditation and patient mortality**: a Danish nationwide population-based study (Anne Mette Falstie-Jensen, Heidi Larsson, Erik Hollnagel, Mette Nørgaard, Marie Louise Overgaard Svendsen, and Søren Paaske Johnsen) • Editor's choice: Improving **clinician–carer communication for safer hospital care**: a study of the 'TOP 5' strategy in patients with **dementia** (Karen Luxford, Anne Axam, Fiona Hasnip, John Dobrohotoff, Maureen Strudwick, Rebecca Reeve, Changhao Hou, and Rosalie Vine) • 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) • 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) • An assessment of facilities and services at Anganwadi centers under the **Integrated Child Development Service** scheme in Northeast District of Delhi, India (Akash Malik, Meenakshi Bhilwar, Neeti Rustagi, and Davendra K. Taneja) • Attitudes towards vital signs monitoring in the **detection of clinical deterioration**: scale development and survey of ward nurses (Wenqi Mok, Wenru Wang, Simon Cooper, Emily Neo Kim Ang, and Sok Ying Liaw) • What affects **local community hospitals**' survival in turbulent times? (Hung-Che Chiang and Shiow-Ing Wang) • The relationship between **accessibility** of healthcare facilities and **medical care utilization** among the middle-aged and elderly population in Taiwan (Ya-Ting Yang, Usman Iqbal, Hua-Lin Ko, Chia-Rong Wu, Hsien-Tsai Chiu, Yi-Chieh Lin, Wender Lin, and Yi-Hsin Elsa Hsu) • What are hospital **nurses'** strengths and weaknesses in **patient safety competence**? Findings from three Korean hospitals (Jee-In Hwang)

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: • Editorial: **What's your excuse for Foley use**? (Sarah L Krein, Sanjay Saint) • Editorial: The **Quadruple Aim**: care, health, cost and meaning in work (Rishi Sikka, Julianne M Morath, Lucian Leape) • A unit-based intervention aimed at improving patient adherence to **pharmacological thromboprophylaxis** (Charles Alexander Baillie, James P Guevara, Raymond C Boston, Todd E H Hecht) • Associations between **safety culture** and **employee engagement** over time: a retrospective analysis (Elizabeth Lee Daugherty Biddison, Lori Paine, Peter Murakami, Carrie Herzke, Sallie J Weaver) • Lack of standardisation between specialties for **human factors content in postgraduate training**: an analysis of specialty curricula in the UK (Paul R Greig, Helen Higham, Emma Vaux) • Impact of **laws aimed at healthcare-associated infection reduction**: a qualitative study (Patricia W Stone, Monika Pogorzelska-Maziarz, Julie Reagan, Jacqueline A Merrill, Brad Sperber, Catherine Cairns, Matthew Penn, Tara Ramanathan, Elizabeth Mothershed, Elizabeth Skillen)

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: • Capturing **diagnosis-timing in ICD-coded hospital data**: recommendations from the WHO ICD-11 topic advisory group on quality and safety (V Sundararajan, P S Romano, H Quan, B Burnand, S E Drösler, S Brien, H A Pincus, and W A Ghali)

Online resources

[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 NG8 **Anaemia** management in people with **chronic kidney disease** http://www.nice.org.uk/guidance/ng8
- NICE Guideline NG9 **Bronchiolitis** in children http://www.nice.org.uk/guidance/ng9
- NICE Guideline NG10 **Violence and aggression**: short-term management in mental health, health and community settings http://www.nice.org.uk/guidance/ng10
- NICE Guideline NG11 **Challenging behaviour and learning disabilities**: prevention and interventions for people with learning disabilities whose behaviour challenges http://www.nice.org.uk/guidance/ng11
- NICE Clinical Guideline 97 **Lower urinary tract** symptoms in men: assessment and management http://www.nice.org.uk/guidance/cg97

[UK] The Edge Issue 8
http://theedge.nhsiq.nhs.uk/
The Edge is a free, online hub produced by NHS Improving Quality for those who are supportive of action for change in health and care. It brings together the latest thinking, learning opportunities and projects. It is aimed at everyone from leaders to front line change activists, improvement specialists to educationalists and researchers to senior leaders.
