



On the Radar

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On the Radar

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Books

Cardiovascular Disease and Diabetes: Policies for Better Health and Quality of Care

OECD Health Policy Studies

Organisation for Economic Cooperation and Development

Paris: OECD, 2015, p.192.

DOI	http://dx.doi.org/10.1787/9789264233010-en
TRIM	D15-18629
Notes	The OECD have released this report reviewing how various OECD countries perform in their ability to prevent, manage and treat cardiovascular disease (CVD) and diabetes. The report looks at how countries deliver programmes and services related to CVD and diabetes. It considers how countries have used available health care resources to reduce the overall burden of CVD and diabetes, and it focuses on the variation in OECD health systems' ability to convert health care inputs (such as expenditure) into health gains.

Reports

RCA²: Improving Root Cause Analyses and Actions to Prevent Harm

National Patient Safety Foundation

Boston: National Patient Safety Foundation, 2015, p. 51.

URL	http://www.npsf.org/?page=RCA2
Notes	<p>The (US) National Patient Safety Foundation has coordinated and published this report examining best practices around Root Cause Analysis (RCA) and offering guidelines to help health professionals standardise the RCA process and improve the way they investigate medical errors, adverse events, and near misses. The report offers guidance on issues including identifying events suitable for RCA, timing of RCA, RCA team size and composition, RCA process, steps, tools, actions, measurements, leadership, and effectiveness and sustainability.</p> <p>This resource has been endorsed by a range of organisations including the Canadian Patient Safety Institute, Children's Health Queensland Hospital and Health Service, ECRI Institute, Institute for Healthcare Improvement, Institute for Safe Medication Practices, The Joint Commission, Kaiser Permanente and the National Association for Healthcare Quality.</p>

Journal articles

A patient-initiated voluntary online survey of adverse medical events: the perspective of 696 injured patients and families

Southwick FS, Cranley NM and Hallisy JA

BMJ Quality & Safety. 2015 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2015-003980
Notes	<p>Paper describing a US survey of patients and families who experienced an adverse event. This survey was initiated by patients and the paper recognises the issue of self-selection. From the nearly 700 experiences captured, the authors report that “Harm was most commonly associated with diagnostic and therapeutic errors, followed by surgical or procedural complications, hospital-associated infections and medication errors.” From the analyses of the narratives what emerges is “a lack of perceived provider and system accountability, deficient and disrespectful communication and a failure of providers to listen”. These are all arguments for patient-centred health care that utilised shared decision making and practices open disclosure when adverse events occur.</p>

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

For information on the Commission’s work on shared decision making, see <http://www.safetyandquality.gov.au/our-work/shared-decision-making/>

For information on the Commission’s work on open disclosure, including the *Australian Open Disclosure Framework*, see www.safetyandquality.gov.au/our-work/open-disclosure/

Outcome of delirium in critically ill patients: systematic review and meta-analysis
 Salluh JIF, Wang H, Schneider EB, Nagarajan N, Yenokyan G, Damluji A, et al
 BMJ. 2015;350.

DOI	http://dx.doi.org/10.1136/bmj.h2538
Notes	This systematic review and meta-analysis reveals the extent – and impact – of delirium in Intensive Care Unit patients. Using 42 studies, covering 16,595 patients, delirium was identified in nearly a third of patients (5,280 or 31.8%). These patients had “ significantly higher risk of mortality during admission ... as well as longer durations of mechanical ventilation and lengths of stay in the intensive care unit and in hospital.

For information on the Commission’s work on cognitive impairment (dementia and delirium), including *A Better Way to Care* resources and the draft *Delirium Clinical Care Standard*, see <http://www.safetyandquality.gov.au/our-work/cognitive-impairment/>

A systems approach to evaluating ionizing radiation: six focus areas to improve quality, efficiency, and patient safety

Perlin JB, Mower L, Bushe C

Journal for healthcare quality : official publication of the National Association for Healthcare Quality. 2015 May-Jun;37(3):173-88.

DOI	http://dx.doi.org/10.1111/JHQ-D-15-00038
Notes	Radiation is used in various forms as part of many care processes. Recognising that this has risks the commentary piece reports on an analysis of practices surrounding the delivery of ionizing radiation, including existing culture, processes, and technology to identify deficiencies and propose solutions. The analysis revealed six focus areas: competency and certification; equipment; monitoring and auditing; education; clinical pathways; and communication and marketing. The authors also suggest solutions that “may advance patient safety and care.”

Wrong-site surgery, retained surgical items, and surgical fires : A systematic review of surgical never events

Hempel S, Maggard-Gibbons M, Nguyen DK, Dawes AJ, Miake-Lye IM, Beroes JM, et al
 JAMA Surgery. 2015 [epub].

DOI	http://dx.doi.org/10.1001/jamasurg.2015.0301
Notes	Paper reporting on a systematic review looking at ‘never events—including wrong-site surgery, retained surgical items, and surgical fires—since 2004. 138 studies were identified. In these studies the estimates for incidence of retained surgical items and wrong-site surgery varied, but the median event rates were about 1.32 per 10,000 and 0.9 per 100,000 procedures, respectively. Various causes and contributing factors were identified, but communication was frequently cited.

Critical outcomes in nonrobotic vs robotic-assisted cardiac surgery

Yanagawa F, Perez M, Bell T, Grim R, Martin J and Ahuja V
 JAMA Surgery. 2015 [epub].

DOI	http://dx.doi.org/10.1001/jamasurg.2015.1098
Notes	This study sought to compare mortality, cost, complications and length of stay (LOS) in robot-assisted and non-robotic cardiac surgical procedures. Using national US data on a range of cardiac surgeries conducted in the period 1 January 2008 and 31 December 2011 the study found that robotic-assisted surgeries had higher median cost but lower mortality, lower LOS and lower complication rates.

The challenges in defining and measuring diagnostic error

Zwaan L, Singh H

Diagnosis. 2015;2(2):97-103.

Evaluation of Outcomes From a National Patient-initiated Second-opinion Program

Meyer AND, Singh H, Graber ML

The American Journal of Medicine 2015 [epub].

URL / DOI	Zwaan and Singh http://www.degruyter.com/view/j/dx.2015.2.issue-2/dx-2014-0069/dx-2014-0069.xml? Meyer et al http://dx.doi.org/10.1016/j.amjmed.2015.04.020
Notes	<p>Diagnosis, including diagnostic error, over-diagnosis, etc. has emerged as a foci in recent times. Hardeep Singh and Mark Graber are both prominent in this research and they have new additions to the literature on diagnosis.</p> <p>Zwaan and Singh report on the views of multidisciplinary expert panel convened to discuss challenges in defining and measuring diagnostic errors in real-world settings. The challenges include:</p> <ol style="list-style-type: none"> 1) difficulties in determining error when the disease or diagnosis is evolving over time and in different care settings 2) accounting for a balance between underdiagnosis and overaggressive diagnostic pursuits, and 3) determining disease diagnosis likelihood and severity in hindsight. <p>Meyer et al report on a study of a second-opinion program that allows beneficiaries to request free second opinions. Looking at data covering 6791 patient-initiated second opinions in the period 1 January 2011 to 31 December 2012, they report that “Patients primarily sought second opinions for help choosing treatment options (41.3%) and for diagnostic concerns (34.8%). Second opinions often resulted in changes in diagnosis (14.8%), treatment (37.4%), or changes in both (10.6%). Clinical impact was estimated as moderate/major in 20.9% of cases for diagnosis and 30.7% of cases for treatment.”</p>

BMJ Quality and Safety

July 2015, Vol. 24, Issue 7

URL	http://qualitysafety.bmj.com/content/24/7
Notes	<p>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:</p> <ul style="list-style-type: none"> • Editorial: Crossing the quality chasm for <i>Clostridium difficile</i> infection prevention (Nasia Safdar, Eli Perencevich) • Editorial: What's your excuse for Foley use? (Sarah L Krein, Sanjay Saint) • Editorial: The role and importance of cognitive studies in patient safety (David W Bates, Aziz Sheikh) • Editorial: Technology, cognition and error (Enrico Coiera) • Editorial: New tools for high reliability healthcare (M Michael Shabot) • The husband's story: from tragedy to learning and action (M Bromiley) • Back to basics: checklists in aviation and healthcare (Robyn Clay-Williams, Lacey Colligan) • Is safe surgery possible when resources are scarce? (Nathan N O'Hara) • The association of hospital prevention processes and patient risk factors with the risk of <i>Clostridium difficile</i> infection: a population-based cohort study (N Daneman, A Guttman, X Wang, X Ma, D Gibson, TA Stukel)

	<ul style="list-style-type: none"> • “It's easier to stick a tube in”: a qualitative study to understand clinicians’ individual decisions to place urinary catheters in acute medical care (Catherine Murphy, Jacqui Prieto, Mandy Fader) • Pseudo-understanding: an analysis of the dilution of value in healthcare (Jens Jacob Fredriksson, David Ebbevi, Carl Savage) • Teamwork, communication and safety climate: a systematic review of interventions to improve surgical culture (Greg D Sacks, Evan M Shannon, Aaron J Dawes, Johnathon C Rollo, David K Nguyen, Marcia M Russell, Clifford Y Ko, Melinda A Maggard-Gibbons) • Role of cognition in generating and mitigating clinical errors (Vimla L Patel, Thomas G Kannampallil, Edward H Shortliffe)
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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"> • Measuring the effect of Choosing Wisely: an integrated framework to assess campaign impact on low-value care (R Sacha Bhatia, Wendy Levinson, Samuel Shortt, Ciara Pendrith, Elana Fric-Shamji, Marjon Kallewaard, Wilco Peul, Jeremy Veillard, A Elshaug, I Forde, E A Kerr) • A patient-initiated voluntary online survey of adverse medical events: the perspective of 696 injured patients and families (Frederick S Southwick, Nicole M Cranley, Julia A Hallisy) • Expanding the scope of Critical Care Rapid Response Teams: a feasible approach to identify adverse events. A prospective observational cohort (Andre Carlos Kajdacsy-Balla Amaral, Andrew McDonald, Natalie G Coburn, Wei Xiong, Kaveh G Shojania, Robert A Fowler, Martin Chapman, Neill K J Adhikari) • Systems modelling and simulation in health service design, delivery and decision making (Martin Pitt, Thomas Monks, Sonya Crowe, Christos Vasilakis)

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"> • Developing a set of quality indicators for breast cancer care in China (Han Bao, Fengjuan Yang, Xinyu Wang, Shaofei Su, Dan Liu, Rong Fu, Huimin Zhang, and Meina Liu) • SEQUenCE: a service user-centred quality of care instrument for mental health services (Lorraine Hester, Lorna Jane O’ Doherty, Rebecca Schnittger, Niamh Skelly, Muireann O’ Donnell, Lisa Butterly, Robert Browne, Charlotte Frorath, C Morgan, D M. McLoughlin, and P Fearon) • Validity of the clinical and administrative databases in detecting post-operative adverse events (Isabel Rodrigo-Rincon, Marta P. Martin-Vizcaino, Belen Tirapu-Leon, Pedro Zabalza-Lopez, Francisco J. Abad-Vicente, and Asuncion Merino-Peralta)

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 NG12 **Suspected cancer**: recognition and referral
<http://www.nice.org.uk/guidance/ng12>
- NICE Guideline NG13 Workplace policy and management practices to improve the **health and wellbeing of employees** <http://www.nice.org.uk/guidance/ng13>
- NICE Quality Standard QS87 **Osteoarthritis** <http://www.nice.org.uk/guidance/qs87>
- NICE Quality Standard QS88 **Personality disorders**: borderline and antisocial
<http://www.nice.org.uk/guidance/qs88>
- NICE Quality Standard QS89 **Pressure ulcers** <http://www.nice.org.uk/guidance/qs89>
- NICE Quality Standard QS90 **Urinary tract infections** in adults
<http://www.nice.org.uk/guidance/qs90>
- NICE Quality Standard QS91 **Prostate cancer** <http://www.nice.org.uk/guidance/qs91>

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