AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

# On the Radar

Issue 230
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## Five years of On the Radar

The first issue of *On the Radar* appeared on 5 July 2010. Initially produced as an internal resource for Commission personnel it quickly developed an audience beyond the Commission. Five years on from that initial issue it has a reach of thousands of subscribers in Australia and in many other countries.

Over the past five years hundreds of papers, reports, online resources and other items have been included—sorted from the thousands of possible items. I hope you have found it useful and relevant and continue to do so.

Dr Niall Johnson
Editor

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*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.

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**On the Radar**
Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

**Books**

*Transforming Health Care Scheduling and Access: Getting to Now*
Institute of Medicine
Washington, DC: The National Academies Press; 2015.

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| URL | www.iom.edu/gettingtonow<br>http://iom.nationalacademies.org/Reports/2015/Transforming-Health-Care-Scheduling-and-Access.aspx |
| TRIM | D15-19576 |
| Notes | The (US) Institute of Medicine has published this report developed by the IOM Committee on Optimizing Scheduling in Health Care to examine issues such as can timely care be ensured in various health care settings, and what are some of the reasons that care is sometimes not timely?<br>The report reviews what is currently known and experienced with respect to health care access, scheduling, and wait times nationally in the USA, and offers preliminary observations about emerging best practices and promising strategies. The report concludes that opportunities exist to implement those practices and strategies (including virtually immediate engagement), and presents recommendations for needed approaches, policies, and leadership. |

*Strategies to Improve Cardiac Arrest Survival: A Time to Act*
Institute of Medicine
Washington, DC: The National Academies Press; 2015. 458 p.

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| URL | http://iom.nationalacademies.org/Reports/2015/Strategies-to-Improve-Cardiac-Arrest-Survival.aspx |
| Notes | Another publication from the (US) Institute of Medicine—which is moving to a new web address of IOM.nationalacademies.org—this time reporting on a study of the current status of, and future opportunities to improve, cardiac arrest treatment and outcomes in the United States. The report (and an accompanying report brief) examines the US system of response to cardiac arrest and identifies opportunities within existing and new treatments, strategies, and research that promise to improve survival and recovery of patients.<br>The report's recommendations include:<br>1. Establish a National Cardiac Arrest Registry<br>2. Foster a culture of action through public awareness and training<br>3. Enhance the capabilities and performance of Emergency Medical Services systems<br>4. Set national accreditation standards related to cardiac arrest for hospitals and health care systems<br>5. Adopt Continuous Quality Improvement programs<br>6. Accelerate research on pathophysiology, new therapies and transaction of science for cardiac arrest<br>7. Accelerate research on the evaluation and adoption of cardiac arrest therapies. |

## Reports

*"Conversation Ready": A Framework for Improving End-of-Life Care*
IHI White Paper
McCutcheon Adams K, Kabcenell A, Little K, Sokol-Hessner L
Cambridge, Massachusetts: Institute for Healthcare Improvement; 2015.

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| URL | http://www.ihi.org/resources/Pages/IHIWhitePapers/ConversationReadyEndofLifeCare.aspx |
| Notes | The (US) Institute for Healthcare Improvement have published this white paper to assist health care organisations in engaging patients in conversations about their wishes for end-of-life care, steward that information, and then respect those wishes at the appropriate time. This white paper describes the IHI's Conversation Ready framework, the changes associated with the framework's five principles that can be implemented to improve end-of-life care, examples of changes tested by organizations, and suggested measures to guide improvement. |

For information on the Commission's work on end-of-life care in acute hospitals, including the recently released *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*, see http://www.safetyandquality.gov.au/our-work/recognising-and-responding-to-clinical-deterioration/end-of-life-care-in-acute-hospitals/

*Focus on: International Comparisons of healthcare quality: What can the UK learn?*
Kossarova L, Blunt I, Bardsley M
London: The Health Foundation and Nuffield Trust; 2015.

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| URL | http://www.qualitywatch.org.uk/content/about-international-comparisons |
| Notes | This report uses 27 of the OECD's Health Care Quality Indicators to examine how quality of care in the UK has changed over time, including when compared 14 similar countries, including Australia. The report's authors examine what international comparisons reveal us about healthcare in the UK, and the value of such comparisons as a means of assessing performance.<br>One possible criticism is that many of the figures mention a 'best' rate; which tends to be the lowest rate for a given indicator when it could be argued that in some instances these low rates may actually be indicative of missed care.<br>The QualityWatch website includes other material, including blog posts that extend some of the subjects touched upon in the report. |

## Journal articles

*Developing a primary care patient measure of safety (PC PMOS): a modified Delphi process and face validity testing*
Hernan AL, Giles SJ, O'Hara JK, Fuller J, Johnson JK, Dunbar JA
BMJ Quality & Safety. 2015 July 3, 2015.

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| DOI | http://dx.doi.org/10.1136/bmjqs-2015-004268 |
| Notes | Paper describing the development and testing of a patient measure of safety in the primary care setting. The authors suggest that the their tool, the PC PMOS (Primary Care Patient Measure of Safety), "allows patients to provide feedback about factors contributing to potential safety incidents" and that it "provides a way for primary care organisations to learn about safety from the patient perspective and make service improvements with the aim of reducing harm in this setting." |

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/

*BMJ Quality and Safety* online first articles

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| URL | http://qualitysafety.bmj.com/content/early/recent |
| Notes | *BMJ Quality and Safety* has published a number of 'online first' articles, including:<br>• Editorial: The ubiquitous **weekend effect**: moving past proving it exists to clarifying what causes it (Richard J Lilford, Yen-Fu Chen)<br>• How can **healthcare standards** be standardised? (Charles D Shaw)<br>• Developing a **primary care patient measure of safety** (PC PMOS): a modified Delphi process and face validity testing (Andrea L Hernan, Sally J Giles, Jane K O'Hara, Jeffrey Fuller, Julie K Johnson, James A Dunbar)<br>• The **SQUIRE Guidelines**: an evaluation from the field, 5 years post release (Louise Davies, Paul Batalden, Frank Davidoff, David Stevens, G Ogrinc)<br>• **Ranking hospitals on avoidable death rates** derived from retrospective case record review: methodological observations and limitations (Gary Abel, Georgios Lyratzopoulos) |

*International Journal for Quality in Health Care* online first articles

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| 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:<br>• **Electronic medication reconciliation** and **medication errors** (Jonathan D Hron, Shannon Manzi, Roger Dionne, Vincent W Chiang, Marcie Brostoff, Stephanie A Altavilla, Al Patterson, and Marvin B Harper) |

**Online resources**

*Improving the quality of care for your community*
The Menzies School of Health research have released a series of summaries of research findings for Aboriginal and Torres Strait Islander Health Workers/Health Practitioners on how care quality in local (Indigenous) communities can be improved. Included in this series are:

- *Improving the quality of **primary health care** for your community*
  http://apo.org.au/files/Resource/improving-quality-primary-health-care.pdf
- *Improving the quality of **type 2 diabetes** care for your community*
  http://apo.org.au/files/Resource/improving-quality-type2-diabetes-care.pdf
- ***Diabetes and depression**: Improving the quality of care for your community*
  http://apo.org.au/files/Resource/diabetes-and-depression.pdf

Also available is an overview summary, *Partnering to Improve Aboriginal and Torres Strait Islander Primary Health Care ABCD National Research Partnership Project*.
http://apo.org.au/files/Resource/abcd_national_research_partnership-_impact_and_research_findings_8.pdf

*Medical Devices Safety Update*
Volume 3, Number 4, July 2015
https://www.tga.gov.au/publication-issue/medical-devices-safety-update-volume-3-number-4-july-2015
The Therapeutic Goods Administration (TGA) has released the latest edition of its medical device safety bulletin. Topics covered in this issue include:

- TGA takes action after analysis of orthopaedic registry data – The TGA has undertaken a range of actions involving **hip, knee and shoulder orthopaedic implants** that have been identified as having higher-than-expected rates of revision.
- **Environmental extremes** add additional hazards for some medical devices – health professionals and health facilities are advised to be alert to risks such as extreme heat and dust and take steps to mitigate their impact on medical devices.
- Dangers for children from **button batteries**
- **Infant sleep positioners and pillows** review –post-market review of infant sleep positioners and pillows
- Recent **safety alerts**
- **TGA databases** – description of two publicly searchable databases, the Database of Adverse Event Notifications (DAEN) and the System for Australian Recall Actions (SARA).

*[USA] Effective Health Care Program reports*
http://effectivehealthcare.ahrq.gov/
The US Agency for Healthcare Research and Quality (AHRQ) has an Effective Health Care (EHC) Program. The EHC has released the following final reports and updates:

- *Treatment of Nonmetastatic Muscle-Invasive Bladder Cancer* http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2094
- *Genetic Testing for Developmental Disabilities, Intellectual Disability, and Autism Spectrum Disorder* http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2095

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