



On the Radar

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On the Radar

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Reports

Cultural competency in the delivery of health services for Indigenous people. Issues paper no 13
Bainbridge R, McCalman J, Clifford A, Tsey K

Produced for the Closing the Gap Clearinghouse.

Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies; 2015. p. 44.

URL	http://www.aihw.gov.au/closingthegap/
Notes	<p>The Australian Institute of Health and Welfare have released, on their Closing the Gap page, this issues paper. The paper In the paper the authors examine the available evidence on cultural competence in international and local literature. They process to define cultural competency; report on available evidence; identify approaches and strategies that are effective in improving cultural competency among health services staff, examine the relationship between cultural competency and health outcomes, and document an evidence-informed conceptual framework. The report starts with the recognition that</p> <ul style="list-style-type: none"> • Cultural competency is a key strategy for reducing inequalities in healthcare access and improving the quality and effectiveness of care for Indigenous people. • Cultural competence is more than cultural awareness—it is the set of behaviours, attitudes, and policies that come together to enable a system, agency, or professionals to work effectively in cross-cultural situations.

Learnings from serious failings in care

Academy of Medical Royal Colleges and Faculties in Scotland (Scottish Academy) Short-Life Working Group on Hospital Reports
Edinburgh2015. p. 27.

URL	http://www.scottishacademy.org.uk/
Notes	<p>Possibly enacting the saying ‘Never let a good crisis go to waste’ the Academy of Medical Royal Colleges and Faculties in Scotland have published this report containing recommendations aimed at addressing systemic failings in NHS care in Scotland. The failings were revealed in a series of reports in 2013–2014. The Working Group responsible for the report identified a number of key issues which contributed to the serious failings in care, including:</p> <ul style="list-style-type: none"> • poor leadership at all levels (including senior clinical staff and management) resulting in a defective culture, a disconnect between clinical staff and management, inappropriate targets and poor accountability mechanisms; • staff shortages, an inappropriate skills mix on the team, inappropriate use of inexperienced staff or failure to supervise; • poor staff morale and motivation; • poor dealings with patients (inadequate care and poor communication); • inadequate complaints handling; and • limitations of external assessments. <p>The Working Group’s recommendations focus on the “urgent need to engender more effective team working, to place quality of care ahead of targets, to ensure appropriate staffing levels and to end the culture of “learned helplessness” experienced by staff when poor standards of patient care are condoned and perpetuated due to a combination of pressures”. The 20 recommendations are grouped into the Leadership, Culture & Professional Engagement, Inadequate Staffing, Quality of Care & Patient Experience and External Review.</p>

The NHS in 2030: A vision of a people-powered, knowledge-powered health system

Bland J, Khan H, Loder J, Symons T, Westlake S
London: Nesta; 2015. p. 48.

URL	http://www.nesta.org.uk/publications/nhs-2030-people-powered-and-knowledge-powered-health-system
Notes	<p>NETSA is a UK charity that describes itself as “an innovation charity that helps people and organisations bring great ideas to life”. Their latest report in the health and ageing area is “an optimistic take on what a health system would look like in 2030 if new knowledge is used differently and more people play a role in managing health”.</p> <p>The report is based upon ‘four axes of change’:</p> <ul style="list-style-type: none"> • the promise of precision medicine • a health knowledge commons stretching beyond traditional actors • a system powered by more people and new kinds of relationships, and • taking advantage of contemporary behavioural insights. <p>The first two concentrate on how new kinds of knowledge could be used differently while the second two concentrate on how more people will be involved in managing health.</p>

New organisational models of primary care to meet the future needs of the NHS: A brief overview of recent reports

Bienkowska-Gibbs T, King S, Saunders CL, Henham M-L.

Cambridge: RAND Europe; 2015. p. 59.

URL	http://www.rand.org/pubs/research_reports/RR1181.html
Notes	<p>Also looking at possible futures for the British NHS is this report from RAND Europe that looks at how primary care could possibly be re-modelled to meet various challenges. Those challenges include ageing population, increasing numbers of patients with multiple long-term conditions and a limited workforce.</p> <ul style="list-style-type: none"> • Models that introduce new roles, or change existing roles, in general practice (e.g. physician associates and pharmacists in general practice, extending roles for allied health professionals and primary care nurses); • Models of collaboration among professionals and among the primary care, secondary care and social care sectors (e.g. 'micro-teams', GPs and specialists working together and/or specialists working in the community, extended roles for community pharmacists); and • New organisational forms for general practice (e.g. primary care federations or networks, super-practices, regional multi-practice organisations, community health organisations, polyclinics and multispecialty community providers). <p>The authors describe the models and offer recommendations on how models of care could be implemented. They make clear that “there is no 'one size fits all' model for delivering primary care and that the way in which new models are implemented may be as important as the models themselves.”</p>

Journal articles

Communication in healthcare: a narrative review of the literature and practical recommendations

Vermeir P, Vandijck D, Degroote S, Peleman R, Verhaeghe R, Mortier E, et al.

International Journal of Clinical Practice. 2015.

DOI	http://dx.doi.org/10.1111/ijcp.12686
Notes	<p>Health care is essentially an information business and thus communication is central to its success (and failing) This paper offers a narrative review examining 69 studies in order to reviewing the literature on the quality of written communication, the impact of communication inefficiencies and recommendations to improve written communication in healthcare. The focus is rather on clinician to clinician communication; expanding the scope to cover clinician-patient may have been too much to contemplate.</p> <p>The rather unsurprising finding is that “poor communication can lead to various negative outcomes: discontinuity of care, compromise of patient safety, patient dissatisfaction and inefficient use of valuable resources, both in unnecessary investigations and physician worktime as well as economic consequences.”</p> <p>The authors suggest making ‘ownership’ or responsibility could help improve matters, along with structured communication to help specify and standardise what content is covered and the quality of the communication.</p>

For information on the Commission’s work on clinical communications, see

<http://www.safetyandquality.gov.au/our-work/clinical-communications/>

Rapid response systems: a systematic review and meta-analysis

Maharaj R, Raffaele I, Wendon J

Critical Care. 2015;19:254.

DOI	http://dx.doi.org/10.1186/s13054-015-0973-y
Notes	Adding to the literature on rapid response systems , medical emergency teams, etc. is this systematic review and meta-analysis that sought to examine their impact on hospital mortality and cardiopulmonary arrest. The authors concluded that such systems – based on the 29 studies included –were associated with a reduction in hospital mortality and cardiopulmonary arrest.

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	<i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including: <ul style="list-style-type: none">• Editorial: ‘Speaking up’ climate: a new domain of culture to measure and explore (Liane Ginsburg)• Patient safety reporting: a qualitative study of thoughts and perceptions of experts 15 years after ‘To Err is Human’ (Imogen Mitchell, Anne Schuster, Katherine Smith, Peter Pronovost, Albert Wu)• “Anybody on this list that you're more worried about?” Qualitative analysis exploring the functions of questions during end of shift handoffs (Colleen M O'Brien, Mindy E Flanagan, A A Bergman, P R Ebright, R M Frankel)• “Mr Smith's been our problem child today...”: anticipatory management communication (AMC) in VA end-of-shift medicine and nursing handoffs (Alicia A Bergman, Mindy E Flanagan, Patricia R Ebright, Colleen M O'Brien, Richard M Frankel)• Environmental factors and their association with emergency department hand hygiene compliance: an observational study (Eileen J Carter, Peter Wyer, James Giglio, Haomiao Jia, G Nelson, V E Kauari, E L Larson)

Online resources

[USA] Patient Safety Primers

<http://psnet.ahrq.gov/primerHome.aspx>

The Patient Safety Primers from the (US) Agency for Healthcare Research and Quality (AHRQ) discuss key concepts in patient safety. Each primer defines a topic, offers background information on its epidemiology and context, and provides links to relevant materials. AHRQ have released a new primer:

- *Support for Clinicians Involved in Errors and Adverse Events (Second Victims)* – while the priority when an adverse event or error occurs in care should always be the harmed patient, the impact on the clinician may also be significant. This primer addresses clinician responses to involvement in errors and adverse events, along with support that can be put in place to respond when such involvement occurs.

<http://psnet.ahrq.gov/primer.aspx?primerID=30>

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