



## On the Radar

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### On the Radar

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### Reports

*Health Literacy: Past, Present, and Future: Workshop Summary*  
The National Academies of Sciences Engineering, and Medicine  
Washington DC: The National Academies Press; 2015. 130 p.

URL	<a href="http://iom.nationalacademies.org/Reports/2015/Health-Literacy-Past-Present-Future.aspx">http://iom.nationalacademies.org/Reports/2015/Health-Literacy-Past-Present-Future.aspx</a>
Notes	The (US) Institute of Medicine have released this summary of workshop that examined the state of health literacy, particularly as it has changed over the last decade. The view is that a decade ago, “there was a lack of recognition of <b>health literacy</b> as a <b>foundational element for high-quality, patient-centered care</b> ... understanding has evolved to the point where we now understand that <b>health literacy</b> is <b>not just a function of individual skills and abilities</b> , it also includes the demands and complexities of the systems with which individuals interact.” This workshop summary includes presentations and discussions of the progress made in the field of health literacy since that time, explores the current state of the field, and discusses possible directions for future health literacy efforts.

For information on the Commission’s work on health literacy, including the *National Statement on Health Literacy*, see <http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/>

*From Safety-I to Safety-II: A White Paper*

Hollnagel E, Wears RL, Braithwaite J

Middelfart, Denmark: Resilient Health Care Net; 2015. p. 43.

URL	<a href="http://resilienthealthcare.net/onewebmedia/WhitePaperFinal.pdf">http://resilienthealthcare.net/onewebmedia/WhitePaperFinal.pdf</a>
Notes	<p>In recent years one of the themes to emerge in discussion about how we improve health services is that of resilience. Resilient health care should mean a health service/system that can cope with surges, errors, etc. and ‘bend but not break’. This white paper has been produced by the Resilient Health Care Net (RHCN). The RHCN characterise themselves as “a non-commercial collaboration of an international group of researchers and practitioners with the aim to apply Resilience Engineering principles in health care”.</p> <p>In this report, ‘<b>Safety I</b>’ is defined as “a state where <b>as few things as possible go wrong</b>. A Safety-I approach presumes that things go wrong because of identifiable failures or malfunctions of specific components: technology, procedures, the human workers and the organisations in which they are embedded.”</p> <p>This is then juxtaposed with ‘<b>Safety II</b>’ in which “Safety management should therefore move from ensuring that ‘as few things as possible go wrong’ to ensuring that ‘<b>as many things as possible go right</b>’. We call this perspective Safety-II; it relates to the system’s ability to succeed under varying conditions”. In this setting, “the purpose of investigations changes to become an understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong.”</p> <p>This is not a call for Safety II to displace the Safety I, but rather “The way forward therefore lies in combining the two ways of thinking. While many of the existing methods and techniques can continue to be used, the assimilation of a Safety-II view will also require new practices to look for what goes right”.</p>

*Environmental Cleaning for the Prevention of Healthcare-Associated Infections (HAI)*

Technical Brief No 22 (Prepared by the ECRI Institute – Penn Medicine Evidence-based Practice Center under Contract No 290-2012-00011-I) AHRQ Publication No 15-EHC020-EF.

Leas BF, Sullivan N, Han JH, Pegues DA, Kaczmarek JL, Umscheid CA

Rockville, MD: Agency for Healthcare Research and Quality; 2015. p. 121.

URL	<p><a href="http://www.effectivehealthcare.ahrq.gov/reports/final/cfm">www.effectivehealthcare.ahrq.gov/reports/final/cfm</a>  <a href="http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&amp;productid=2103">http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&amp;productid=2103</a></p>
Notes	<p>The US Agency for Healthcare Research and Quality (AHRQ) have published this report into how cleaning in hospitals can aid in preventing and reducing healthcare associated infections (HAIs). The report includes a review of 80 clinical studies examining environmental cleaning of high-touch surfaces in hospital rooms.</p> <p>The report shows that the researchers found limited studies that directly compare disinfection methods, monitoring strategies or implementation efforts.</p> <p>Recommendations for future areas of study include: the examination and comparison of emerging strategies; the inclusion of patient colonisation and infection rates as outcomes; and the identification of surfaces posing the greatest risk of pathogen transmission.</p>

For information on the Commission’s work on healthcare associated infections, see <http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/>

*Evaluation of complex health and care interventions using retrospective matched control methods*

Davies A, Ariti C, Georghiou T, Bardsley M

London: Nuffield Trust; 2015. p. 28.

URL	<a href="http://www.nuffieldtrust.org.uk/publications/evaluation-complex-health-care-interventions-using-retrospective-matched-control-analysis">http://www.nuffieldtrust.org.uk/publications/evaluation-complex-health-care-interventions-using-retrospective-matched-control-analysis</a>
Notes	<p>The UK’s Nuffield Trust has published this ‘guide for evaluators’. As the website notes, “One of the recurrent problems when evaluating the impact of new care models on outcomes is how to know ‘what would have happened anyway’. One approach that can be used is retrospective matched control analysis, whereby the impact of an intervention can be measured in terms of differences in the outcome relative to a matched control group.” This brief (28-page) guide outlines ten steps towards retrospective matching to evaluate new health and care service models. The ten steps to retrospective matched control analysis are:</p> <ol style="list-style-type: none"> <li>1. Clarify the aims of the service and the evaluation</li> <li>2. Decide on the number of people needed to demonstrate an effect</li> <li>3. Ensure permission is granted to access person-level datasets</li> <li>4. Ensure there are data on who received the new services, and some information about the service received</li> <li>5. Identify the potential control population</li> <li>6. Create longitudinal patient-level histories of service use</li> <li>7. Identify matched controls</li> <li>8. Monitor outcome variables for those receiving the new service and matched controls</li> <li>9. Undertake summative analysis</li> <li>10. Continuously monitor.</li> </ol>

*State of Patient Experience 2015: A Global Perspective on the Patient Experience Movement*

A Report on the Beryl Institute Benchmarking Study

Wolf JA

Dallas/Fort Worth: The Beryl Institute; 2015. p. 24.

URL	<a href="http://www.theberylinstitute.org/?page=PXBenchmarking2015">http://www.theberylinstitute.org/?page=PXBenchmarking2015</a>
Notes	The USA-based Beryl Institute focuses on patient experience. They have just published this brief (24-page) report on their ‘benchmarking study’ offering a “global perspective on the patient experience movement”.

**Journal articles**

*The arc of health literacy*

Koh HK, Rudd RE

Journal of the American Medical Association. 2015 [epub].

DOI	<a href="http://dx.doi.org/10.1001/jama.2015.9978">http://dx.doi.org/10.1001/jama.2015.9978</a>
Notes	This short commentary piece on health literacy recognises the barrier to better care that poor health literacy poses. While lamenting that health literacy is still palpably too limited, the piece sets out how thinking on health literacy has changed. The role of the clinician, institution and system (as well as the patient) in improving health literacy are discussed.

*Association between frailty and 30-day outcomes after discharge from hospital*  
 Kahlon S, Pederson J, Majumdar SR, Belga S, Lau D, Fradette M, et al.  
 Canadian Medical Association Journal. 2015;187(11):799-804.

*Understanding variation in 30-day surgical readmission in the era of accountable care: Effect of the patient, surgeon, and surgical subspecialties*  
 Gani F, Lucas DJ, Kim Y, Schneider EB, Pawlik TM  
 JAMA Surgery. 2015 [epub].

DOI	Kahlon et al <a href="http://dx.doi.org/10.1503/cmaj.150100">http://dx.doi.org/10.1503/cmaj.150100</a> Gani et al <a href="http://dx.doi.org/10.1001/jamasurg.2015.2215">http://dx.doi.org/10.1001/jamasurg.2015.2215</a>
Notes	<p>A pair of items on 30-day readmission (and other outcomes), one looking at 30-day outcomes after hospital discharge among 495 general internal medicine patients in 2 Canadian hospitals and that other on re-admission in the 30 days after surgery among 22,559 surgical patients at a US hospital.</p> <p>The first, Kahlon et al, found that frailty is a predictor of re-admission, “was common and associated with a substantially increased risk of early readmission or death after discharge from medical wards” and suggest that using frailty scoring may assist in identifying patients at greatest risk of re-admission. The authors report that the “composite of <b>30-day readmission or death was higher among frail</b> than among nonfrail patients (39 [24.1%] v. 46 [13.8%])”.</p> <p>The other paper, Gani et al, suggest that ‘patient-level factors’(which may include frailty) account for the bulk of variation in re-admission “while only a minority of the variation was attributable to factors at the surgical subspecialty and individual surgeon level”. The factors associated with greater odds of 30-day readmission included ethnicity, increasing comorbidity, postoperative complications and extended length of stay. The <b>overall 30-day readmission was 13.2%</b> (n=2975) but varied across the 8 different surgical subspecialties examined, ranging from 24.8% following transplant surgery (n = 557) to 2.1% following breast, melanoma, or endocrine surgery (n = 32).</p>

*Music and communication in the operating theatre*  
 Weldon S-M, Korciakangas T, Bezemer J, Kneebone R  
 Journal of Advanced Nursing. 2015 [epub].

DOI	<a href="http://dx.doi.org/10.1111/jan.12744">http://dx.doi.org/10.1111/jan.12744</a>
Notes	<p>The role of interruption or distraction to lapses in care has been examined in various settings, for example medication delivery. This paper looks at the disruptive potential of something that it often seen as making the working environment, music, more pleasant and its impact on communication in the operating theatre. Apparently music is commonplace in operating theatres – the authors cite studies stating that music is played in 53-72% of surgical operations. This study was an ethnographic observational study of teamwork in operating theatres through video recordings of 20 operations in 2 operating theatres over a 6 month period in which more than 5000 ‘request/response’ interactions were observed. The authors report that “repeated requests were five times more likely to occur in cases that played music than those that did not. A repeated request can add 4-68 seconds each to operation time and increased tensions due to frustration at ineffective communication.”</p>

*Evaluation of a continuous monitoring and feedback initiative to improve quality of anaesthetic care: a mixed-methods quasi-experimental study*

Benn J, Arnold G, D'Lima D, Wei I, Moore J, Aleva F, et al  
Health Services and Delivery Research. 2015 2015/08/03;3(32).

DOI	<a href="http://dx.doi.org/10.3310/hsdr03320">http://dx.doi.org/10.3310/hsdr03320</a>
Notes	<p>Modern anaesthesia is regarded as safe and adverse events in anaesthesia are relatively uncommon. However, that is not to say that quality assurance and improvement are unnecessary or of little value. This extensive (282 page) report describes a three-year project that provided 44 anaesthetists with basic and subsequently enhanced personalised feedback. The authors sought to determine whether or not this initiative improved anaesthetic quality measures over time and whether or not anaesthetists would engage with the feedback and view it as useful, through conducting surveys and interviews.</p> <p>The authors report that providing <b>comprehensive personalised feedback</b> to anaesthetists as part of a long-term programme, which they had co-designed, was <b>effective</b> in improving measures of <b>postoperative pain, nausea and quality of recovery</b> from surgery, as well as engaging the local professional group. They argue that such a feedback initiative could be of broader benefit to health-care professionals and patients if implemented elsewhere.</p>

*Advancing Medication Safety: Establishing a National Action Plan for Adverse Drug Event Prevention*

Harris Y, Hu DJ, Lee C, Mistry M, York A, Johnson TK  
Joint Commission Journal on Quality and Patient Safety. 2015;41(8):351-60.

URL	<a href="http://www.ingentaconnect.com/content/jcaho/jcqs/2015/00000041/00000008/art0003">http://www.ingentaconnect.com/content/jcaho/jcqs/2015/00000041/00000008/art0003</a>
Notes	<p>Paper describing the development and implementation of a US National Action Plan to focus on <b>Adverse Drug Event</b> prevention. The <b>Action Plan</b> on ADEs <b>focuses</b> on ADEs that are <b>clinically significant</b>, account for the <b>greatest number of measurable harms</b>, and are <b>largely preventable</b>. It was thus determined to target three medication classes: <b>anticoagulants, diabetes agents</b> (insulin and oral hypoglycemic agents), and <b>opioids</b>. The Action Plan is organised around four key areas: surveillance; evidence-based prevention; payment, policy incentives, and oversight; and research opportunities to advance medication safety.</p>

For information on the Commission's work on medication safety, see <http://www.safetyandquality.gov.au/our-work/medication-safety/>

*Connecting Patients and Clinicians: The Anticipated Effects of Open Notes on Patient Safety and Quality of Care*

Bell SK, Folcarelli PH, Anselmo MK, Crotty BH, Flier LA, Walker J  
Joint Commission Journal on Quality and Patient Safety. 2015;41(8):378-84.

URL	<a href="http://www.ingentaconnect.com/content/jcaho/jcqs/2015/00000041/00000008/art0006">http://www.ingentaconnect.com/content/jcaho/jcqs/2015/00000041/00000008/art0006</a>
Notes	<p>How much to share with patients, how transparent to be in terms of risks, uncertainty and sharing decisions are generally seen as positives. But the further step of opening up clinicians' notes to their patients is more contested. One side of the debate is the Open Notes movement promoting This commentary piece looks at some of the pros and cons and speculates over how access may influence patient safety and care quality.</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/](http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/)

*Barriers and facilitators related to the implementation of surgical safety checklists: a systematic review of the qualitative evidence*

Bergs J, Lambrechts F, Simons P, Vlayen A, Marneffe W, Hellings J, et al  
 BMJ Quality & Safety. 2015 [epub].

DOI	<a href="http://dx.doi.org/10.1136/bmjqs-2015-004021">http://dx.doi.org/10.1136/bmjqs-2015-004021</a>
Notes	Checklists, particularly those for surgical safety, have been widely implemented in recent years. This review, focusing on the qualitative evidence (18 studies), looked at the implementation aspects. The analysis reveals that implementation of something that may appear simple is not always so, particularly given the complexity of the health care setting. The authors note that “implementation requires change in the workflow of healthcare professionals as well as in their perception of the checklist and the perception of patient safety in general.” From this they conclude that “The complex reality in which the checklist needs to be implemented requires an approach that includes more than eliminating barriers and supporting facilitating factors. Implementation leaders must facilitate team learning to foster the mutual understanding of perspectives and motivations, and the realignment of routines.”

*BMJ Quality and Safety online first articles*

URL	<a href="http://qualitysafety.bmj.com/content/early/recent">http://qualitysafety.bmj.com/content/early/recent</a>
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• Findings from a novel approach to publication <b>guideline revision</b>: user road testing of a draft version of <b>SQUIRE 2.0</b> (Louise Davies, Kyla Z Donnelly, Daisy J Goodman, Greg Ogrinc)</li> <li>• <b>Patient safety incident reporting</b>: 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)</li> <li>• Are reductions in <b>emergency department length of stay</b> associated with improvements in quality of care? A difference-in-differences analysis (Marian J Vermeulen, Astrid Guttmann, Therese A Stukel, Ashif Kachra, Marco L A Sivilotti, Brian H Rowe, Jonathan Dreyer, R Bell, M Schull)</li> <li>• What happens when <b>healthcare innovations collide</b>? (Sachin R Pendharkar, Jaana Woiceshyn, Giovani J C da Silveira, Diane Bischak, Ward Flemons, Finlay McAlister, William A Ghali)</li> </ul>

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

URL	<a href="http://intqhc.oxfordjournals.org/content/early/recent?papetoc">http://intqhc.oxfordjournals.org/content/early/recent?papetoc</a>
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"> <li>• <b>Cancer patients’ preferences of care</b> within hospitals: a systematic literature review (Gitte Stentebjerg Petersen, J L Knudsen, and M M Vinter)</li> <li>• <b>Task shifting of mental health care services</b> in Ghana: ease of referral, perception and concerns of stakeholders about quality of care (Vincent I O, Agyapong, Akwasi Osei, Conor K Farren, and Eilish McAuliffe)</li> <li>• The role of stable housing as a determinant of <b>poverty-related quality of life</b> in vulnerable individuals (Karine Baumstarck, L Boyer, and P Auquier)</li> </ul>

	<ul style="list-style-type: none"><li>• <b>Accreditation and improvement in process quality of care:</b> a nationwide study (Søren Bie Bøgh, Anne Mette Falstie-Jensen, Paul Bartels, Erik Hollnagel, and Søren Paaske Johnsen)</li><li>• <b>Quality of primary care by advanced practice nurses:</b> a systematic review (Melanie Swan, S Ferguson, A Chang, E Larson, and A Smaldone)</li><li>• <b>Why do outcomes of CABG care vary between urban and rural areas in Taiwan? A perspective from quality of care</b> (Tsung-Hsien Yu, Yu-Chang Hou, Yu-Chi Tung, and Kuo-Piao Chung)</li></ul>
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