



On the Radar

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On the Radar

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Consultation on the future of clinical practice guidelines

The Commission and the National Health and Medical Research Council (NHMRC) are seeking to develop a coherent national approach to the selection and development of clinical practice guidelines in Australia. As part of this joint work, the Commission has undertaken to develop a prioritised list of topics for clinical practice guideline development.

A Discussion Paper setting out an initial list of topics and a possible model for the nomination and assessment of topics for clinical practice guideline development has been developed for the Commission.

An online survey has been developed specifically to gather your feedback, comments and other input regarding this work. Please visit <https://www.surveymonkey.com/r/KHL6QC3> to provide your feedback. This survey will be available until 7 September 2015.

The Commission is hosting a series of consultation events on the initial list and the possible model for the nomination and assessment of topics for clinical practice guideline development.

For further information, including the downloadable Discussion Paper, see

<http://www.safetyandquality.gov.au/our-work/prioritising-clinical-practice-guideline-development/>

Journal articles

Hospital Board And Management Practices Are Strongly Related To Hospital Performance On Clinical Quality Metrics

Tsai TC, Jha AK, Gawande AA, Huckman RS, Bloom N, Sadun R
Health Affairs. 2015;34(8):1304-11.

DOI	http://dx.doi.org/10.1377/hlthaff.2014.1282
Notes	<p>The role and relation of hospital board and management practice to the safety and quality of care is not always clear. There have been moves to safety and quality to be key aspects of governance and management in health facilities and services. This study used surveys of hospitals in the USA and England and suggests that those hospitals where boards “paid greater attention to clinical quality had management that better monitored quality performance” and where board “used clinical quality metrics more effectively had higher performance by hospital management staff on target setting and operations.”</p> <p>Reflecting the significance of governance in driving safety and quality, Standard 1 of the <i>National Safety and Quality Health Service (NSQHS) Standards</i> is the Governance for Safety and Quality in Health Service Organisations standard.</p>

For information on the *National Safety and Quality Health Service (NSQHS) Standards*, see <http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/>

For Many Patients Who Use Large Amounts Of Health Care Services, The Need Is Intense Yet Temporary

Johnson TL, Rinehart DJ, Durfee J, Brewer D, Batal H, Blum J, et al
Health Affairs. 2015;34(8):1312-9.

DOI	http://dx.doi.org/10.1377/hlthaff.2014.1186
Notes	<p>The belief that a small proportion of patients ‘consume’ a large proportion of health resources/expenditure is quite widespread. The belief is that this is particularly true of those with co-morbid conditions and/or at the end of life and that the final year of life sees high levels of ‘health care usage’. It is also often seen that many of these patients have various social or socio-economic risk factors.</p> <p>This examination of 4,774 ‘super-utilizers’ or ‘frequent flyers’ (patients who accumulate multiple emergency department visits and hospital admissions) in a “urban safety-net integrated delivery system for the period May 1, 2011–April 30, 2013” in the US state of Colorado found that “consistently 3 percent of adult patients met super-utilizer criteria and accounted for 30 percent of adult charges.” However, they also report finding that of those identified as ‘super-utilizers’ on 1 May 2011 less than half them were still classified as such after 6 months and less than a third (28 per cent) were after a year. Small numbers of the cohort either remained, died or cycled in and out; the majority left the cohort and did not return. The authors report that while there is a small “consistent percentage of the adult population ...qualified as super-utilizers at any given time, with relatively stable population-level demographic profiles, health status... and spending” this obscures “significant instability at the individual level, which may have led to oversimplification of the problem”. Clearly this has implications for programs aimed at reducing the health utilisation.</p>

Ambulance Diversion Associated With Reduced Access To Cardiac Technology And Increased One-Year Mortality

Shen Y-C, Hsia RY

Health Affairs. 2015;34(8):1273-80.

DOI	http://dx.doi.org/10.1377/hlthaff.2014.1462
Notes	This paper examines what affects ambulance diversion or bypass (when a hospital emergency department (ED) is temporarily closed to incoming ambulance traffic) has on access to technology, likelihood of treatment, and ultimately health outcomes for Medicare patients with acute myocardial infarction in 26 counties in California. The results led to the perhaps unsurprising conclusion that ambulance bypass or diversion has effects for patients. The authors report that “patients whose nearest hospital ED had significant ambulance diversions experienced reduced access to hospitals with cardiac technology. This led to a 4.6 percent decreased likelihood of revascularization and a 9.8 percent increase in one-year mortality compared to patients who did not experience diversion.”

Test result communication in primary care: a survey of current practice

Litchfield I, Bentham L, Lilford R, McManus RJ, Hill A, Greenfield S.

BMJ Quality & Safety. 2015 [epub].

Laboratory testing in general practice: a patient safety blind spot

Elder NC

BMJ Quality & Safety. 2015 [epub].

Do not assume that no news is good news: test result management and communication in primary care

Kwan JL, Cram P

BMJ Quality & Safety. 2015 [epub].

How well do health professionals interpret diagnostic information? A systematic review

Whiting PF, Davenport C, Jameson C, Burke M, Sterne JAC, Hyde C, et al

BMJ Open. 2015 [epub].

DOI	Litchfield et al http://dx.doi.org/10.1136/bmjqs-2014-003712 Elder http://dx.doi.org/10.1136/bmjqs-2015-004644 Kwan and Cram http://dx.doi.org/10.1136/bmjqs-2015-004645 Whiting et al http://dx.doi.org/10.1136/bmjopen-2015-008155
Notes	A number of items looking at diagnostic testing, particularly as used in primary care. The pieces by Elder and Kwan and Cram are both editorials responding to Litchfield et al who surveyed staff and patients of 50 general practices across the UK to determine the methods of managing the testing and result communication process. This information was augmented by interviews with lab staff. The vast majority “reported that the default method for communicating normal results required patients to telephone the practice and 40% of practices required that patients also call for abnormal results”. Further, “ over 80% had no fail-safe system for ensuring that results had been returned to the practice from laboratories” and that it was only when patients called that the absence of results was known. Laboratory staff identified the most persistent sources for missing results “included sample handling, misidentification of samples and the inefficient system for collating and resending misdirected results”

	<p>Kwan and Cram note that clinicians “quickly learn that ordering tests is the easy part; managing the resulting data becomes the far more challenging task” and that it is obvious that “the test result management and communication process is in urgent need of improvement”. They note that solutions suggested have focussed on:</p> <ol style="list-style-type: none"> 1. process standardisation with clear assignment of responsibility and accountability for each step across the multidisciplinary team 2. management tools embedded in the electronic health record (EHR) and 3. improved patient engagement in the process. <p>Elder also reflects on the how such approaches may advance solutions. However, she also notes that “Although missing or delayed test results have traditionally been seen by researchers as medical errors, they are not necessarily perceived that way by practicing physicians. Because these events rarely lead to significant patient harm, occur commonly and are part of a complex system, practicing physicians are much less likely to consider them medical errors at all, and thus tolerate the frequent problems in their practices.”</p> <p>One tension lies in whose responsibility this is. As Elder notes, there is some hope that the patient can help. “Empowering patients to know what tests are being recommended and how the results will inform care, with shared decision making about test ordering may make patients more likely to complete the test, and to better understand the results they receive.”</p> <p>As Kwan and Cram note, “In a perfect world, all tests would be appropriately ordered, processed and reported in a manner tailored to the individual preference of each patient.” Until such time, then they suggest patients heed the US Agency for Healthcare Research and Quality’s advice ‘If you have a test, do not assume that no news is good news. Ask how and when you will get the results’.</p> <p>Whiting et al used a systematic review to examine how well clinicians interpret and understand the results of diagnostics. From the 24 studies identified and included in their review, common measures of test accuracy are not well understood by clinicians (this also brings to mind a recent Australian study looking at how well GPs understood the terminology used in hospital discharge letters – not as well as they might).</p>
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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

September 2015, Vol. 24, Issue 9

URL	http://qualitysafety.bmj.com/content/24/9
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: Safety in healthcare is a moving target (Charles Vincent, Rene Amalberti) • Editorial: Temporal trends in patient safety in the Netherlands: reductions in preventable adverse events or the end of adverse events as a useful metric? (Kaveh G Shojania, Perla J Marang-van de Mheen) • The problem with checklists (Ken Catchpole, Stephanie Russ) • Emotional harm from disrespect: the neglected preventable harm (Lauge Sokol-Hessner, Patricia Henry Folcarelli, Kenneth E F Sands)

	<ul style="list-style-type: none"> • Ranking hospitals on avoidable death rates derived from retrospective case record review: methodological observations and limitations (Gary Abel, Georgios Lyratzopoulos) • 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) • How effective are patient safety initiatives? A retrospective patient record review study of changes to patient safety over time (Rebecca Baines, Maaike Langelaan, Martine de Bruijne, Peter Spreeuwenberg, C Wagner) • Exploring demographic and lifestyle associations with patient experience following telephone triage by a primary care doctor or nurse: secondary analyses from a cluster randomised controlled trial (Fiona C Warren, Raff Calitri, Emily Fletcher, Anna Varley, Tim A Holt, Valerie Lattimer, David Richards, Suzanne Richards, Chris Salisbury, Rod S Taylor, J L Campbell) • Patient and carer identified factors which contribute to safety incidents in primary care: a qualitative study (Andrea L Hernan, Sally J Giles, Jeffrey Fuller, Julie K Johnson, Christine Walker, James A Dunbar) • Are we recording postoperative complications correctly? Comparison of NHS Hospital Episode Statistics with the American College of Surgeons National Surgical Quality Improvement Program (Muralidharan Parthasarathy, Vicki Reid, Laura Pyne, Thomas Groot-Wassink)
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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"> • Do pneumonia readmissions flagged as potentially preventable by the 3M PPR software have more process of care problems? A cross-sectional observational study (Ann M Borzecki, Qi Chen, Joseph Restuccia, Hillary J Mull, Michael Shwartz, Kalpana Gupta, A Hanchate, J Strymish, A Rosen) • Do not assume that no news is good news: test result management and communication in primary care (Janice L Kwan, Peter Cram) • Laboratory testing in general practice: a patient safety blind spot (Nancy C Elder) • The impact of interruptions on the duration of nursing interventions: a direct observation study in an academic emergency department (Gai Cole, Dicky Stefanus, Heather Gardner, Matthew J Levy, Eili Y Klein)

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"> • Differences between nurse- and physician-assessed ICU characteristics using a standardized survey (Deena Kelly Costa, Courtney Colonna Kuza, and Jeremy M. Kahn) • The burden of acute myocardial infarction after a regional cardiovascular center project in Korea (Arim Kim, Seok-Jun Yoon, Young-Ae Kim, and Eun Jung Kim) • Development and validation of patient-reported outcomes scale for hypertension (Li Zhi, Liu Qiaojun, and Zhang Yanbo)

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| | <ul style="list-style-type: none">• Resilient health care: turning patient safety on its head (Jeffrey Braithwaite, Robert L. Wears, and Erik Hollnagel) |
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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 NG14 **Melanoma:** assessment and management
<http://www.nice.org.uk/guidance/ng14>
- NICE Guideline NG15 **Antimicrobial stewardship:** systems and processes for effective antimicrobial medicine use <http://www.nice.org.uk/guidance/ng15>
- NICE Quality Standard QS97 **Drug allergy:** diagnosis and management
<http://www.nice.org.uk/guidance/qs97>
- NICE Quality Standard QS98 **Nutrition:** improving maternal and child nutrition
<http://www.nice.org.uk/guidance/qs98>

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