AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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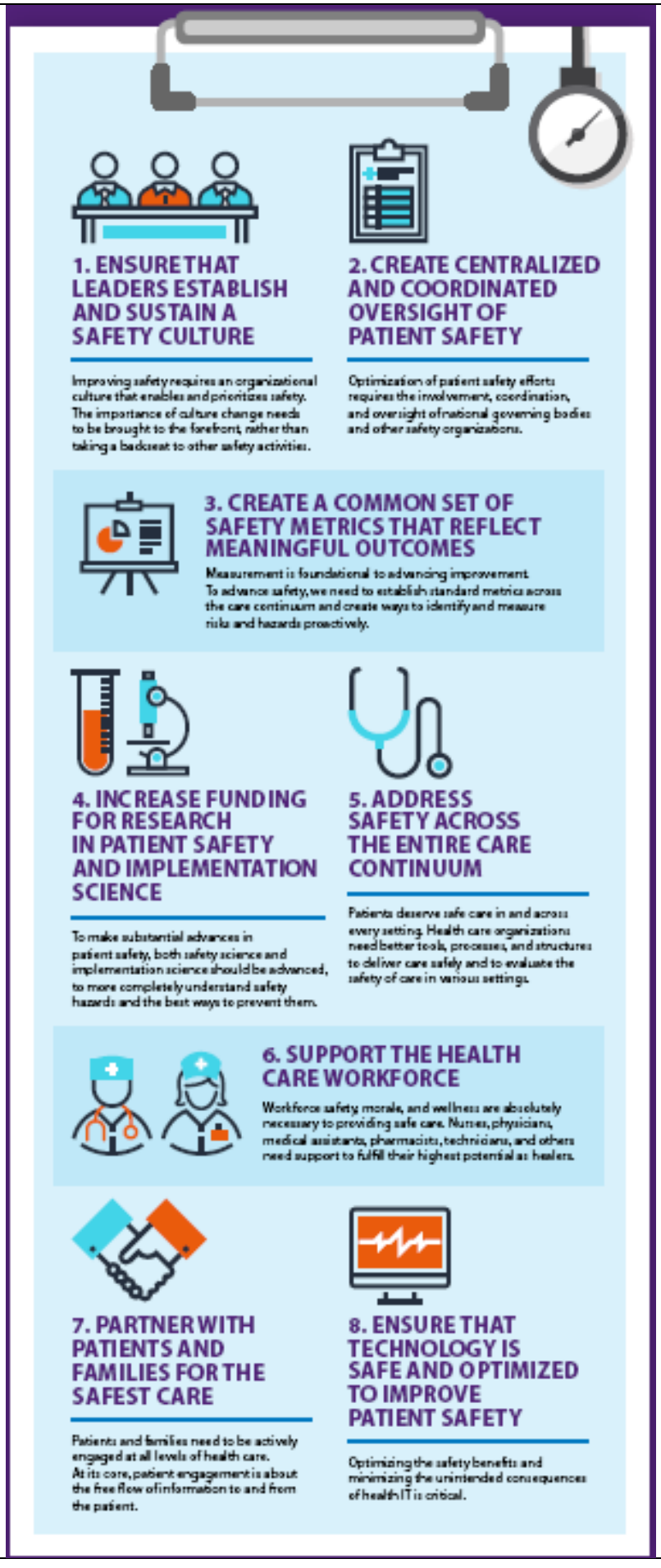
Reports

Free from Harm: Accelerating Patient Safety Improvement Fifteen Years After To Err Is Human
Expert Panel Convened by The National Patient Safety Foundation's Lucian Leape Institute
Boston: National Patient Safety Foundation; 2015. p. 59.

URL	http://www.npsf.org/?freefromharm
Notes	The {US} National Patient Safety Foundation convened an expert panel to reflect on the publication of the To Err Is Human report fifteen year ago and to consider the current state of the patient safety field and set the stage for the next 15 years. The report of the panel calls for the adoption of a total systems approach and a culture of safety, and calls for action by government, regulators, health professionals, and others to place higher priority on patient safety science and implementation. The report includes eight recommendations: 1. Ensure that leaders establish and sustain a safety culture 2. Create centralized and coordinated oversight of patient safety 3. Create a common set of safety metrics that reflect meaningful outcomes 4. Increase funding for research in patient safety and implementation science 5. Address safety across the entire care continuum 6. Support the health care workforce 7. Partner with patients and families for the safest care 8. Ensure that technology is safe and optimized to improve patient safety.


1. ENSURE THAT LEADERS ESTABLISH AND SUSTAIN A SAFETY CULTURE
Improving safety requires an organizational culture that enables and prioritizes safety. The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities.
2. CREATE CENTRALIZED AND COORDINATED OVERSIGHT OF PATIENT SAFETY
Optimization of patient safety efforts requires the involvement, coordination, and oversight of national governing bodies and other safety organizations.
3. CREATE A COMMON SET OF SAFETY METRICS THAT REFLECT MEANINGFUL OUTCOMES
Measurement is foundational to advancing improvement. To advance safety, we need to establish standard metrics across the care continuum and create ways to identify and measure risks and hazards proactively.
4. INCREASE FUNDING FOR RESEARCH IN PATIENT SAFETY AND IMPLEMENTATION SCIENCE
To make substantial advances in patient safety, both safety science and implementation science should be advanced, to more completely understand safety hazards and the best ways to prevent them.
5. ADDRESS SAFETY ACROSS THE ENTIRE CARE CONTINUUM
Patients deserve safe care in and across every setting. Health care organizations need better tools, processes, and structures to deliver care safely and to evaluate the safety of care in various settings.
6. SUPPORT THE HEALTH CARE WORKFORCE
Workforce safety, morale, and wellness are absolutely necessary to providing safe care. Nurses, physicians, medical assistants, pharmacists, technicians, and others need support to fulfill their highest potential as healers.
7. PARTNER WITH PATIENTS AND FAMILIES FOR THE SAFEST CARE
Patients and families need to be actively engaged at all levels of health care. At its core, patient engagement is about the free flow of information to and from the patient.
8. ENSURE THAT TECHNOLOGY IS SAFE AND OPTIMIZED TO IMPROVE PATIENT SAFETY
Optimizing the safety benefits and minimizing the unintended consequences of health IT is critical.

Journal articles

Care that matters: Quality measurement and health care
Saver BG, Martin SA, Adler RN, Candib LM, Deligiannidis KE, Golding J, et al
PLoS Med. 2015;12(11):e1001902.

DOI	http://dx.doi.org/10.1371/journal.pmed.1001902
Notes	This paper provides a critique of many of the existing quality measures in use in healthcare and then proposes a set of 'core principles' for quality measures that have greater validity and utility. The authors – from their US perspective – argue that there is limited evidence that many "quality" measures lead to improved health outcomes and that these are often based on "easily measured, intermediate endpoints such as risk-factor control or care processes, not on meaningful, patient-centered outcomes; their use interferes with individualized approaches to clinical complexity and may lead to gaming, overtesting, and overtreatment". The core principles that they suggest for the development and application of health care quality measures assert that quality measures must: 1. address clinically meaningful, patient-centred outcomes; 2. be developed transparently and be supported by robust scientific evidence linking them to improved health outcomes in varied settings; 3. include estimates, expressed in common metrics, of anticipated benefits and harms to the population to which they are applied; 4. balance the time and resources required to acquire and report data against the anticipated benefits of the metric; 5. be assessed and reported at appropriate levels; they should not be applied at the provider level when numbers are too small or when interventions to improve them require the action(s) of a system.

Harms from discharge to primary care: mixed methods analysis of incident reports
Williams H, Edwards A, Hibbert P, Rees P, Prosser Evans H, Panesar S, et al.
British Journal of General Practice. 2015; 65(641):e829-e37.

DOI	http://dx.doi.org/10.3399/bjgp15X687877
Notes	This study used a mixed methods analysis to examine 598 patient safety incident reports in England and Wales related to 'Discharge' from the National Reporting and Learning System. The authors note that "Discharge from hospital presents significant risks to patient safety, with up to one in five patients experiencing adverse events within 3 weeks of leaving hospital." In their analysis four main themes emerged: errors in **discharge communication** (n = 151; 54% causing harm); errors in **referrals to community care** (n = 136; 73% causing harm); errors in **medication** (n = 97; 87% causing harm); and lack of **provision of care adjuncts** such as dressings (n = 62; 94% causing harm). Common contributory factors identified were **staff factors** (not following referral protocols); and **organisational factors** (lack of clear guidelines or inefficient processes). The authors identified improvement opportunities including developing and testing electronic discharge methods with agreed minimum information requirements and unified referrals systems to community care providers; and promoting a safety culture with 'safe discharge' checklists, discharge coordinators, and family involvement.

Accessible and continuous primary care may help reduce rates of emergency department use. An international survey in 34 countries
van den Berg MJ, van Loenen T, Westert GP
Family Practice. 2015 October 28, 2015.

DOI	http://dx.doi.org/10.1093/fampra/cmv082
Notes	The extent to which some attendance to hospital emergency departments (EDs) could be prevented by better access or provision of general practice care has been debated, somewhat inconclusively to date. This paper reports on a study using survey data from 34 countries (31 European countries, Australia, New Zealand and Canada). The data were collected between 2011 and 2013 and contain survey data from 60991 patients and 7005 GPs, within 7005 general practices The authors report that: • 29.4% of patients had visited the ED in the past year – this varied between 18% and 40%. • ED visits show a significant and negative relation with better accessibility of primary care. Patients with a regular doctor who knows them personally were less likely to attend EDs. The Australian data reveal that 25.5% attended an ED rather than a GP as they had something GPs do not treat; 23.8% reported that a GP was not available; 7.9% that the ED was more convenient to; 5.9% expected shorter waiting times; 3.5% ED delivered better care; and 2.1% for financial reasons. The author's suggest that "**Good accessibility** and **continuity of primary care may** well **reduce ED use**. In some countries, it may be worthwhile to invest in more continuous relationships between patients and GPs or to eliminate factors that hamper people to use primary care (e.g. for costs or travelling)."

Access to effective antimicrobials: a worldwide challenge
Laxminarayan R, Matsoso P, Pant S, Brower C, Røttingen J-A, Klugman K, et al.
The Lancet. 2015 [epub].

DOI	http://dx.doi.org/10.1016/S0140-6736(15)00474-2
Notes	Paper describing some of the benefits – and paradoxes – of antimicrobial access and resistance. The authors note that there have been "substantial improvements in life expectancy and access to antimicrobials, especially in low income and lower-middle-income countries, but increasing pathogen resistance to antimicrobials threatens to roll back this progress". In this paper they cover the importance of effective antimicrobials, the disease burden caused by limited access to antimicrobials, attributable to resistance to antimicrobials, and the potential effect of vaccines in restricting the need for antibiotics. Among their key messages: • Antibiotic consumption in humans is increasing worldwide. • No access and delays in access to antibiotics kill more people than antibiotic resistance. They estimate that universal provision of antibiotics could avert a mean of 445 000 community-acquired pneumonia deaths. • Resistance to antibiotics threatens improvements made in child survival. Globally, an estimated 214 000 neonatal sepsis deaths are attributable to resistant pathogens each year. • Scaling up vaccines against pneumococcus and *Haemophilus influenzae* type b (Hib) could avert the need for antibiotics worldwide and reduce selection pressure.

	• Antibiotics are an essential element of animal health, but the increasing use of antibiotics in sub-therapeutic concentrations for growth promotion and disease prevention (as a substitute for hygiene) is placing substantial selection pressure for resistance to evolve. A one-health approach to improving animal health that recognises the interlinked nature of animal and human health is essential.

For information on the Commission's work on antimicrobial use and resistance in Australia, see http://www.safetyandquality.gov.au/national-priorities/amr-and-au-surveillance-project/

BMJ Quality and Safety
January 2016, Vol. 25, Issue 1

URL	http://qualitysafety.bmj.com/content/25/1
Notes	A new issue of *BMJ Quality and Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality and Safety* include: • Editorial: Online **emergency department ratings**, **patient satisfaction** and the age-old issue of **communication** (Megan L Ranney, Clayton A Peimer) • Editorial: Identifying **adverse events after outpatient surgery**: improving measurement of patient safety (Amy K Rosen, Hillary J Mull) • Editorial: **Point-of-care decision support** for reducing **inappropriate test use**: easier said than done (Kevin Levitt, Kaveh G Shojania, R Sacha Bhatia) • What happens when **healthcare innovations collide**? (Sachin R Pendharkar, Jaana Woiceshyn, Giovani J C da Silveira, Diane Bischak, Ward Flemons, Finlay McAlister, William A Ghali) • What do patients say about **emergency departments** in online reviews? A qualitative study (Austin S Kilaru, Zachary F Meisel, Breah Paciotti, Yoonhee P Ha, Robert J Smith, Benjamin L Ranard, Raina M Merchant) • Electronic health record-based triggers to detect **adverse events after outpatient orthopaedic surgery** (Mariano E Menendez, Stein J Janssen, David Ring) • Associations between **safety culture and employee engagement** over time: a retrospective analysis (Elizabeth Lee Daugherty Biddison, Lori Paine, Peter Murakami, Carrie Herzke, Sallie J Weaver) • **Systems modelling and simulation** in health service design, delivery and decision making (Martin Pitt, Thomas Monks, Sonya Crowe, Christos Vasilakis) • Observation for assessment of **clinician performance**: a narrative review (Arianna F Yanes, Lisa M McElroy, Zachary A Abecassis, Jane Holl, Donna Woods, Daniela P Ladner) • **Guideline-based decision support** has a small, non-sustained effect on transthoracic echocardiography ordering frequency (Joel C Boggan, Ryan D Schulteis, Mark Donahue, David L Simel)

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Procedural instruction in **invasive bedside procedures**: a systematic review and meta-analysis of effective teaching approaches (Grace C Huang, Jakob

	I McSparron, Ethan M Balk, Jeremy B Richards, C Christopher Smith, Julia S Whelan, Lori R Newman, Gerald W Smetana) • **Social media and healthcare quality improvement**: a nascent field (Megan L Ranney, Nicholas Genes) • Risk-adjusted survival for adults following **in-hospital cardiac arrest** by day of week and time of day: observational cohort study (Emily J Robinson, Gary B Smith, Sarah G Power, David A Harrison, Jerry Nolan, Jasmeet Soar, Ken Spearpoint, Carl Gwinnutt, Kathryn M Rowan) • **Remote video auditing** with real-time feedback in an academic surgical suite improves safety and efficiency metrics: a cluster randomised study (Frank J Overdyk, Oonagh Dowling, Sheldon Newman, David Glatt, M Chester, D Armellino, B Cole, G S Landis, D Schoenfeld, J F DiCapua) • Editorial: The case for **routine goals-of-care documentation** (Christopher Yarnell, Robert Fowler) • From the closest observers of patient care: a thematic analysis of **online narrative reviews of hospitals** (Naomi S Bardach, Audrey Lyndon, Renée Asteria-Peñaloza, L Elizabeth Goldman, Grace A Lin, R Adams Dudley) • Effect of patient-centred bedside rounds on **hospitalised patients' decision control, activation and satisfaction** with care (Kevin J O'Leary, Audrey Killarney, Luke O Hansen, Sasha Jones, M Malladi, K Marks, H M Shah) • Fifteen years after *To Err is Human*: **a success story to learn from** (Peter J Pronovost, James I Cleeman, Donald Wright, Arjun Srinivasan) • Tip of the iceberg: **patient safety incidents in primary care** (Urmimala Sarkar) • **Human factors in healthcare**: welcome progress, but still scratching the surface (Patrick Waterson, Ken Catchpole)

International Journal for Quality in Health Care online first articles

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: • Patients' and families' perspectives of **patient safety at the end of life**: a video-reflexive ethnography study (Aileen Collier, Ros Sorensen, Rick Iedema) • Quality evaluation of medical care for **breast cancer** in Japan (Hirofumi Mukai, Takahiro Higashi, Masaoki Sasaki, Tomotaka Sobue) • **ICU** physicians are unable to accurately predict **length of stay** at admission: A prospective study (Antonio Paulo Nassar Jr, Pedro Caruso) • Participating physician preferences regarding a **pay-for-performance** incentive design: a discrete choice experiment (Tsung-Tai Chen, Mei-Shu Lai, Kuo-Piao Chung)

Online resources

Clinical Communiqué
Victorian Institute of Forensic Medicine
Volume 2 Issue 4 December 2015
http://www.vifmcommuniques.org/volume-2-issue-4-december-2015/
Clinical Communiqué is a newsletter written by clinicians, using a case-study approach to report on lessons learned from deaths investigated by the Coroners' Court.
This edition explores the "challenging scenarios of managing a deteriorating patient in a rural or regional setting, and the obstacles that are faced when attempting to transfer a critically ill patient for ongoing treatment."

[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 NG29 **Intravenous fluid therapy** in children and young people in hospital http://www.nice.org.uk/guidance/ng29
- NICE Guideline NG30 **Oral health promotion**: general dental practice http://www.nice.org.uk/guidance/ng30
- NICE Guideline NG31 Care of **dying adults** in the **last days of life** http://www.nice.org.uk/guidance/ng31
- NICE Guideline NG32 **Older people: independence and mental wellbeing** http://www.nice.org.uk/guidance/ng32
- Quality Standard QS105 **Intrapartum care** http://www.nice.org.uk/guidance/qs105
- Quality Standard QS106 **Bladder Cancer** http://www.nice.org.uk/guidance/qs106

[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:

- *Diagnosis of Right Lower Quadrant Pain and Suspected Acute Appendicitis* http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2158
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[UK] Research into the 'weekend effect' on hospital mortality
https://www.gov.uk/government/publications/research-into-the-weekend-effect-on-hospital-mortality
From the UK Department of Health comes this summary of research exploring the link between weekend hospital admissions and poorer patient outcomes including higher rates of mortality. The resource includes links to the studies discussed.
