



## On the Radar

Issue 256

18 January 2016

*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.

*On the Radar* is available online, via email or as a PDF document from <http://www.safetyandquality.gov.au/publications-resources/on-the-radar/>

If you would like to receive *On the Radar* via email, you can subscribe on our website <http://www.safetyandquality.gov.au/> or by emailing us at [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au). You can also send feedback and comments to [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au).

For information about the Commission and its programs and publications, please visit <http://www.safetyandquality.gov.au>

You can also follow us on Twitter @ACSQHC.

### On the Radar

Editor: Dr Niall Johnson [niall.johnson@safetyandquality.gov.au](mailto:niall.johnson@safetyandquality.gov.au)

Contributors: Niall Johnson, Shaun Larkin

### Reports

*How High-Need Patients Experience the Health Care System in Nine Countries*

Sarnak DO, Ryan J

New York: The Commonwealth Fund; 2016. p. 16.

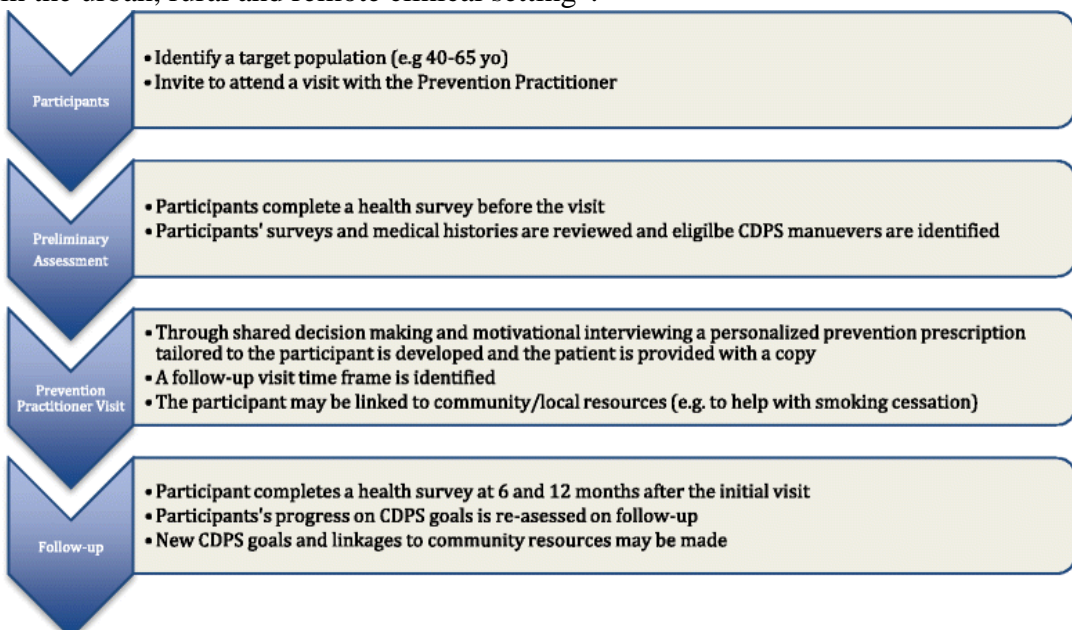
URL	<a href="http://www.commonwealthfund.org/publications/issue-briefs/2016/jan/high-need-patients-nine-countries">http://www.commonwealthfund.org/publications/issue-briefs/2016/jan/high-need-patients-nine-countries</a>
Notes	This Issues brief from the (US) Commonwealth Fund examines the experience and impact of ‘high need’ patients in a number of countries, including Australia. Based on data from one of the Commonwealth Fund’s regular international surveys the brief investigates health care use, quality, and experiences among high-need patients in nine countries compared with other older adults. Here high-need patients are defined as those age 65 and older with at least three chronic conditions or a functional limitation in activities of daily living, like dressing or bathing. High-need patients use a greater amount of health care services and also experience more coordination problems and financial barriers to care compared with other older adults. In the USA, five percent of the adult population accounts for 50 percent of the nation’s health care costs and 10 percent accounts for 65 percent of total costs. From the survey results, Australia has a smaller population of these older high needs patient than the USA, but a similar level to the other seven nations surveyed (Canada, France, Germany, Netherlands, Norway, Sweden and Switzerland).

	<p>The Australian patients display a lower level of functional limitations but higher rates of ‘avoidable’ hospital department visits, cost-related access problems (which may help account for the higher hospital visits), poorer co-ordination of care, and reported less confidence in their care (and thought mistakes had occurred more often). More positively, they reported a higher level of contact from health care providers between visits and higher rates of treatment plans being in place.</p>
--	--

**Journal articles**

*Developing clinical decision tools to implement chronic disease prevention and screening in primary care: the BETTER 2 program (building on existing tools to improve chronic disease prevention and screening in primary care)*

Manca DP, Campbell-Scherer D, Aubrey-Bassler K, Kandola K, Aguilar C, Baxter J, et al. *Implementation Science*. 2015;10(1):1-10.

<p>DOI / URL</p>	<p><a href="http://dx.doi.org/10.1186/s13012-015-0299-9">http://dx.doi.org/10.1186/s13012-015-0299-9</a>  <a href="http://www.implementationscience.com/content/10/1/107">http://www.implementationscience.com/content/10/1/107</a></p>
<p>Notes</p>	<p>This Canadian paper provides an update on the BETTER trial (Building on Existing Tools to Improve Chronic Disease Prevention and Screening in Family Practice). The BETTER trial had demonstrated the effectiveness of an approach to chronic disease prevention and screening (CDPS) through a new skilled role of a ‘prevention practitioner’ (PP). The BETTER 2 program has updated, revised and adapted the integrated evidence algorithms and tool kits of the earlier work. The authors hope that the integrated clinical decision-making tools of BETTER 2 “provide resources for clinicians and policymakers that address patients’ complex care needs beyond single disease approaches and can be adapted to facilitate CDPS in the urban, rural and remote clinical setting”.</p>  <p>Figure: The BETTER 2 chronic disease prevention and screening prevention practitioner intervention</p>

*The role of emotion in patient safety: Are we brave enough to scratch beneath the surface?*

Heyhoe J, Birks Y, Harrison R, O’Hara JK, Cracknell A, Lawton R

Journal of the Royal Society of Medicine. 2015 [epub].

DOI	<a href="http://dx.doi.org/10.1177/0141076815620614">http://dx.doi.org/10.1177/0141076815620614</a>
Notes	<p>Health care is a human activity and one that engender strong emotions. Those emotions are often left unexplored. This piece explores emotion in relation patient safety, including</p> <ul style="list-style-type: none"> <li>• the emotions that health professionals experience in relation to making a medical error and describe the impact on healthcare professionals and on their professional and patient relationships.</li> <li>• how positive and negative emotions can contribute to clinical decision making and affect responses to clinical situations</li> <li>• the implications for training, practice and research</li> <li>• strategies for understanding and responding to the influence of emotion in clinical practice.</li> </ul>

*Can patient safety incident reports be used to compare hospital safety? Results from a quantitative analysis of the English National Reporting and Learning System data*

Howell A-M, Burns EM, Bouras G, Donaldson LJ, Athanasiou T, Darzi

PLoS ONE. 2015;10(12):e0144107.

DOI	<a href="http://dx.doi.org/10.1371/journal.pone.0144107">http://dx.doi.org/10.1371/journal.pone.0144107</a>
Notes	<p>Paper reporting on an analysis of nearly 6 million incident reports in the English National Reporting and Learning System (NRLS). The study sought to examine the utility of such reporting systems in various ways, including whether annual hospital incident reporting rates can be used as a surrogate indicator of individual hospital safety, which hospital characteristics are correlated with high incident reporting rates, whether a high reporting hospital is safer than those lower reporting hospitals and to determine which health-care professionals report more incidents of patient harm, which report more near miss incidents and what hospital factors encourage reporting.</p> <p>The authors report:</p> <ul style="list-style-type: none"> <li>• not finding many hospital characteristics that significantly influence overall reporting rate</li> <li>• no association between size of hospital, number of staff, mortality outcomes or patient satisfaction outcomes and incident reporting rate.</li> <li>• hospitals where staff reported more incidents had reduced litigation claims</li> <li>• when clinician staffing is increased fewer incidents reporting patient harm are reported, whilst near misses remain the same</li> <li>• certain specialties report more near misses than others, and doctors report more harm incidents than near misses</li> <li>• staff survey results showed that open environments and reduced fear of punitive response increases incident reporting.</li> </ul> <p>They conclude that <b>reporting rates should not be used to assess hospital safety</b> and note that “Different healthcare professionals focus on different types of safety incidents and focusing on these areas whilst creating a responsive, confidential learning environment will increase staff engagement with error disclosure.”</p>

*Association between day of delivery and obstetric outcomes: observational study*

Palmer WL, Bottle A, Aylin P

BMJ. 2015;2015-11-24 23:30:42;351.

DOI	<a href="http://dx.doi.org/10.1136/bmj.h5774">http://dx.doi.org/10.1136/bmj.h5774</a>
Notes	<p>The ‘weekend effect’ of poorer outcomes in after hours or weekend treatment has been documented previously. This English retrospective observational study (examining 1 332 835 deliveries and 1 349 599 births between 1 April 2010 and 31 March 2012) sought to determine if there was a relationship between day of delivery and outcomes. The outcomes studied were perinatal mortality and—for both neonate and mother—infections, emergency readmissions, and injuries. The authors report that “<b>Performance across four of the seven measures was significantly worse for women admitted, and babies born, at weekends.</b> In particular, the perinatal mortality rate was 7.3 per 1000 babies delivered at weekends, 0.9 per 1000 higher than for weekdays”.</p> <p>The do also note that they found “No consistent association between outcomes and staffing”.</p> <p>But, as they also conclude, “This study provides an evaluation of the “weekend effect” in obstetric care, covering a range of outcomes. The results would suggest <b>approximately 770 perinatal deaths and 470 maternal infections per year above what might be expected</b> [in England] if performance was consistent across women admitted, and babies born, on different days of the week.”</p>

*Team training for safer birth*

Cornthwaite K, Alvarez M, Siassakos D

Best Practice & Research Clinical Obstetrics & Gynaecology. 2015;29(8):1044-57.

DOI	<a href="http://dx.doi.org/10.1016/j.bpobgyn.2015.03.020">http://dx.doi.org/10.1016/j.bpobgyn.2015.03.020</a>
Notes	<p>This review piece discusses some of the strategies that can help make childbirth safer, particularly when there is an obstetric emergency, including the importance of team training, leadership, communications, and situational awareness. The authors also examine how teamwork training can be incorporated into training and contribute to training being a positive and enjoyable experience that contributes to improved clinical outcomes and better birth experience for women (and clinicians).</p>

*The effect of contact precautions on frequency of hospital adverse events*

Croft LD, Liquori M, Ladd J, Day H, Pineles L, Lamos E, et al.

Infection Control & Hospital Epidemiology. 2015;36(11):1268-74.

DOI	<a href="http://dx.doi.org/10.1017/ice.2015.192">http://dx.doi.org/10.1017/ice.2015.192</a>
Notes	<p>Patients for whom contact precautions have been implemented (usually to help stop the spread of healthcare associated infections) are visited by clinicians less often. This case control study (conducted in an American tertiary hospital using two cohorts of 148 patients each) sought to determine if this leads to these patients being at greater risk of adverse events.</p> <p>104 (35.1%) patients experienced at least one adverse event during their hospital stay. <b>Contact precautions were associated with fewer non-infectious adverse events</b> and although not statistically significant, with <b>fewer severe adverse events</b>. Preventable adverse events did not significantly differ between patients on contact precautions and patients not on contact precautions.</p>

For information on the Commission’s work on healthcare associated infection, see

<http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/>

*A prospective controlled trial of an electronic hand hygiene reminder system*

Ellison RT, Barysaukas CM, Rundensteiner EA, Wang D, Barton B

Open Forum Infectious Diseases. 2015 December 1, 2015;2(4).

DOI	<a href="http://dx.doi.org/10.1093/ofid/ofv121">http://dx.doi.org/10.1093/ofid/ofv121</a>
Notes	Hand hygiene is something that we expect clinicians to perform routinely; up to dozens of times a day. It is know that this is somewhat problematic and compliance rates vary. This paper discusses an electronic method for prompting hand hygiene. This prospective controlled trial was conducted in two intensive care units (ICUs). In one an audible chime sounded each time a room was entered or exited. This led to increased handwashing events in the test ICU initially. However, the effect quickly declined. A combination of a chime and real-time computer monitor feedback of current hygiene compliance rates produced an increase in compliance that was sustained.

*Empowering patients in the hospital as a new approach to reducing the burden of health care-associated infections: the attitudes of hospital health care workers*

Seale H, Chughtai AA, Kaur R, Phillipson L, Novytska Y, Travaglia J

American Journal of Infection Control [epub].

DOI	<a href="http://dx.doi.org/10.1016/j.ajic.2015.10.003">http://dx.doi.org/10.1016/j.ajic.2015.10.003</a>
Notes	Another form of prompting or reminding healthcare workers about hand hygiene is getting patients, families and/or carers to ask. This papers reports on a small interview study of (Australian) hospital staff asking about the idea of patient empowerment. Respondents were unfamiliar with the concept of patient empowerment in relation to hand hygiene but were reportedly receptive and “were surprised that hospitals had not yet adopted the concept. However, they felt that a lack of support, busy workloads, and negative attitudes would be key barriers to the implementation of any empowerment programs.”.

*Surgical site infection reduction by the Solutions for Patient Safety Hospital Engagement Network*

Schaffzin JK, Harte L, Marquette S, Zieker K, Wooton S, Walsh K, et al

Pediatrics. 2015 Nov;136(5):e1353-60.

DOI	<a href="http://dx.doi.org/10.1542/peds.2015-0580">http://dx.doi.org/10.1542/peds.2015-0580</a>
Notes	Paper reporting on the development and implementation of a care bundle to reduce surgical site infections amongst children. The authors report a <b>21% reduction in surgical site infection rates</b> , from an average of 2.5 per 100 procedures to 1.8 per 100 procedures, with the reduction sustained over the 15 month follow-up period.

*Smarter clinical checklists: how to minimize checklist fatigue and maximize clinician performance*

Grigg E

Anesth Analg. 2015 Aug;121(2):570-3.

DOI	<a href="http://dx.doi.org/10.1213/ANE.0000000000000352">http://dx.doi.org/10.1213/ANE.0000000000000352</a>
Notes	Checklists have become quite commonplace in various domains, with the WHO Surgical Safety Checklist perhaps the best known. This article examines a number of strategies for ensuring their efficacy and minimising the burden on clinicians. The strategies discussed include enhancing device and software operability and developing algorithms to incorporate and analyse incoming data.

*Identifying the Optimal Role for Pharmacists in Care Transitions: A Systematic Review*  
 Ensing HT, Stuijt CCM, Bemt BJFvd, Dooren AAv, Karapinar-Çarkit F, Koster ES, et al  
 Journal of Managed Care & Specialty Pharmacy. 2015;21(8):614-36.

URL	<a href="http://www.jmcp.org/doi/abs/10.18553/jmcp.2015.21.8.614">http://www.jmcp.org/doi/abs/10.18553/jmcp.2015.21.8.614</a>
Notes	<p>Paper reporting on a review looking at how pharmacists can contribute to the safe transition between care settings. The review sought to identify the components of pharmacist intervention that improve clinical outcomes during care transitions. 30 studies met the inclusion criteria. The authors report:</p> <ul style="list-style-type: none"> <li>• In isolated post-discharge intervention programs, evidence tends towards collaborating with nurses and tailoring to individual patient needs.</li> <li>• In multifaceted intervention programs, performing medication reconciliation alone is insufficient in reducing post-discharge clinical outcomes and should be combined with active patient counselling and a clinical medication review.</li> <li>• Close collaboration between pharmacists and physicians is beneficial.</li> <li>• It is important to secure continuity of care by integrating pharmacists in these multifaceted programs across health care settings.</li> </ul>

*"SWARMIing" to improve patient care: a novel approach to root cause analysis*  
 Li J, Boulanger B, Norton J, Yates A, Swartz CH, Smith A, et al.  
 Joint Commission Journal on Quality and Patient Safety. 2015;41(11):494-501.

URL	<a href="http://www.ingentaconnect.com/content/jcaho/jcjq/2015/00000041/00000011/art0003">http://www.ingentaconnect.com/content/jcaho/jcjq/2015/00000041/00000011/art0003</a>
Notes	<p>This paper discusses an to root cause analyses (RCAs) termed “SWARMIing” that seeks to establish a consistent approach to rapidly investigating adverse or other undesirable events. The authors describe SWARMIs” which are conducted without unnecessary delay after an event, an interdisciplinary team undertakes thoughtful analysis of events reported by frontline staff.</p> <p>The SWARMI process has five key steps:</p> <ol style="list-style-type: none"> <li>1. introductory explanation of the process</li> <li>2. introduction of everyone in the room</li> <li>3. review of the facts that prompted the SWARMI</li> <li>4. discussion of what happened, with investigation of the underlying systems factors; and</li> <li>5. conclusion, with proposed focus areas for action and assignment of task leaders with specific deliverables and completion dates.</li> </ol>

*Intervention to improve the quality of antimicrobial prescribing for urinary tract infection: a cluster randomized trial*  
 Vellinga A, Galvin S, Duane S, Callan A, Bennett K, Cormican M, et al  
 Canadian Medical Association Journal. 2015 [epub].

DOI	<a href="http://dx.doi.org/10.1503/cmaj.150601">http://dx.doi.org/10.1503/cmaj.150601</a>
Notes	<p>Paper describing an Irish intervention antimicrobial prescribing for urinary tract infection in general practice. The study involved providing training and information to general practices on antimicrobial prescribing, including information on guidelines and delayed prescribing, including within patient management software. Monthly audit reports were also provided. The authors report that the proportion of antimicrobial prescribing according to guidelines for urinary tract infection increased and was sustained.</p>

*Antibiotic prescribing and patient satisfaction in primary care in England: cross-sectional analysis of national patient survey data and prescribing data*

Ashworth M, White P, Jongasma H, Schofield P, Armstrong D  
British Journal of General Practice. 2016;66(642):e40-6.

DOI	<a href="http://dx.doi.org/10.3399/bjgp15X688105">http://dx.doi.org/10.3399/bjgp15X688105</a>
Notes	One of the issues raised when discussing antibiotic prescribing is that of patient expectation and how that may influence prescribing. This retrospective cross-sectional study of general practices in England sought to determine the relationship between antibiotic prescribing in general practice and reported patient satisfaction by using a dataset covering 7800 (95.5%) practices and 33.7 million antibiotic prescriptions issued to a registered population of 53.8 million patients. The authors report that antibiotic prescribing volume was a significant positive predictor of all ‘doctor satisfaction’ and ‘practice satisfaction’ scores in the GPPS, and was the strongest predictor of overall satisfaction out of 13 prescribing variables. They conclude that “Patients were less satisfied in practices with frugal antibiotic prescribing. A cautious approach to antibiotic prescribing may require a trade-off in terms of patient satisfaction.”

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

*Interactive telemedicine: Effects on professional practice and health care outcomes*

Flodgren G, Rachas A, Farmer AJ, M I, Shepperd S

Cochrane Database of Systematic Reviews. 2015 (9):Art. No.: CD002098.

DOI	<a href="http://dx.doi.org/10.1002/14651858.CD002098.pub2">http://dx.doi.org/10.1002/14651858.CD002098.pub2</a>
Notes	This Cochrane review sought to assess the effectiveness, acceptability, and costs of interactive telemedicine (TM), delivered in addition to, or as an alternative to, usual care as compared to usual care alone. The reviews author conclude that “the use of TM in the management of heart failure appears to lead to similar health outcomes as face-to-face or telephone delivery of care; there is evidence that TM can improve the control of blood glucose in those with diabetes. The cost to a health service, and acceptability by patients and healthcare professionals, is not clear due to limited data reported for these outcomes. The effectiveness of TM may depend on a number of different factors, including those related to the study population e.g. the severity of the condition and the disease trajectory of the participants, the function of the intervention e.g., if it is used for monitoring a chronic condition, or to provide access to diagnostic services, as well as the healthcare provider and healthcare system involved in delivering the intervention.”

*Quality and safety in orthopaedics: learning and teaching at the same time: AOA critical issues*

Black KP, Armstrong AD, Hutzler L, Egol KA

Journal of Bone & Joint Surgery. 2015;97(21):1809-15.

DOI	<a href="http://dx.doi.org/10.2106/JBJS.O.00020">http://dx.doi.org/10.2106/JBJS.O.00020</a>
Notes	While many safety and quality issues may apply across many or all domains, each domain can have its specific issues. This review piece review discusses quality and safety in orthopaedics, including developing safety metrics and teaching about quality and safety. The development of a safety culture focusing on error prevention, teamwork, transparency, and continuous learning is seen as key.

*Systematic review of patient safety interventions in dentistry*

Bailey E, Tickle M, Campbell S, O'Malley L

BMC Oral Health. 2015;15(1):1-11.

DOI	<a href="http://dx.doi.org/10.1186/s12903-015-0136-1">http://dx.doi.org/10.1186/s12903-015-0136-1</a>
Notes	<p>In a somewhat similar vein is this item looking at dentistry, particularly patient safety interventions. The systematic review reports finding little evidence of effective patient safety approaches, with the exception of surgical safety checklists, which were successful in preventing wrong tooth extractions.</p> <p>The Commission recently published the <i>NSQHS Standards Guide for Dental Practices and Services</i> to aid dental practices to improve the safety and quality of care using the National Safety and Quality Health Service (NSQHS) Standards as a framework for improvement. The guide is available from <a href="http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/information-for-dental-practices/">http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/information-for-dental-practices/</a></p>

*Quality and patient safety teams in the perioperative setting*

Serino MF

AORN Journal. 2015;102(6):617-28.

DOI	<a href="http://dx.doi.org/10.1016/j.aorn.2015.10.006">http://dx.doi.org/10.1016/j.aorn.2015.10.006</a>
Notes	<p>Commentary piece discussing how a US healthcare facility developed and implemented a perioperative quality and patient safety strategic plan. The author examines the benefits of strategies including daily rounds, plan-do-study-act cycles, teamwork training, and dedicated project time.</p>

*Evaluation of perioperative medication errors and adverse drug events*

Nanji KC, Patel A, Shaikh S, Seger DL, Bates DW

Anesthesiology. 2016 Jan;124(1):25-34.

DOI	<a href="http://dx.doi.org/10.1097/ALN.0000000000000904">http://dx.doi.org/10.1097/ALN.0000000000000904</a>
Notes	<p>Paper examining issues around medications given by anaesthesiologists in the perioperative setting. The prospective observational study undertaken in a 1,046-bed US academic hospital found <b>least one medication error or adverse drug event occurred in nearly half of the 277 operations</b> (3,671 medication administrations) observed over an 8 month period. Approximately 1 in 20 perioperative medication administrations resulted in a medication error or adverse drug event; 80% of these errors were deemed preventable. More than one-third of the medication errors led to observed adverse drug events, and the remaining two-thirds had the potential for harm. None of the errors resulted in death, but 2% were considered life-threatening.</p>

*The effect of a staged, emergency department specific rapid response system on reporting of clinical deterioration*

Considine J, Rawet J, Currey J.

Australasian Emergency Nursing Journal. 2015;18(4):218-26.

DOI	<a href="http://dx.doi.org/10.1016/j.aenj.2015.07.001">http://dx.doi.org/10.1016/j.aenj.2015.07.001</a>
Notes	<p>Paper reporting on the staged implementation of a rapid response system in the emergency department of an Australian hospital. The study was a retrospective cross sectional design that used stratified random sampling to select 50 patients with shortness of breath, chest pain or abdominal pain per each year studied (2009–2012) for a total of 600 patients.</p>



	Then study found the <b>frequency of clinical deterioration</b> in the sample was <b>14.8%</b> (318 episodes/89 patients). Over the intervention there was improved recognition of clinical deterioration as unreported deterioration decreased each year. Patients who deteriorated during ED care had a longer median ED length of stay, were 31.9% more likely to need hospital admission and 4.9% more likely to die in hospital.
--	---

*Reducing excess readmissions: promising effect of hospital readmissions reduction program in US hospitals*

Lu N, Huang K-C, Johnson JA

International Journal for Quality in Health Care. 2015 [epub].

DOI	<a href="http://dx.doi.org/10.1093/intqhc/mzv090">http://dx.doi.org/10.1093/intqhc/mzv090</a>
Notes	This paper examines the effect of the (US) Hospital Readmissions Reduction Program (HRRP) on 30-day inpatient readmissions for pneumonia (PN), acute myocardial infarction (AMI) and heart failure (HF) among hospitals identified as having excess readmissions. The study looked at the thirty-day hospital readmission ratios for PN, AMI and HF for 3395 short-term acute care hospitals in the USA following the implementation of the HRRP in October 2012 to reduce (US) Medicare payments to hospitals with excess readmissions. The authors report finding that there was a “significant decrease in excess readmissions for PN, AMI and HF between FY 2013 and FY 2015...The effect of HRRP on excess readmissions was greater for small hospitals, public hospitals and hospitals located in rural areas.”

*Bad apples or spoiled barrels? Multilevel modelling analysis of variation in high-risk prescribing in Scotland between general practitioners and between the practices they work in*

Guthrie B, Donnan PT, Murphy DJ, Makubate B, Dreischulte T.

BMJ Open. 2015;5(11).

DOI	<a href="http://dx.doi.org/10.1136/bmjopen-2015-008270">http://dx.doi.org/10.1136/bmjopen-2015-008270</a>
Notes	This Scottish study examined the new prescribing of a high-risk NSAID (non-steroidal anti-inflammatory drug) as a means of exploring whether variation in high-risk prescribing is driven by individuals (a ‘bad apple’ problem) or by practices having higher or lower risk prescribing cultures (a ‘spoiled barrel’ problem). The study undertaken was a multilevel logistic regression modelling of routine cross-sectional data from 38 Scottish general practices for 181,010 encounters between 398 general practitioners (GPs) and 26,539 patients particularly vulnerable to adverse drug events (ADEs) of non-steroidal anti-inflammatory drugs (NSAIDs) due to age, comorbidity or co-prescribing. The researchers found that a new high-risk NSAID was initiated in 1953 encounters (1.1% of encounters, 7.4% of patients). The authors conclude that “There was much <b>more variation</b> in high-risk prescribing <b>between GPs than between practices</b> , and only targeting practices with higher than average rates will miss most high-risk NSAID prescribing. Primary care prescribing safety improvement should ideally target all practices, but encourage practices to consider and act on variation between prescribers in the practice.”

*A Trial of Wound Irrigation in the Initial Management of Open Fracture Wounds*

The Flow Investigators, Bhandari M, Jeray KJ, Petrisor BA, Devereaux PJ, Heels-Ansdell D, et al. New England Journal of Medicine. 2015;373(27):2629-41.

DOI	<a href="http://dx.doi.org/10.1056/NEJMoa1508502">http://dx.doi.org/10.1056/NEJMoa1508502</a>
Notes	<p>The issue of how to irrigate open fractures has been an open question. Open fractures require wound irrigation and débridement to remove contaminants and this study investigated the effects of castile soap versus normal saline irrigation delivered by means of high, low, or very low irrigation pressure.</p> <p>This Canadian study involved more than 2,500 patients and the authors report that “rates of reoperation were similar regardless of irrigation pressure, a finding that indicates that <b>very low pressure is an acceptable</b>, low-cost alternative for the irrigation of open fractures.” They also noted that the <b>reoperation rate was higher in the soap group than in the saline group.</b></p>

*The Potential of Twitter as a Data Source for Patient Safety*

Nakhasi A, Bell SG, Passarella RJ, Paul MJ, Dredze M, Pronovost PJ  
Journal of Patient Safety. 2016 [epub].

DOI	<a href="http://dx.doi.org/10.1097/PTS.0000000000000253">http://dx.doi.org/10.1097/PTS.0000000000000253</a>
Notes	<p>The use of feedback through various forms of social media has been raised previously. Thus study gathered Twitter comments that contained one of a number of specific phrases to then examine the comments patients (and others) made (in English in the period January to August 2012). The authors report that of the 1000-odd tweets, 839 (83%) identified the type of error (26% of which were procedural errors, 23% were medication errors, 23% were diagnostic errors, and 14% were surgical errors). A total of 850 (84%) identified a tweet source (90% of which were by the patient and 9% by a family member). A total of 519 (52%) identified an emotional response, 47% of which expressed anger or frustration, 21% expressed humour or sarcasm, and 14% expressed sadness or grief. Of the tweets, 6.3% mentioned an intent to pursue malpractice litigation.</p> <p>The authors conclude that “Twitter is a relevant data source to obtain the patient perspective on medical errors. Twitter may provide an opportunity for health systems and providers to identify and communicate with patients who have experienced a medical error”</p> <p>Ways for more systematic and/or targeted gathering and analysis of social media comments and feedback clearly exist. These could involve other key words/phrases, methods to find a particular services patients/customers, etc. These could be tailored to different scales and purposes. But it also then would raise issues such as how may patients perceive and react to such collection or monitoring? Twitter users may not be representative of the overall or even the patient population; but does that change the value or utility of this feedback? A health service may consider such collection as an additional dataset – to add to survey results, complaints, etc. – to try and develop a fuller view of the patient experience and as part of their performance monitoring.</p>

URL	<a href="http://qualitysafety.bmj.com/content/early/recent">http://qualitysafety.bmj.com/content/early/recent</a>
Notes	<p>BMJ Quality and Safety has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• Editorial: Swimming ‘upstream’ to tackle the <b>social determinants of health</b> (Tara Kiran, Andrew D Pinto)</li> <li>• The <b>Medicines Advice Service</b> Evaluation (MASE): a randomised controlled trial of a pharmacist-led telephone based intervention designed to improve <b>medication adherence</b> (Imogen Lyons, Nicholas Barber, David K Raynor, Li Wei)</li> <li>• Editorial: <b>Balancing quality of care and resource utilisation</b> in acute care hospitals (Andre C K B Amaral, Brian H Cuthbertson)</li> <li>• Why ‘Universal Precautions’ are needed for <b>medication lists</b> (Rita Shane)</li> <li>• Understanding <b>patient-centred readmission factors</b>: a multi-site, mixed-methods study (S Ryan Greysen, James D Harrison, Sunil Kripalani, Eduard Vasilevskis, Edmondo Robinson, Joshua Metlay, Jeffery L Schnipper, David Meltzer, Neil Sehgal, G W Ruhnke, M V Williams, A D Auerbach)</li> </ul>

## Online resources

[UK] *A zero cost way to reduce missed hospital appointments*

<https://www.gov.uk/government/publications/reducing-missed-hospital-appointments-using-text-messages/a-zero-cost-way-to-reduce-missed-hospital-appointments>

This UK Department of Health document reports on a study that examined the content of appointment reminders (usually send as text messages) in order to assess their effectiveness in reducing missed appointments. In 2014 to 2015 around 5.6 million (9% of the total) NHS outpatient appointments were missed in England, so a reduction in this could have a substantial benefit. The study found that “The best form of words, which told the patients the specific waste to the NHS of not attending, **reduced missed appointments by 23%** compared to the standard message”

[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 NG33 **Tuberculosis** <https://www.nice.org.uk/guidance/ng33>
- NICE Quality Standard QS107 **Preventing unintentional injury** in under 15s <https://www.nice.org.uk/guidance/qs107>
- NICE Quality Standard QS108 **Multiple sclerosis** <https://www.nice.org.uk/guidance/qs108>

---

## Disclaimer

*On the Radar* is an information resource of the Australian Commission on Safety and Quality in Health Care. The Commission is not responsible for the content of, nor does it endorse, any articles or sites listed. The Commission accepts no liability for the information or advice provided by these external links. Links are provided on the basis that users make their own decisions about the accuracy, currency and reliability of the information contained therein. Any opinions expressed are not necessarily those of the Australian Commission on Safety and Quality in Health Care.