AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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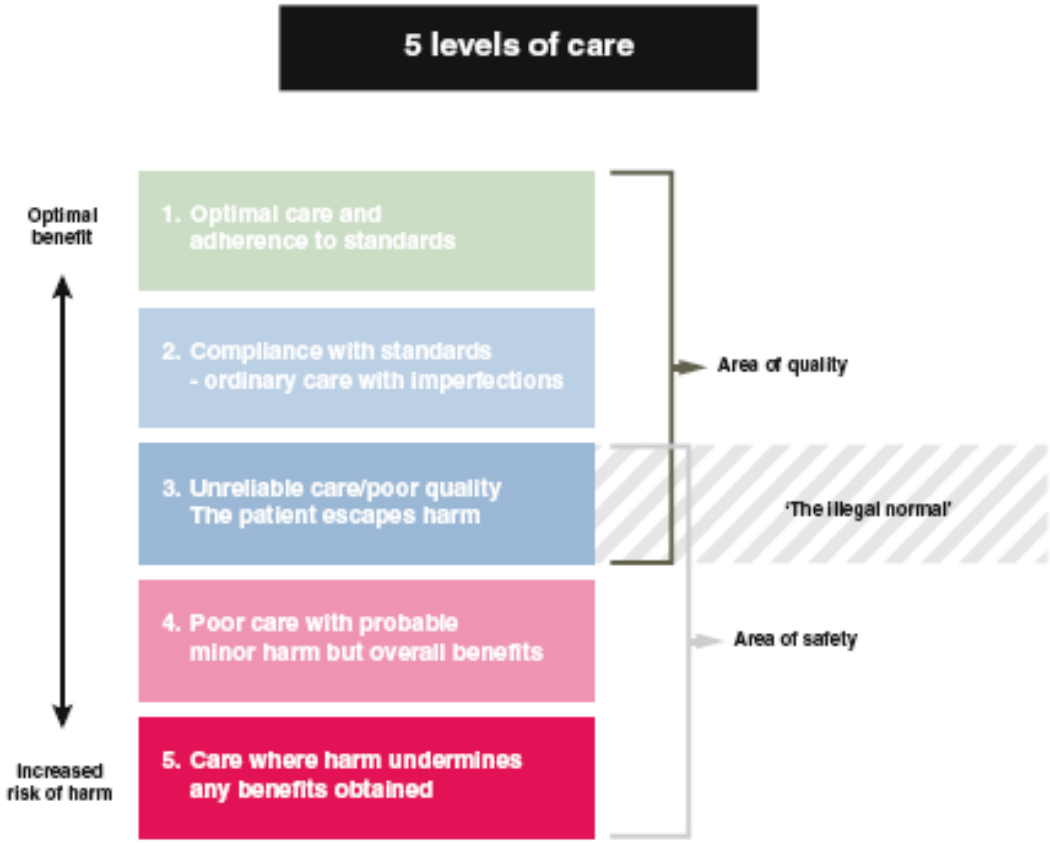
Guide for managers and practitioners: Credentialing health practitioners and defining and managing practitioners' scope of clinical practice
Australian Commission on Safety and Quality in Health Care
Sydney: ACSQHC; 2015. p. 40.

URL	http://www.safetyandquality.gov.au/publications/credentialing-health-practitioners-and-defining-their-scope-of-clinical-practice-a-guide-for-managers-and-practitioners-december-2015/
Notes	The Australian Commission on Safety and Quality in Health Care has released this guide to assist managers and practitioners in determining and managing their scope of practice. This practical guide will also help to ensure that only health practitioners who are suitably experienced, trained and qualified to practice in a competent and ethical manner are appointed to health services. The guide includes the requirements for assessing and credentialing an individual health practitioner and then determining their scope of practice when: • initially appointed and at reappointment • renewing their scope of practice • concerns arise in respect of their scope of practice.

Books

Safer Healthcare: Strategies for the Real World
Vincent CA, Amalberti R
Springer Open; 2016.
ISBN 978-3-319-25557-6 ISBN 978-3-319-25559-0 (eBook)

DOI	http://dx.doi.org/10.1007/978-3-319-25559-0
Notes	Charles Vincent and René Amalberti are both regarded as being preeminent in the patient safety field. They bring their considerable expertise to bear on the issue of safety and particularly how to address safety in the real and complex world of health care. They argue that a patient focussed view is essential and there is a "need to see safety through the patient's eyes, to consider how safety is managed in different contexts and to develop a wider strategic and practical vision in which patient safety is recast as the management of risk over time." They argue that there is also a need for "strategies which are aimed at managing risk in the often complex and adverse daily working conditions of healthcare… strategies that are explicitly aimed at managing risk 'in the real world'. They discuss safety strategies for care in a number of settings, including in hospital, in primary care and in the home. This short book is available free under a Creative Commons license. 

Journal articles

The value of consultant-led ward rounds for patient safety
Bokey EL, Chapuis PH, Dent OF
Medical Journal of Australia 2016; 204 (3): 100-101.

DOI	http://dx.doi.org/10.5694/mja15.00889
Notes	Bokey et al argue for the value of consultant-led, multi-disciplinary ward rounds, which they suggest appear to be declining in frequency and importance in NSW hospitals perhaps linked to constraints on "medical resources, staffing and conditions of appointment". They report a paucity of research to objectively support an impact on patient safety, but that studies identified show improved communication between team members and with patients, reduced length of stay, and improved detection of deterioration. Studies of systematic, safe and complete patient review during ward rounds using checklists showed they improved patient safety.

Non-reimbursement for preventable health care-acquired conditions
Davis C
Medical Journal of Australia 2016; 204 (3): 98-99

DOI	http://dx.doi.org/10.5694/mja15.00952
Notes	This article discusses "the decision by Australia's largest private health insurer Medibank to not reimburse hospitals for 165 hospital-acquired complications that it deems preventable" and its "stated objective of improving patient care and thereby containing costs." It discusses some of the implicit assumptions and provides international examples of similar approaches.

Information on the use of patient safety information generated from administrative hospital datasets can be found at http://www.safetyandquality.gov.au/wp-content/uploads/2015/08/Use-of-patient-safety-information-generated-from-administrative-hospital-datasets.pdf

Financial incentives and mortality: taking pay for performance a step too far
Gupta K, Wachter RM, Kachalia A
BMJ Quality & Safety. 2016 February 18, 2016.

DOI	http://qualitysafety.bmj.com/content/early/2016/02/17/bmjqs-2015-004835.short
Notes	In a somewhat related vein is this piece rather lamenting the use of some quality metrics, particularly related to hospital-related mortality, as mechanism for devising pay-for-performance schemes. The authors point out a number of limitations of these approaches.

Patients' views of adverse events in primary and ambulatory care: a systematic review to assess methods and the content of what patients consider to be adverse events
Lang S, Garrido MV, Heintze C
BMC Family Practice. 2016;17(1):1-9.

DOI	http://dx.doi.org/10.1186/s12875-016-0408-0
Notes	This systematic review focused on 19 studies to look at how patients perceived errors and adverse events in health care. Form their review, patients take a broad view of patient safety (Vincent and Amalberti also argue that the "perimeter of patient safety has expanded" as more types of harm have moved from being seen as inevitable consequences to preventable). Many of the events identified related to communication and service quality issues.

For information on the Commission's work on patient and consumer centred care, see http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Reducing emergency admissions through community based interventions
Wallace E, Smith SM, Fahey T, Roland M
BMJ. 2016;352:h6817.

DOI	http://dx.doi.org/10.1136/bmj.h6817
Notes	Reducing unnecessary or preventable hospital admissions is something of an abiding concern to try and reduce pressures (and costs) on hospitals. This paper looks at some of the issues around the identification, prevention of hospital admission, and management of patients at high risk of emergency admission. The author's key messages include: • The risk prediction tools for identifying people at high risk of future emergency admission have limitations • Current evidence does not support community-initiated case management as an effective way of reducing emergency admissions • Efforts should focus on the prediction of admissions for conditions that are more amenable to prevention in the community, particularly those accounting for most emergency admissions • Interventions that involve coordinated care of inpatients as they are discharged to primary care and those targeting the length of inpatient stay seem promising.

Electronic Health Record Adoption and Rates of In-hospital Adverse Events
Furukawa MF, Eldridge N, Wang Y, Metersky M
Journal of Patient Safety. 2016 [epub].

DOI	http://dx.doi.org/10.1097/pts.0000000000000257
Notes	Paper reporting on a study examining the association between hospitals adopting electronic health records and rates of adverse events. The study was a retrospective analysis of patient discharges using data from the (USA) 2012 and 2013 Medicare Patient Safety Monitoring System covering adult patients hospitalised with either acute cardiovascular disease, pneumonia, or conditions requiring surgery. The primary outcomes evaluated were the rates of 21 in-hospital adverse events (grouped into hospital-acquired infections, adverse drug events, general events (such as falls and pressure ulcers) and post-procedural events. Among all study patients, the occurrence rate of adverse events was 2.3 percent (7,820 adverse events). However, as the authors report, "Patients exposed to fully electronic health records, however, had 17–30 percent lower odds of any adverse event."

For information on the Commission's work on safety in e-health, see http://www.safetyandquality.gov.au/our-work/safety-in-e-health/

BMJ Quality and Safety
March 2016, Vol. 25, Issue 3

URL	http://qualitysafety.bmj.com/content/25/3
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: **Assessing patient-centred care** through direct observation of clinical encounters (Jennifer N Stojan, Michael A Clay, Monica L Lypson)

	• Editorial: Swimming 'upstream' to tackle the **social determinants of health** (Tara Kiran, Andrew D Pinto) • The underappreciated role of **habit** in **highly reliable healthcare** (Timothy J Vogus, Brian Hilligoss) • The problem with **Plan-Do-Study-Act cycles** (Julie E Reed, Alan J Card) • Patient safety room of horrors: a novel method to assess medical students and entering residents' ability to identify **hazards of hospitalisation** (Jeanne M Farnan, Sean Gaffney, Jason T Poston, Kris Slawinski, Melissa Cappaert, Barry Kamin, Vineet M Arora) • Providers contextualise care more often when they discover **patient context** by asking: meta-analysis of three primary data sets (Alan Schwartz, Saul J Weiner, Amy Binns-Calvey, Frances M Weaver) • Addressing basic resource needs to improve **primary care quality**: a community collaboration programme (Seth A Berkowitz, A Catherine Hulberg, Clemens Hong, B J Stowell, K J Tirozzi, C Y Traore, S J Atlas) • Reliable implementation of evidence: a qualitative study of **antenatal corticosteroid administration** in Ohio hospitals (Heather C Kaplan, Susan N Sherman, Charlena Cleveland, L M Goldenhar, C M Lannon, J L Bailit) • **Patient and family engagement**: a survey of US hospital practices (Jeph Herrin, Kathleen G Harris, K Kenward, S Hines, M S Joshi, D L Frosch) • What methods are used to apply **positive deviance** within healthcare organisations? A systematic review (Ruth Baxter, Natalie Taylor, Ian Kellar, Rebecca Lawton) • Value of small sample sizes in **rapid-cycle quality improvement projects** (E Etchells, M Ho, K G Shojania)

Sociology of Health & Illness
February 2016
Volume 38, Issue 2

URL	http://onlinelibrary.wiley.com/doi/10.1111/shil.2016.38.issue-2/issuetoc
Notes	This issue of *Sociology of Health & Illness* has the theme of The **Sociology of Healthcare Safety and Quality**. Articles in this issue of *Sociology of Health & Illness* include: • Towards a **sociology of healthcare safety and quality** (Davina Allen, Jeffrey Braithwaite, Jane Sandall and Justin Waring) • **Healthcare quality and safety**: a review of **policy, practice and research** (Justin Waring, Davina Allen, Jeffrey Braithwaite and Jane Sandall) • What is the role of **individual accountability in patient safety**? A multi-site ethnographic study (Emma-Louise Aveling, Michael Parker and Mary Dixon-Woods) • Enacting **corporate governance of healthcare safety and quality**: a dramaturgy of hospital boards in England (Tim Freeman, Ross Millar, Russell Mannion and Huw Davies) • The social practice of rescue: the **safety implications of acute illness trajectories** and patient categorisation in medical and maternity settings (Nicola Mackintosh and Jane Sandall) • Sensemaking and the **co-production of safety**: a qualitative study of primary medical care patients (Penny Rhodes, Ruth McDonald, Stephen Campbell, Gavin Daker-White and Caroline Sanders)

	• Chains of (dis)trust: exploring the underpinnings of **knowledge-sharing and quality care** across mental health services (Patrick R Brown and Michael W. Calnan) • Spatio-temporal elements of articulation work in the achievement of **repeat prescribing safety** in UK general practice (Suzanne Grant, Jessica Mesman and Bruce Guthrie) • **Infections and interaction** rituals in the organisation: clinician accounts of speaking up or remaining silent in the face of threats to patient safety (Julia E. Szymczak)

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: • Dual-process cognitive interventions to enhance **diagnostic reasoning**: a systematic review (Kathryn Ann Lambe, Gary O'Reilly, Brendan D Kelly, Sarah Curristan) • Maintaining the link between methodology and method in **ethnographic health research** (Justin Waring, Lorelei Jones) • **Financial incentives and mortality**: taking **pay for performance** a step too far (Kiran Gupta, Robert M Wachter, Allen Kachalia) • Balancing stakeholder needs in the **evaluation of healthcare quality improvement** (Laura C Leviton, Lori Melichar)

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: • Incidence and impact of proxy response in **measuring patient experience**: secondary analysis of a large postal survey using propensity score matching (Chris Graham) • Performance results for a workstation-integrated **radiology peer review quality assurance** program (Margaret M O'Keeffe, Todd M Davis, and Kerry Siminoski) • Cohort study for evaluation of **dose omission** without justification in a teaching general hospital in Bahia, Brazil (Bartyra Leite, Sostenes Mistro, Camile Carvalho, Sanjay R. Mehta, and Roberto Badaro)

Online resources

[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:

- *Home-Based Primary Care Interventions* http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2183

[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 Guideline NG37 **Fractures** (complex): assessment and management http://www.nice.org.uk/guidance/ng37
- NICE Guideline NG38 **Fractures** (non-complex): assessment and management http://www.nice.org.uk/guidance/ng38
- NICE Guideline NG39 **Major trauma**: assessment and initial management http://www.nice.org.uk/guidance/ng39
- NICE Guideline NG40 **Major trauma**: service delivery http://www.nice.org.uk/guidance/ng40
- NICE Guideline NG41 **Spinal injury**: assessment and initial management http://www.nice.org.uk/guidance/ng41
- NICE Quality Standard QS115 **Antenatal and postnatal mental health** http://www.nice.org.uk/guidance/qs115

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