# Australian COmmission on Safety and Quality in Health Care logo with Radar imageOn the Radar

Issue 265

21 March 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 HUmail@safetyandquality.gov.auU.
You can also send feedback and comments to HUmail@safetyandquality.gov.auU.

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

Contributors: Niall Johnson

**Reports**

*Chronic failure in primary medical care*

Swerissen H, Duckett SJ, Wright J

Melbourne: Grattan Institute; 2016 March 2016. 50 p.

|  |  |
| --- | --- |
| URL | <http://grattan.edu.au/report/chronic-failure-in-primary-care/> |
| Notes | This latest report from the Grattan Institute asserts that the Australian primary care is proving sub-optimal care for patients with chronic diseases. The report’s authors claim that * ineffective management of chronic diseases costs the Australian health system more than $320 million each year in avoidable hospital admissions
* that the primary care system provides only half the recommended care for many chronic conditions
* each year there are more than a quarter of a million admissions to hospital for health problems that potentially could have been prevented.

Chronic conditions affect many Australians and the numbers have been growing. To address these primary care needs to function well. This report argues, as have others, that the fee-for-service model is unsuited to managing and preventing chronic disease. The authors perceive a role for Primary Health Networks in helping patients receive better care for their chronic conditions. |

*Patient Safety: Hospitals Face Challenges Implementing Evidence-Based Practices*

United States Government Accountability Office

Washington, DC: United States Government Accountability Office; 2016.

|  |  |
| --- | --- |
| URL | <http://www.gao.gov/products/GAO-16-308> |
| Notes | It is no secret that implementation (and sustained implementation and impact) is where some of the biggest challenges lie in safety and quality interventions. This brief (34-page) report from the US U.S. Government Accountability Office (GAO) examined how six American hospitals tried to implement a number of evidence-based safety practices. Three key challenges affected the efforts to implement evidence-based patient safety practices, including:1. Obtaining data to identify adverse events in their own hospitals
2. Determining which patient safety practices should be implemented
3. Ensuring that staff consistently implement the practices over time.
 |

**Journal articles**

*Interprofessional teamwork and team interventions in chronic care: A systematic review*

Körner M, Bütof S, Müller C, Zimmermann L, Becker S, Bengel J

Journal of Interprofessional Care. 2016;30(1):15-28.

|  |  |
| --- | --- |
| DOI | <http://dx.doi.org/10.3109/13561820.2015.1051616> |
| Notes | In some ways linking to the Grattan Institute report above, this systematic review sought to examine the evidence around teamwork and teams for chronic disease care. While from the 23 include studies there was evidence that there are interventions that have been successful in improving teamwork and safety culture,  “there is no consensus about the main features of IPT [interprofessional teamwork] and the most effective team interventions in chronic care. However, the findings may be used to standardize the implementation and evaluation of IPT and team interventions in practice and for further research.” |

*Improving the governance of patient safety in emergency care: a systematic review of interventions*

Hesselink G, Berben S, Beune T, Schoonhoven L

BMJ Open. 2016;6(1).

|  |  |
| --- | --- |
| DOI | <http://dx.doi.org/10.1136/bmjopen-2015-009837> |
| Notes | At first glance it would seem that managing patient safety may be more straightforward in some settings than others. One setting that may seem more challenging is that of emergency care. This article reports on a systematic review that sought to focus on interventions that aim to improve the governance of patient safety within emergency care on effectiveness, reliability, validity and feasibility. From, the 18 included studies that authors found “The use of a **simulation-based training programme** and **well-designed incident reporting systems** led to a statistically significant improvement of safety knowledge and attitudes by ED staff and an increase of incident reports within EDs, respectively.” |

*Parent-reported errors and adverse events in hospitalized children*

Khan A, Furtak SL, Melvin P, Rogers JE, Schuster MA, Landrigan CP

JAMA Pediatrics. 2016 [epub].

|  |  |
| --- | --- |
| DOI | <http://dx.doi.org/10.1001/jamapediatrics.2015.4608> |
| Notes | This paper reports on the study in a US hospital of parents perceptions of safety incidents affecting their children. The study was prospective cohort study conducted in 2 general paediatric units at a children’s hospital between May 2013 and October 2014. Parents of randomly selected inpatients (ages 0-17 years) were invited to participate via written survey whether their child experienced any safety incidents during their hospitalisation. Two reviewers classified the incidents and then categorised medical errors as harmful or non-harmful Patient medical records were also reviewed to determine the number of parent-reported errors that were present in the medical record. The authors report that “Of the 383 parents surveyed (81% response rate), 34 parents (**8.9%**) **reported** 37 **safety incidents**. Among these, 62% (n = 23, 6.0 per 100 admissions) were determined to be medical errors on physician review, 24% (n = 9) were determined to be other quality problems, and 14% (n = 5) were determined to be neither. Thirty percent (n = 7, 1.8 per 100 admissions) of medical errors caused harm”.The authors concluded that “Parents frequently reported errors and preventable AEs, many of which were not otherwise documented in the medical record. Families are an underused source of data about errors, particularly preventable AEs. Hospitals may wish to consider incorporating family reports into routine safety surveillance systems.” These conclusions are in line with other similar studies showing that patients and their families can add a useful perspective. |

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/>

*Accuracy of the Safer Dx Instrument to Identify Diagnostic Errors in Primary Care*

Al-Mutairi A, Meyer AND, Thomas EJ, Etchegaray JM, Roy KM, Davalos MC, et al

Journal of General Internal Medicine. 2016:1-7.

|  |  |
| --- | --- |
| DOI | <http://dx.doi.org/10.1007/s11606-016-3601-x> |
| Notes | Recent years have seen the emergence of the issue of diagnostic error. This article describes the development and characteristics of a structured tool to assist in the reviewing of medical records to determine if a diagnostic error occurred. The tool, the Safer Dx, consists of 11 questions assessing diagnostic processes in the patient–provider encounter and a main outcome question to determine diagnostic error. |

*Patient Safety Science in Cardiothoracic Surgery: An Overview*

Sanchez JA, Ferdinand FD, Fann JI

The Annals of Thoracic Surgery. 2016;101(2):426-33.

|  |  |
| --- | --- |
| DOI | <http://dx.doi.org/10.1016/j.athoracsur.2015.12.034> |
| Notes | As has been noted previously, there are many aspects of patient safety and quality that are pertinent across domains of care and there are also facets that can be specific to particular domains. This commentary focuses on cardiothoracic surgery and reviews how understanding issues such as human error, accident causation, and high reliability can improve safety of care delivered by cardiac surgical teams. |

*BMJ Quality and Safety*

April 2016, Vol. 25, Issue 4

|  |  |
| --- | --- |
| URL | <http://qualitysafety.bmj.com/content/25/4> |
| 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: Does **Tall Man lettering** prevent **drug name confusion** errors? Incomplete and conflicting evidence suggest need for definitive study (Bruce L Lambert, Scott R Schroeder, William L Galanter)
* Editorial: The **health information technology safety framework**: building great structures on vast voids (Ross Koppel)
* Editorial: To RCT or not to RCT? The ongoing saga of **randomised trials in quality improvement** (Gareth Parry, Maxine Power )
* Why **evaluate** ‘common sense’ **quality and safety interventions**? (Angus IG Ramsay, Naomi J Fulop)
* **Measuring and improving patient safety** through health information technology: The **Health IT Safety Framework** (Hardeep Singh, Dean F Sittig)
* **Tall Man lettering** and **potential prescription errors**: a time series analysis of 42 children's hospitals in the USA over 9 years (Wenjun Zhong, James A Feinstein, Neil S Patel, Dingwei Dai, Chirs Feudtner)
* One size fits all? Mixed methods evaluation of the impact of **100% single-room accommodation** on staff and patient experience, safety and costs (Jill Maben, Peter Griffiths, Clarissa Penfold, Michael Simon, Janet E Anderson, Glenn Robert, Elena Pizzo, Jane Hughes, Trevor Murrells, James Barlow)
* A cluster-randomised quality improvement study to improve two **inpatient stroke quality indicators** (Linda Williams, Virginia Daggett, James E Slaven, Zhangsheng Yu, Danielle Sager, Jennifer Myers, Laurie Plue, Heather Woodward-Hagg, Teresa M Damush)
* Findings from a novel approach to publication guideline revision: user road testing of a draft version of **SQUIRE 2.0** (Louise Davies, Kyla Z Donnelly, Daisy J Goodman, Greg Ogrinc)
* Developing a **primary care patient measure of safety** (PC PMOS): a modified Delphi process and face validity testing (Andrea L Hernan, Sally J Giles, Jane K O'Hara, Jeffrey Fuller, Julie K Johnson, James A Dunbar)
* **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)
* **Compromised communication**: a qualitative study exploring Afghan families and health professionals’ experience of interpreting support in Australian maternity care (Jane Yelland, Elisha Riggs, Josef Szwarc, Sue Casey, Philippa Duell-Piening, D Chesters, S Wahidi, F Fouladi, S Brown)
 |

*Health Expectations*

Volume 19, Issue 2, April 2016

|  |  |
| --- | --- |
| URL | <http://onlinelibrary.wiley.com/doi/10.1111/hex.2016.19.issue-2/issuetoc> |
| Notes | A new issue of *Health Expectations* has been published. Articles in this issue of *Health Expectations* include:* Editorial Briefing: **Patient participation in contemporary health care**: promoting a versatile patient role (Kyriakos Souliotis)
* **Patients' expectations of medicines** – a review and qualitative synthesis (Ulrica Dohnhammar, Joanne Reeve and Tom Walley)
* **Self-management support** from the perspective of patients with a chronic condition: a thematic synthesis of qualitative studies (Jolanda Dwarswaard, Ellen J M Bakker, AnneLoes van Staa and Hennie R Boeije)
* Service **user involvement in mental health care**: an evolutionary concept analysis (Samantha L Millar, Mary Chambers and Melanie Giles)
* Seeing it through their eyes: a qualitative study of the **pregnancy experiences** of women with a body mass index of 30 or more (Tina Lavender and Debbie M Smith)
* Development and validation of a **question prompt list** for parents of children with **attention-deficit/hyperactivity disorder**: a Delphi study (Rana Ahmed, Kirsten J McCaffery and Parisa Aslani)
* Trust, temporality and systems: how do **patients** understand **patient safety** in **primary care**? A qualitative study (Penny Rhodes, Stephen Campbell and Caroline Sanders)
* Combined verbal and numerical expressions increase **perceived risk of medicine side-effects**: a randomized controlled trial of EMA recommendations (Peter Knapp, Peter H Gardner and Elizabeth Woolf)
* **Experiences and preferences of patients** visiting an otorhinolaryngology outpatient clinic: a qualitative study (Janneke E van Leijen-Zeelenberg, Geert Willem Huismans, Jeroen A S Bisschop, Jan Wouter Brunings, Arno J A van Raak, Dirk Ruwaard, Hubertus J M Vrijhoef and Bernd Kremer)
* Factors associated with a **positive attitude** towards receiving **cancer information**: a population-based study in Spain (Belén Sanz-Barbero, María Eugenia Prieto and Naiara Cambas)
* **Patients' expectations** about **total knee arthroplasty** outcomes (Sofia de Achaval, Michael A Kallen, Benjamin Amick, Glenn Landon, Sherwin Siff, David Edelstein, Hong Zhang and Maria E Suarez-Almazor)
* An exploration of how young people and parents use **online support** in the context of living with **cystic fibrosis** (Susan Kirk and Linda Milnes)
* Exploring **access and attitudes** to regular **sexually transmitted infection screening**: the views of young, multi-ethnic, inner-city, female students (Rebecca Normansell, Vari M Drennan and Pippa Oakeshott)
* Involving **patients** in **health technology funding** decisions: stakeholder perspectives on processes used in Australia (Edilene Lopes, Jackie Street, Drew Carter and Tracy Merlin)
* The **NHS Health Check programme**: insights from a qualitative study of patients (Hanif Ismail and Karl Atkin)
* Association between **patient activation and patient-assessed quality of care** in **type 2 diabetes**: results of a longitudinal study (Eindra Aung, Maria Donald, Joseph R Coll, Gail M Williams and Suhail A R Doi)
* From admission to discharge in **mental health** services: a qualitative analysis of service **user involvement** (Nicola Wright, Emma Rowley, Arun Chopra, Kyriakos Gregoriou and Justin Waring)
* **GPs’ perceptions and experiences** of **public awareness campaigns** for cancer: a qualitative enquiry (Trish Green, Karl Atkin and Una Macleod)
* It's complicated – Factors predicting **decisional conflict in prenatal diagnostic testing** (Cécile Muller and Linda D Cameron)
* **Teenage mothers** of black and minority ethnic origin want access to a range of **mental and physical health support**: a participatory research approach (Maria Muzik, R Kirk, E Alfafara, J Jonika and R Waddell)
* A qualitative exploration of the impact of the **economic recession** in Spain on **working, living and health conditions**: reflections based on immigrant workers' experiences (Elena Ronda, Erica Briones-Vozmediano, Tanyse Galon, Ana M García, Fernando G Benavides and A A Agudelo-Suárez)
* Mismatch between health-care professionals' and patients' views on a **diabetes patient decision aid**: a qualitative study (Ping Yein Lee, Ee Ming Khoo, Wah Yun Low, Yew Kong Lee, Khatijah Lim Abdullah, Syahidatul Akmal Azmi and Chirk Jenn Ng)
* **Assessing subjective quality of life** domains after multiple sclerosis diagnosis disclosure (Katia Mattarozzi, Federica Casini, Elisa Baldin, Martina Baldini, Alessandra Lugaresi, Paola Milani, Erika Pietrolongo, Alberto Gajofatto, Maurizio Leone, Trond Riise, Luca Vignatelli, Roberto D'Alessandro and on behalf of G.E.Ro.N.I.Mu.S. group)
* Barriers to **shared decision making in mental health care**: qualitative study of the Joint Crisis Plan for psychosis (Simone Farrelly, Helen Lester, Diana Rose, Max Birchwood, Max Marshall, Waquas Waheed, R Claire Henderson, George Szmukler and Graham Thornicroft)
* Does a **decision aid** for **prostate cancer** affect different aspects of decisional regret, assessed with new regret scales? A randomized, controlled trial (Julia J van Tol-Geerdink, Jan Willem H Leer, C J Wijburg, I M van Oort, H Vergunst, E J van Lin, J A Witjes and P F M Stalmeier)
* Monitoring and evaluation of **patient involvement in clinical practice guideline development**: lessons from the Multidisciplinary Guideline for Employment and Severe Mental Illness, the Netherlands (Alida . van der Ham, Nicole van Erp and Jacqueline E W Broerse)
* **Patients' perspectives** on the role of their **complaints** in the regulatory process (Renée Bouwman, Manja Bomhoff, Paul Robben and R Friele)
 |

*HealthcarePapers*

Vol. 15 No. 3 2016

|  |  |
| --- | --- |
| URL | <http://www.longwoods.com/publications/healthcarepapers/24404> |
| Notes | A new issue of *HealthcarePapers* has been published with the theme ‘A Policy Framework for Health Systems to Promote Triple Aim Innovation’. Articles in this issue of *HealthcarePapers* include:* Guest Editorial: Moving from a Learning-Disabled to a **Rapid-Learning Healthcare System**: Good Governance for Innovation (Geoffrey M Anderson)
* A Policy Framework for Health Systems to **Promote Triple Aim Innovation** (Amol Verma and Sacha Bhatia)
* Taking Triple Aim at the **Triple Aim** (Stirling Bryan and Cam Donaldson)
* The **Culture of Care** (Ewan Affleck)
* The **Need for Bold Thinking** (Mimi Lowi-Young and Gwen DuBois-Wing)
* **Promoting Triple Value Healthcare** in Countries with Universal Healthcare (Muir Gray and Anant Jani)
* **Strategic Clinical Networks**: Alberta’s Response to Triple Aim (Tom Noseworthy, Tracy Wasylak and Blair J. O’Neill)
* The Triple Aim is the Right **Framework for Healthcare Innovation** in Canada (Amol Verma and Sacha Bhatia)
 |

*Healthcare Policy*

Vol. 11 No. 3, 2016

|  |  |
| --- | --- |
| URL | <http://www.longwoods.com/publications/healthcarepapers/24408> |
| Notes | A new issue of *Healthcare Policy* has been published. Articles in this issue of *Healthcare Policy* include:* Editorial: **De-prescribing**: When Less Is More in Healthcare (Jennifer Zelmer)
* Usefulness of a **KT Event** to Address Practice and Policy Gaps Related to **Integrated Care** (Karen Jackson, Omenaa Boakye and Nicole Wallace)
* Examining **Primary Healthcare Performance** through a Triple Aim Lens (Bridget L Ryan, Judith Belle Brown, Richard H Glazier and B Hutchison)
* **Cross Border Healthcare** Requests to Publicly Funded Healthcare Insurance: Empirical Analysis (Lydia Stewart Ferreira)
* **Patient Satisfaction** with Wait-Times for Breast Cancer Surgery in Newfoundland and Labrador (Maria Mathews, Dana Ryan, Vereesh Gadag and Roy West)
* Impact of Type of Medical Specialist Involvement in **Chronic Illness Care on Emergency Department** Use (Jean-Louis Larochelle, Debbie Ehrmann Feldman and Jean-Frédéric Levesque)
* **Inappropriate Ambulance Use**: A Qualitative Study of Paramedics’ Views (D DeJean, M Giacomini, M Welsford, L Schwartz and P Decicca)
* **Appropriateness for Total Joint Replacement**: Perspectives of Decision-Makers (Nathalie Clavel, Carolyn De Coster, Marie-Pascale Pomey, Claudia Sanmartin, Éric Bohm, Michael J. Dunbar, Cy Frank, Gillian Hawker and Tom Noseworthy)
 |

*Milbank Quarterly*

December 2015 (Volume 93, Issue 4)

|  |  |
| --- | --- |
| URL | <http://www.milbank.org/the-milbank-quarterly/current-issue> |
| Notes | A new issue of the *Milbank Quarterly* hasbeen published. Articles in this issue of the *Milbank Quarterly* include:* Shelter in the Storm: **Health Care Systems and Climate Change** (Georges C Benjamin)
* The US Supreme Court and the **Future of Reproductive Health** (Sara Rosenbaum)
* Big **Pharma Profits** and the **Public Loses** (Catherine D DeAngelis)
* **Global Health Security** After Ebola: Four Global Commissions (Lawrence O Gostin)
* **Robotic Surgery**: An Example of When Newer Is Not Always Better but Clearly More Expensive (Gail R Wilensky)
* Injurious **Inequalities** (David Rosner)
* Knowledge of and Attitudes Toward Evidence-Based Guidelines for and Against **Clinical Preventive Services**: Results from a National Survey (Paula M Lantz, W Douglas Evans, Holly Mead, C Alvarez, and L Stewart)
* Differing Strategies to Meet **Information-Sharing Needs**: Publicly Supported Community Health Information Exchanges Versus Health Systems’ Enterprise Health Information Exchanges (JR Vest and B A Kash)
* Strategic Planning in **Population Health and Public Health Practice**: A Call to Action for Higher Education (Charles Phelps, Guruprasad Madhavan, Rino Rappuoli, Scott Levin, Edward Shortliffe, and R Colwell)
* Evidence and the Politics of **Deimplementation**: The Rise and Decline of the “Counseling and Testing” Paradigm for HIV Prevention at the US Centers for Disease Control and Prevention (David Merritt Johns, Ronald Bayer, and Amy L Fairchild)
* **Community-Academic Partnerships**: A Systematic Review of the State of the Literature and Recommendations for Future Research (Amy Drahota, Rosemary D Meza, Brigitte Brikho, Meghan Naaf, Jasper A Estabillo, Emily D Gomez, S F Vejnoska, S Dufek, A C Stahmer, and G A Aarons)
 |

*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:* Editorial: **Premature closure**? Not so fast (Gurpreet Dhaliwal)
* **Information transfer** in multidisciplinary **operating room teams**: a simulation-based observational study (David Cumin, Carmen Skilton, Jennifer Weller)
 |

**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:

* *Noninvasive Treatments for* ***Low Back Pain*** <https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2192>
* *Management of* ***Gout***<https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2196>
* ***Lung Cancer Screening*** *Decision Aid and Tools for Health Care Professionals and Patients* <https://www.effectivehealthcare.ahrq.gov/tools-and-resources/patient-decision-aids/lung-cancer-screening/>

*[USA] CDC Guideline for Prescribing Opioids for Chronic Pain*

[http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1er.htm](http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1er.htm?s_cid=rr6501e1er_e)

The US Centers for Disease Control and Prevention have released this guideline providing recommendations for primary care providers who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses

1. when to initiate or continue opioids for chronic pain;
2. opioid selection, dosage, duration, follow-up, and discontinuation; and
3. assessing risk and addressing harms of opioid use.

The guideline is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including abuse, dependence, overdose, and death.

**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.