



## On the Radar

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### On the Radar

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### *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures*

Medical Board of Australia

Melbourne: Medical Board of Australia; 2016. p. 6.

URL	<a href="http://www.medicalboard.gov.au/News/2016-05-09-media-statement.aspx">http://www.medicalboard.gov.au/News/2016-05-09-media-statement.aspx</a>
Notes	<p>A recent issue of <i>On the Radar</i> referred to the UK's Royal College of Surgeons (RCS) and General Medical Council (GMC) simultaneous release of guidance around cosmetic surgery. Now the Medical Board of Australia has issued guidelines for medical practitioners who perform cosmetic medical and surgical procedures. The guidelines apply to all medical practitioners, including specialist plastic surgeons, cosmetic surgeons and cosmetic physicians regardless of their qualifications.</p> <p>The new guidelines take effect on 1 October 2016 and require:</p> <ul style="list-style-type: none"> <li>• a seven-day cooling off period for all adults before major procedures</li> <li>• a three-month cooling off period before major procedures for all under 18s and a mandatory evaluation by a registered psychologist, general practitioner or psychiatrist</li> <li>• a seven day cooling off period before minor procedures for all under 18s, and when clinically indicated, evaluation by a registered psychologist, general practitioner or psychiatrist</li> </ul>

	<ul style="list-style-type: none"> <li>• the treating medical practitioner to take explicit responsibility for post-operative patient care and for making sure there are emergency facilities when they are using sedation, anaesthesia or analgesia</li> <li>• a mandatory consultation before a medical practitioner prescribes schedule 4 (prescription only) cosmetic injectables and</li> <li>• medical practitioners to provide patients with detailed written information about costs.</li> </ul> <p>The guidelines provide explicit guidance on patient assessment and informed consent, and require doctors to provide clear information to consumers about risks and possible complications.</p>
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## Reports

*A different ending: Addressing inequalities in end of life care. Overview Report*  
 Care Quality Commission  
 Newcastle Upon Tyne: Care Quality Commission; 2016. p. 44.

*A different ending: Addressing inequalities in end of life care. Good practice case studies*  
 Care Quality Commission  
 Newcastle Upon Tyne: Care Quality Commission; 2016. p. 16.

URL	<a href="http://www.cqc.org.uk/content/different-ending-end-life-care-review">http://www.cqc.org.uk/content/different-ending-end-life-care-review</a>
Notes	This review of end of life care in the UK found that was/is variation in the quality of care at the end of life as providers do not always understand or fully consider their needs. The review identified examples of good practice, but also found that action is needed to make sure everyone has the same access to high quality, personalised care at the end of their lives, regardless of their diagnosis, age, ethnic background, sexual orientation, gender identity, disability or social circumstances. Along with the report is a short collection of case studies and a series of ‘people’s experiences’ describing some of the experiences of particular groups in society, including people with specific health conditions (including cancer, mental health conditions), older people, homeless people, people from minorities, LGBTI people, people with learning disabilities, etc.

For information on the Commission’s work on end of life care, including the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*, see <http://www.safetyandquality.gov.au/our-work/end-of-life-care-in-acute-hospitals/>

## Journal articles

*Medication Safety Systems and the Important Role of Pharmacists*  
 Mansur JM  
 Drugs & Aging. 2016;33(3):213-21.

DOI	<a href="http://dx.doi.org/10.1007/s40266-016-0358-1">http://dx.doi.org/10.1007/s40266-016-0358-1</a>
Notes	Review article reiterating the centrality of pharmacists to medication safety. As is noted in the abstract, “The pharmacist is uniquely trained to be able to impact medication safety at the individual patient level through medication management skills that are part of the clinical pharmacist’s role, but also to analyze the performance of medication processes and to lead redesign efforts to mitigate drug-related outcomes that may cause harm.”

	The paper discusses an approach to medication safety systems that helps to ensure safety along the medication use process the ways pharmacists contribute to safety, by providing “a blueprint for creating a foundation for medication safety programs within healthcare organizations”.
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For information on the Commission’s work on medication safety, see <http://www.safetyandquality.gov.au/our-work/medication-safety/>

*The interplay between teamwork, clinicians’ emotional exhaustion, and clinician-rated patient safety: a longitudinal study*

Welp A, Meier LL, Manser T

Critical Care. 2016;20(1):1-10.

DOI	<a href="http://dx.doi.org/10.1186/s13054-016-1282-9">http://dx.doi.org/10.1186/s13054-016-1282-9</a>
Notes	<p>That our performance degrades when we are emotionally exhausted, fatigued or depressed is recognisable to all of us. But for clinicians it can pose a safety risk for their patients.</p> <p>This paper reports on a study that asked 2100 2100 nurses and physicians working in 55 intensive care units about interpersonal and cognitive-behavioural aspects of teamwork, emotional exhaustion, and patient safety at three points with a 3-month lag. The study led the authors to conclude “interrelations between teamwork, clinician burnout, and clinician-rated patient safety unfold over time. Interpersonal and cognitive-behavioral teamwork play specific roles in a process leading from clinician emotional exhaustion to decreased clinician-rated patient safety. Emotionally exhausted clinicians are less able to engage in positive interpersonal teamwork, which might set in motion a vicious cycle: negative interpersonal team interactions negatively affect cognitive-behavioral teamwork and vice versa. Ultimately, ineffective cognitive-behavioral teamwork negatively impacts clinician-rated patient safety. Thus, reducing clinician emotional exhaustion is an important prerequisite of managing teamwork and patient safety. From a practical point of view, team-based interventions targeting patient safety are less likely to be effective when clinicians are emotionally exhausted.”</p>

*Use of national burden to define operative emergency general surgery*

Scott JW, Olufajo OA, Brat GA, Rose JA, Zogg CK, Haider AH, et al.

JAMA Surgery. 2016:e160480.

DOI	<a href="http://dx.doi.org/10.1001/jamasurg.2016.0480">http://dx.doi.org/10.1001/jamasurg.2016.0480</a>
Notes	<p>Following a recent item in <i>On the Radar</i> on <b>emergency general surgery (EGS)</b> in the UK is this American study that used national (US) data to look into the issue there. The study identified 421 476 patient encounters associated with operative EGS and found that overall <b>mortality rate was 1.23%</b>, the <b>complication rate was 15.0%</b>, and mean cost per admission was USD13 241.</p> <p><b>Seven particular procedures</b> “collectively accounted for <b>80.0% of procedures, 80.3% of deaths, 78.9% of complications</b>, and 80.2% of inpatient costs nationwide.” The seven included partial colectomy, small-bowel resection, cholecystectomy, operative management of peptic ulcer disease, lysis of peritoneal adhesions, appendectomy, and laparotomy. The authors suggest that “National quality benchmarks and cost reduction efforts should focus on these common, complicated, and costly EGS procedures.”</p>

*System level action required for wide-scale improvement in quality of primary healthcare: synthesis of feedback from an interactive process to promote dissemination and use of aggregated quality of care data*

Bailie J, Laycock A, Matthews V, Bailie RS

Frontiers in Public Health. 2016;4.

DOI	<a href="http://dx.doi.org/10.3389/fpubh.2016.00086">http://dx.doi.org/10.3389/fpubh.2016.00086</a>
Notes	Paper reporting on a study into perceived barriers and enablers to addressing gaps in Australian Aboriginal and Torres Strait Islander chronic illness care and child health, and to identify key drivers for improvement. The authors 5 primary drivers and 11 secondary drivers of high-quality care, and also identified strategies to address barriers and enablers for improving care. The perceived <b>barriers</b> to addressing gaps in care included both <b>health system and staff attributes</b> . Primary <b>drivers</b> were: <b>staff capability</b> to deliver high-quality care; availability and use of <b>clinical information systems</b> and <b>decision support tools</b> ; embedding of <b>quality improvement processes</b> and <b>data-driven decision-making</b> ; appropriate and effective <b>recruitment and retention</b> of staff; and community capacity, <b>engagement</b> and mobilization for health. Suggested strategies included mechanisms for increasing clinical supervision and support, staff retention, reorientation of service delivery, use of information systems and community health literacy.

*Simulation-based training: the missing link to lastingly improved patient safety and health?*

Milerder LP, Schmölzer GM

Postgraduate Medical Journal. 2016.

DOI	<a href="http://dx.doi.org/10.1136/postgradmedj-2015-133732">http://dx.doi.org/10.1136/postgradmedj-2015-133732</a>
Notes	Commentary piece discussing how simulation based training (SBT) may contribute to enhancing safety through the development of individual and team behaviours and skills

*The promise of big data: Improving patient safety and nursing practice*

Linnen D

Nursing. 2016;46(5):28-34.

DOI	<a href="http://dx.doi.org/10.1097/01.NURSE.0000482256.71143.09">http://dx.doi.org/10.1097/01.NURSE.0000482256.71143.09</a> <a href="http://pdfs.journals.lww.com/nursing/9000/00000/The_promise_of_big_data_Improving_patient_safety.99790.pdf">http://pdfs.journals.lww.com/nursing/9000/00000/The_promise_of_big_data_Improving_patient_safety.99790.pdf</a>
Notes	The concept – and alleged potential – of ‘big data’ is rather pervasive. But it is not always clear just quite how this may be operationalised and what it may mean. Moving from the nebulous to the more concrete is this piece by a ‘nursing informatics specialist’ that reflects on how big data can benefit nursing, including enhancing patient safety and nursing practice. This past week has also seen the Senate Select Committee on Health release its latest report, <i>Big health data: Australia's big potential</i> . The report is available at <a href="http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Sixth_Interim_Report">www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Sixth_Interim_Report</a>

*Establishing a process for conducting cross-jurisdictional record linkage in Australia*

Moore HC, Guiver T, Woollacott A, de Klerk N, Gidding HF

Australian and New Zealand Journal of Public Health. 2016;40(2):159-64.

DOI	<a href="http://dx.doi.org/10.1111/1753-6405.12481">http://dx.doi.org/10.1111/1753-6405.12481</a>
Notes	For some time the idea of data linkage has been held out as a means to aggregate

	<p>and unleash the potential of the many data collections we already have in Australia. A number of data linkage entities and projects have been developed. The authors of this paper sought to “describe the realities of conducting a cross-jurisdictional data linkage project involving state and Australian Government-based data collections to inform future national data linkage programs of work.” They outline the processes involved in conducting a Proof of Concept data linkage project including the implementation of national data integration principles, data custodian and ethical approval requirements, and establishment of data flows which saw the approval process taking more than 2 years and involving nine approval and regulatory bodies to allow data to be linked across 12 datasets involving three data linkage centres. Such a tale may seem rather to dissuade others but the authors claim that “positive outcomes were realised, primarily the development of strong collaborations across key stakeholder groups including community engagement” and that they have “identified several recommendations and enhancements to ...further streamline the process for data linkage studies involving Australian Government data.”</p>
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*Journal for Healthcare Quality*  
 May/June 2016, Volume 38, Issue 3

URL	<a href="http://journals.lww.com/jhqonline/toc/2016/05000">http://journals.lww.com/jhqonline/toc/2016/05000</a>
Notes	<p>A new issue of the <i>Journal for Healthcare Quality</i> has been published. Articles in this issue of the <i>Journal for Healthcare Quality</i> include:</p> <ul style="list-style-type: none"> <li>• <b>Preventable Readmission Risk Factors</b> for Patients With Chronic Conditions (Rico, Florentino; Liu, Yazhuo; Martinez, Diego A.; Huang, Shuai; Zayas-Castro, José L.; Fabri, Peter J.)</li> <li>• Reducing Racial Disparities in <b>Breast Cancer Survivors' Ratings of Quality Cancer Care</b>: The Enduring Impact of Trust (Sheppard, Vanessa B.; Hurtado-de-Mendoza, Alejandra; Talley, Costellia H.; Zhang, Yihong; Cabling, Mark L.; Makambi, Kepher H.)</li> <li>• Is It Feasible to Use <b>Electronic Health Records for Quality Measurement</b> of Adolescent Care? (Gardner, William; Morton, Suzanne; Tinoco, Aldo; Scholle, Sarah Hudson; Canan, Benjamin D.; Kelleher, K J.)</li> <li>• <b>Family Physicians' Quality Interventions and Performance Improvement</b> for Hypertension through Maintenance of Certification (Peterson, Lars E.; Blackburn, Brenna; Puffer, James C.; Phillips, R L Jr)</li> <li>• <b>Measuring Hospital-Wide Mortality</b>—Pitfalls and Potential (Mackenzie, Simon J.; Goldmann, Don A.; Perla, Rocco J.; Parry, Gareth J.)</li> <li>• Routinization of <b>HIV Testing</b> in an Inpatient Setting: A Systematic Process for Organizational Change (Mignano, Jamie L.; Miner, Lucy; Cafeo, Christina; Spencer, Derek E.; Gulati, Mangla; Brown, Travis; Borkoski, Ruth; Gibson-Magri, Kate; Canzoniero, Jenna; Gottlieb, Jonathan E.; Rowen, Lisa)</li> </ul>

*BMJ Quality and Safety* online first articles

URL	<a href="http://qualitysafety.bmj.com/content/early/recent">http://qualitysafety.bmj.com/content/early/recent</a>
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• Opportunities to improve <b>clinical summaries</b> for patients at <b>hospital discharge</b> (Erin Sarzynski, Hamza Hashmi, Jeevarathna Subramanian, Laurie Fitzpatrick, Molly Polverento, M Simmons, K Brooks, C Given)</li> <li>• Editorial: What is the potential of <b>patient shadowing</b> as a patient-centred</li> </ul>

	method? (Elisa Giulia Liberati)
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*International Journal for Quality in Health Care* online first articles

URL	<a href="http://intqhc.oxfordjournals.org/content/early/recent?papetoc">http://intqhc.oxfordjournals.org/content/early/recent?papetoc</a>
Notes	<p><i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• Do <b>integrated care structures</b> foster processes of integration? A quasi-experimental study in <b>frail elderly care</b> from the professional perspective (Benjamin Janse, Robbert Huijsman, Ruben Dennis Maurice de Kuyper, Isabelle Natalina Fabbriotti)</li> </ul>

## Online resources

[UK] NICE Guidelines and Quality Standards

<http://www.nice.org.uk>

The UK’s National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest updates are:

- NICE Clinical guideline CG42 **Dementia: supporting people with dementia and their carers in health and social care** <https://www.nice.org.uk/guidance/cg42>
- NICE Clinical guideline CG98 **Jaundice in newborn babies under 28 days** <https://www.nice.org.uk/guidance/cg98>

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