



On the Radar

Issue 280
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Six years of On the Radar

The first issue of *On the Radar* appeared on 5 July 2010. Initially produced as an internal resource for Commission personnel it quickly developed an audience beyond the Commission. Six years and 280 issues later the intent remains much the same – a succinct synopsis of recent material relevant to safety and quality in health care. I hope you have found it useful and relevant and continue to do so.

Dr Niall Johnson
Editor

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.

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On the Radar

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Journal articles

Non-beneficial treatments in hospital at the end of life: a systematic review on extent of the problem
M Cardona-Morrell, JCH Kim, RM Turner, M Anstey, IA Mitchell, K Hillman
International Journal for Quality in Health Care. 2016 [epub].

DOI	http://dx.doi.org/10.1093/intqhc/mzw060
Notes	Paper reporting on a literature review of 38 English-language studies from ten countries, including two from Australia, assessing objective dimensions of non-beneficial medical or surgical diagnostic, therapeutic or non-palliative procedures administered to older adults at the end of life.

	<p>On average, across the studies, 33–38% of patients near the end of life received non-beneficial treatment. For this study, the expression “non-beneficial treatment” indicates a treatment that was administered with little or no hope of it having any effect.</p> <p>The most commonly reported non-beneficial treatments were admissions to ICU for patients with advanced incurable disease or pre-existing limitations of treatment; administration of CPR for terminal patients with or without prior limitation of treatment orders; and initiation or continuation of chemotherapy in the last 14 days to 1 month of life. The study suggests that these outcomes could be adopted as indicators of non-beneficial care and monitored routinely to inform hospital practice.</p> <p>The perception of death as treatment failure continues to drive the medicalization of death, prolongation of patient suffering and prevent high-quality end-of-life care worldwide.</p> <p>A co-author of this study, Imogen Mitchell, is also clinical advisor for the Commission’s end-of-life care work.</p>
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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/endoflifecare>

Effectiveness of insertion and maintenance bundles to prevent central-line-associated bloodstream infections in critically ill patients of all ages: a systematic review and meta-analysis
Ista E, van der Hoven B, Kornelisse RF, van der Starre C, Vos MC, Boersma E, et al
The Lancet Infectious Diseases. 2016;16(6):724-34.

DOI	http://dx.doi.org/10.1016/S1473-3099(15)00409-0
Notes	Paper reporting on a review and meta-analysis examining the effectiveness of central-line bundles (insertion or maintenance or both) to prevent central-line-associated bloodstream infections (CLABSIs) infections. The review of 79 studies fed into a meta-analysis finding “the incidence of infections decreased significantly from median 6·4 per 1000 catheter-days (IQR 3·8–10·9) to 2·5 per 1000 catheter-days (1·4–4·8) after implementation of bundles (IRR 0·44, 95% CI 0·39–0·50, p<0·0001; I ² =89%).”

For information on the Commission’s work on health care associated infection, see www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Extended opening hours and patient experience of general practice in England: multilevel regression analysis of a national patient survey (Thomas E Cowling, Matthew Harris, Azeem Majeed) • Opening up to Open Notes and adding the patient to the team (Caroline Lubick Goldzweig) • Implementation of a structured hospital-wide morbidity and mortality rounds model (Edmund S H Kwok, Lisa A Calder, Emily Barlow-Krelina, Craig Mackie, Andrew J E Seely, A A Cwinn, J R Worthington, J R Frank)

International Journal for Quality in Health Care online first articles

URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
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">• Non-beneficial treatments in hospital at the end of life: a systematic review on extent of the problem (M Cardona-Morrell, JCH Kim, RM Turner, M Anstey, IA Mitchell, K Hillman)

Online resources

Clinical Communiqué

Victorian Institute of Forensic Medicine

Volume 3 Issue 2 June 2016

<http://www.vifmcommuniques.org/volume-3-issue-2-june-2016/>

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 focuses on the risks associated with **central venous catheter insertions**. This edition examines three cases where complications arose following central venous catheter insertion. One catheter migrated too far, another catheter went the wrong way, and the last caused damage to its adjacent structures. Each of these are recognised albeit uncommon complications of central venous catheters, yet the cases continue to illustrate the many difficulties in the recognition of catheter misplacement.

[USA] *Always Events Toolkit*

<http://www.ihl.org/resources/Pages/Tools/Always-Events-Toolkit.aspx>

The US Institute for Health Improvement (IHI) has produced this toolkit to help promote the concept of ‘Always Events’ (as opposed to ‘never events’ that are events that should never happen to patients). According to the IHI, Always Events “are aspects of the care experience that are so important to patients and their care partners that health care providers must aim to perform them consistently for every individual, every time.” The Always Events Toolkit offers guidance for health care leaders and point-of-care teams in partnering with patients and their care partners to co-design, reliably implement, and sustain and spread Always Events to dramatically improve the care experience.

[USA] *Patient Safety Primers*

<https://psnet.ahrq.gov/primers/>

The Patient Safety Primers from the (US) Agency for Healthcare Research and Quality (AHRQ) discuss key concepts in patient safety. Each primer defines a topic, offers background information on its epidemiology and context, and provides links to relevant materials.

- *Learning Through Debriefing* – Debriefing is an important strategy for learning from defects and for improving performance. It is one of the central learning tools in simulation and is also recommended after a real-life emergency response.

<https://psnet.ahrq.gov/primers/primer/36>

[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 Quality Standard QS122 **Bronchiolitis in children**
<https://www.nice.org.uk/guidance/qs122>
- NICE Quality Standard QS123 **Home care for older people**
<https://www.nice.org.uk/guidance/qs123>
- NICE Quality Standard QS124 **Suspected cancer** <https://www.nice.org.uk/guidance/qs124>

[UK] S.A.F.E Resource Pack

<http://www.rcpch.ac.uk/safe-resource/>

The (UK) Royal College of Paediatrics and Child Health have developed a new set of quality improvement tools as part of the S.A.F.E. programme, a Health Foundation funded project. They aim to improve communication, build a safety-based culture and deliver better health outcomes for children and young people.

S.A.F.E stands for Situation Awareness For Everyone. The RCPCH has developed this programme, with two main aims:

- to provide an evidence base to support the concept that improved situation awareness leads to improved outcomes for paediatric patients in acute settings
- to support the spread of improved situation awareness by providing a resource that hospitals can use to improve it locally.

The resource pack includes an introduction, plus 6 sections each with information, tools and worked examples. The sections are:

- Quality improvement
- Patient safety culture
- Structured communication
- Recognising deterioration
- The 'huddle'
- Evaluation and spread.

[UK] Understanding Children's Heart Surgery Outcomes

<http://childrenshearturgery.info/>

Communicating risk and interpreting hospital and surgeon outcome statistics is sometimes difficult. This website has been developed to help people make sense of published survival data about children's heart surgery in the UK and Ireland. The site hopes to assist in:

- understanding how the NHS monitors children's heart surgery
- exploring what survival rates can and can't tell you
- exploring published data for hospitals in the UK and Ireland.

An editorial in *The Lancet* ([http://dx.doi.org/10.1016/S0140-6736\(16\)30888-1](http://dx.doi.org/10.1016/S0140-6736(16)30888-1)) welcomed this move and suggests that "Many more areas of medicine requiring risk communication should take this initiative as a long overdue and most welcome example."

[UK] National Institute for Health Research

<https://discover.dc.nihr.ac.uk/portal/home>

The UK's National Institute for Health Research (NIHR) Dissemination Centre has released the latest 'Signals' research summaries. This latest release includes:

- Local steroid injections may help **sciatica**
- **Telehealth** may help some people be more active after a **heart attack**
- How to improve '**do not resuscitate**' decisions in England
- Topical steroids better than vitamin D for treating **scalp psoriasis**
- An anticoagulant, bivalirudin, may not be safer than the alternative, heparin, when **unblocking arteries** in the heart
- Education and the offer of support help GPs spot **early signs of psychosis**
- Dealing with a **measles outbreak** cost 20 times that of increasing **vaccination** cover
- **Pain on injection** of a widely used **anaesthetic** may be reduced if a common anti-sickness drug is given first
- A scan may help decide if surgery is required as follow-on treatment for **head and neck cancer**
- Links between **antipsychotics in pregnancy** and harmful outcomes for baby may be influenced by mother's lifestyle

[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:

- **Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews**
<https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2254>
- **Diagnosis and Management of Infantile Hemangioma**
For Clinicians: *Management of Infantile Hemangioma*
<https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2245>
For Consumers: *Treating Infantile Hemangiomas in Children*
<https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2246>
For Policymakers: *Management of Infantile Hemangioma*
<https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2248>

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