



## On the Radar

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### On the Radar

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

Contributors: Niall Johnson, Amanda Mulcahy

### Books

*Healthcare Reform, Quality and Safety: Perspectives, Participants, Partnerships and Prospects in 30 Countries*  
Braithwaite J, Matsuyama Y, Mannion R, Johnson J, editors  
Farnham: Ashgate; 2015.

URL	<a href="https://www.routledge.com/Healthcare-Reform-Quality-and-Safety-Perspectives-Participants-Partnerships/Braithwaite-Matsuyama-Johnson/p/book/9781472451408">https://www.routledge.com/Healthcare-Reform-Quality-and-Safety-Perspectives-Participants-Partnerships/Braithwaite-Matsuyama-Johnson/p/book/9781472451408</a>
Notes	This edited collection brings together contributions on the experiences of healthcare reform in 30 countries in low, middle and high income settings. The various chapters seek to analyse the impact of health-reform initiatives on the quality and safety of care. They note that popular reforms in less well-off countries include boosting equity, providing infrastructure, and reducing mortality and morbidity in maternal and child health, whereas countries with higher GDP per capita have had a on new IT systems or trialling innovative funding models. Countries are also embracing ways to enhance quality of care and keep patients safe, via mechanisms such as accreditation, clinical guidelines and hand hygiene campaigns. The authors, particularly the editors, call for more widespread and rigorous use of evidence and evaluation to guide policy in healthcare, as noted in a paper drawing on this book appeared in the <i>International Journal for Quality in Health Care</i> recently ( <a href="http://dx.doi.org/10.1093/intqhc/mzw113">http://dx.doi.org/10.1093/intqhc/mzw113</a> ), “all reformers and advocates of better-quality of care should include well-designed evaluation in their initiatives. Too often, improvement is assumed, not measured. That is perhaps the key message”.

## Reports

*Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*  
 Review of Hospital Safety and Quality Assurance in Victoria  
 Melbourne: State of Victoria, Department of Health and Human Services; 2016. p. 309.  
 TRIM D16-36558

*Better, Safer Care: Delivering a world-leading healthcare system*  
 Victorian Government  
 Melbourne: State of Victoria, Department of Health and Human Services; 2016. p. 8.  
 TRIM D16-36559

URL	<a href="https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review">https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review</a>
Notes	<p>The Victorian government commissioned a review following the discovery of a cluster of tragically avoidable perinatal deaths at Djerriwarrh Health Services. The review was a detailed and extensive analysis into how the Department of Health &amp; Human Services oversees and supports quality and safety of care across the Victorian hospital system. The Review made an extensive list of recommendations, including a number of recommendations calling for structural reforms.</p> <p>The lengthy report of the review, <i>Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care. Report of the Review of Hospital Safety and Quality Assurance in Victoria</i> and the Victorian government's response, <i>Better, Safer Care: Delivering a world-leading healthcare system</i>, are both available from <a href="https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review">https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review</a></p> <p><i>Better, Safer Care, Delivering a world-leading healthcare system</i> describes the response to the Review's recommendations under four areas of emphasis:</p> <ul style="list-style-type: none"> <li>• Setting the goal that no one is harmed in our hospitals</li> <li>• Supporting strong leadership in hospital governance</li> <li>• Sharing excellence across the health system</li> <li>• Collecting data about patients' experiences and feeding that back across the system to improve patient care.</li> </ul> <p>As part of this response, new organisations will be established to simplify the current system and better respond to the needs of patients and healthcare workers:</p> <ul style="list-style-type: none"> <li>• <b>Safer Care Victoria</b> will work with health services to monitor and improve the quality and safety of care delivered across the health system, with the goal of achieving zero avoidable patient harm.</li> <li>• A new <b>health information agency</b> will analyse and share information across the system</li> <li>• The <b>Victorian Clinical Council</b> will provide clinical expertise to the Government, the department and health services on how to make the system safer and provide better care to all</li> <li>• The <b>Ministerial Board Advisory Committee</b> will ensure hospital and health service boards have the right mix of skills, knowledge and experience to strengthen local governance and decision making.</li> </ul>

*New care models: Emerging innovations in governance and organisational form*

Collins B

London: The King's Fund; 2016. 66 p.

URL	<a href="http://www.kingsfund.org.uk/publications/new-care-models">http://www.kingsfund.org.uk/publications/new-care-models</a>
Notes	<p>The UK charity The King’s Fund has released this report that examines the experience of a number of ‘vanguard sites’ that were selected to develop the multispecialty community provider (MCP) and primary and acute care system (PACS) new care models so as to pool budgets and integrate services more closely. The report looks at the different approaches being taken by five sites to contracting, governance and other organisational infrastructure.</p> <p>The policy implications identified include:</p> <ul style="list-style-type: none"> <li>• <b>Successful care models</b> are based on <b>trusting relationships</b> and <b>collaborative organisational cultures</b>, often developed over time, which enable clinical teams as well as organisational leaders to work together effectively. The challenge is how to build clinical collaboration and system leadership in a statutory context that was not designed for this purpose.</li> <li>• The vanguards have shown just how important it is to build collaborative relationships between the organisations and leaders involved in developing new care models. Delivering results will take time, but there needs to be a focus on the relational elements of new care models as well as the technical elements.</li> </ul>

## Journal articles

*Fostering transparency in outcomes, quality, safety, and costs*

Austin J, McGlynn EA, Pronovost PJ

Journal of the American Medical Association. 2016 [epub].

DOI	<a href="http://dx.doi.org/10.1001/jama.2016.14039">http://dx.doi.org/10.1001/jama.2016.14039</a>
Notes	<p>In this Viewpoint piece in <i>JAMA</i>, the authors call for greater transparency and reporting in health care and identify a range of benefits that such transparency may bring. They make recommendations about how “Policy makers can help enhance the effectiveness of performance measurement and reporting in a number of ways”, including:</p> <ul style="list-style-type: none"> <li>• Creating an independent health data standard-setting body</li> <li>• Building the science of performance measures</li> <li>• Improving the communication of data to patients.</li> </ul>

*Clinician-identified problems and solutions for delayed diagnosis in primary care: a PRIORITIZE study*

Car LT, Papachristou N, Bull A, Majeed A, Gallagher J, El-Khatib M, et al

BMC Family Practice. 2016;17(1):131.

DOI	<a href="http://dx.doi.org/10.1186/s12875-016-0530-z">http://dx.doi.org/10.1186/s12875-016-0530-z</a>
Notes	<p>Issues around diagnosis have been attracting much attention of late. This article looked at the specific issue of delayed diagnosis in primary care. The study surveyed 500 primary care clinicians in London to garner their views on barriers and solutions to delays in diagnosis. From these surveys 33 discrete problems associated with delays in diagnosis and 27 possible solutions were identified. The main issues identified included the inability to meet <b>patients' care needs</b> and <b>inadequate communication</b> between secondary and primary care. The solutions suggested included improving <b>training</b> of primary care doctors and <b>enhancing communication</b> among providers and between providers and patients, especially around <b>test results</b>.</p>

*Viewing Prevention of Catheter-Associated Urinary Tract Infection as a System: Using Systems Engineering and Human Factors Engineering in a Quality Improvement Project in an Academic Medical Center*

Rhee C, Phelps ME, Meyer B, Reed WG

Joint Commission Journal on Quality and Patient Safety. 2016;42(10):447-71.

URL	<a href="http://www.ingentaconnect.com/contentone/jcaho/jcqs/2016/00000042/00000010/art00003">http://www.ingentaconnect.com/contentone/jcaho/jcqs/2016/00000042/00000010/art00003</a>
Notes	Paper describing how an approach combining human factors and systems engineering was used to reduce catheter-associated urinary tract infections ( <b>CAUTI</b> ) at US academic medical centre/hospital. The authors report that these efforts were associated with a marked reduction (81.5%) in CAUTI at the end of the 3-year project compared to the pre-intervention period.

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

[www.safetyandquality.gov.au/our-work/healthcare-associated-infection/](http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/)

*Communication and general concern criterion prior to activation of the rapid response team: a grounded theory*

Martland J, Chamberlain D, Hutton A, Smigielski M

Australian Health Review. 2016;40(5):477-83.

DOI	<a href="http://dx.doi.org/10.1071/AH15123">http://dx.doi.org/10.1071/AH15123</a>
Notes	This study used focus groups to explore issues around clinical communication and how it relates to activation of a rapid response team. It references the Commission’s recognising and responding to clinical deterioration program. The authors conclude that poor communication between clinicians can increase staff anxiety levels and concern.

For information about the Commission’s work on recognising and responding to clinical deterioration,

see <https://www.safetyandquality.gov.au/our-work/recognising-and-responding-to-clinical-deterioration/>

*A framework for administrative claim data to explore healthcare coordination and collaboration*

Uddin S, Kelaher M, Srinivasan U

Australian Health Review. 2016;40(5):500-10.

DOI	<a href="http://dx.doi.org/10.1071/AH15058">http://dx.doi.org/10.1071/AH15058</a>
Notes	This study describes a new research framework that can be applied to electronic health insurance claim databases, to show networking between services for patients. It encourages services to consider using claims data to evidence coordination and collaboration by examining the interactions between services. It is a novel framework for using healthcare data for improved collaboration between services.

*Getting It Right for Patient Safety: Specimen Collection Process Improvement From Operating Room to Pathology*

D’Angelo R, Mejabi O

American Journal of Clinical Pathology. 2016;146(1):8-17.

DOI	<a href="http://dx.doi.org/10.1093/ajcp/aqw057">http://dx.doi.org/10.1093/ajcp/aqw057</a>
Notes	Paper describing how one US hospital devised and implemented interventions for streamlining, standardizing, and mistake proofing the processes and eliminating waste and inefficiency to identify and reduce the risk of specimen labelling defects.

URL	<a href="http://www.publish.csiro.au/ah/issue/7977">http://www.publish.csiro.au/ah/issue/7977</a>
Notes	<p>A new issue of <i>Australian Health Review</i> has been published. Articles in this issue of <i>Australian Health Review</i> include:</p> <ul style="list-style-type: none"> <li>• Communication and general concern criterion prior to activation of the <b>rapid response team</b>: a grounded theory (Jarrad Martland, Diane Chamberlain, Alison Hutton and Michael Smigielski)</li> <li>• <b>Continuity of care</b> in the <b>post partum</b> period: general practitioner experiences with communication (Wendy E Brodribb, Benjamin L Mitchell and Mieke L Van Driel)</li> <li>• <b>Health service utilisation</b> by people living with <b>chronic non-cancer pain</b>: findings from the Pain and Opioids IN Treatment (POINT) study (Suzanne Nielsen, Gabrielle Campbell, Amy Peacock, Kimberly Smith, Raimondo Bruno, Wayne Hall, Milton Cohen and Louisa Degenhardt)</li> <li>• A framework for <b>administrative claim data</b> to explore <b>healthcare coordination</b> and collaboration (Shahadat Uddin, Margaret Kelaher and Uma Srinivasan)</li> <li>• Trends and disparities in <b>sepsis hospitalisations</b> in Victoria, Australia (Timothy Ore)</li> <li>• Comparison of <b>medication policies</b> to guide <b>nursing practice</b> across seven Victorian health services (Mariann Fossum, Lee Hughes, Elizabeth Manias, Paul Bennett, Trisha Dunning, Alison Hutchinson, Julie Considine, Mari Botti, Maxine M Duke and Tracey Bucknall)</li> <li>• Preferred strategies for <b>workforce development</b>: feedback from aged care workers (Sarojini Choy and Amanda Henderson)</li> <li>• <b>Nursing staff work patterns</b> in a residential aged care home: a time–motion study (Siyu Qian, Ping Yu and David Hailey)</li> <li>• Becoming a <b>clinician researcher</b> in allied health (Desley Harvey, David Plummer, Ilsa Nielsen, Robyn Adams and Tilley Pain)</li> <li>• Flying blind: trying to find solutions to <b>Indigenous oral health</b> (Andrea M de Silva, Jacqueline Martin-Kerry, Alexandra Geale and Deborah Cole)</li> <li>• The role of technology in Australian <b>youth mental health</b> reform (Jane M Burns, Emma Birrell, Marie Bismark, Jane Pirkis, Tracey A Davenport, Ian B Hickie, Melissa K Weinberg and Louise A Ellis)</li> <li>• Contribution of <b>mobile health applications</b> to <b>self-management</b> by consumers: review of published evidence (Kevin Anderson and Lynne M Emmerton)</li> </ul>

URL	<a href="http://www.longwoods.com/publications/healthcarepapers/24655">http://www.longwoods.com/publications/healthcarepapers/24655</a>
Notes	<p>A new issue of <i>HealthcarePapers</i> has been published with the theme ‘Regionalization: What Have We Learned?’. Articles in this issue of <i>HealthcarePapers</i> include:</p> <ul style="list-style-type: none"> <li>• <b>Regionalization Does Not Equal Integration</b> (Adalsteinn D Brown, Peter W T. Pisters and C David Naylor)</li> <li>• <b>Regionalization: What Have We Learned?</b> (Gregory P Marchildon)</li> <li>• What Can We Learn from the <b>UK’s</b> “Natural Experiments” of the <b>Benefits of Regions?</b> (Gwyn Bevan)</li> <li>• <b>Regionalization Lessons from Denmark</b> (Karsten Vrangbaek)</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Health System Regionalization</b> – the <b>New Zealand</b> Experience (Tim Tenbenschel)</li> <li>• <b>Transforming Regions into High-Performing Health Systems</b> Toward the Triple Aim of Better Health, Better Care and Better Value for Canadians (Yves Bergevin, Bettina Habib, Keesa Elicksen-Jensen, Stephen Samis, Jean Rochon, Jean-Louis Denis and Denis Roy)</li> <li>• <b>Regionalization</b> as One Manifestation of the Pursuit of the Holy Grail (Stephen Duckett)</li> <li>• The <b>Politics of Regionalization</b> (Katherine Fierlbeck)</li> <li>• Lost in Maps: <b>Regionalization and Indigenous Health</b> Services (Josée G. Lavoie, Derek Kornelsen, Yvonne Boyer and Lloy Wylie)</li> </ul>
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#### *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>• Estimating <b>deaths due to medical error</b>: the ongoing controversy and why it matters (Kaveh G Shojania, Mary Dixon-Woods)</li> </ul>

#### *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>• <b>Triple Aim in Canada</b>: developing capacity to lead to better health, care and cost (Elina Farmanova, Christine Kirvan, Jennifer Verma, Geetha Mukerji, Nurdin Akunov, Kaye Phillips, Stephen Samis)</li> <li>• Metafrontier frameworks for studying <b>hospital productivity growth and quality changes</b> (Kuan-Chen Chen, Li-Nien Chien, Yi-Hsin Hsu, Ming-Miin Yu)</li> <li>• A randomized comparison between <b>league tables</b> and <b>funnel plots</b> to inform <b>health care decision-making</b> (Anders Anell, Oskar Hagberg, Fredrik Liedberg, Stefan Ryden)</li> </ul>

### Online resources

#### *Cochrane Consumers and Communication top five priority Cochrane Reviews*

<http://www.latrobe.edu.au/chcp/projects/research-priority-setting>

The Cochrane Consumers and Communication project conducted a priority setting project that involved extensive consultation with consumers, carers, health professionals, policy makers and research funders, to identify priority Cochrane Review topics in health communication and participation. From this process, the following Cochrane Review topics were selected as priorities:

1. **Improving communication about end of life care** – Cochrane Review title: Interventions for communication about end of life care among health professionals and patients and their families or carers
2. **Patient and family involvement in patient safety** – Cochrane Review title: Interventions to increase patient and family involvement in escalation of care for acute life threatening illness
3. **Improving future doctors’ communication skills** Cochrane Review title: Interventions for improving medical students’ communication skills in doctor-patient consultations

4. **Consumer engagement strategies** – Cochrane Review title: Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material
5. **Promoting patient-centred care** – Cochrane Review title: Interventions to promote patient-centred care approach in clinical consultations

[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 QS133 ***Children's attachment***  
<https://www.nice.org.uk/guidance/qs133>

[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:

- ***Omega-3 Fatty Acids and Maternal and Child Health: An Updated Systematic Review***  
<http://www.ahrq.gov/research/findings/evidence-based-reports/er224-abstract.html>

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