



## On the Radar

Issue 298

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### On the Radar

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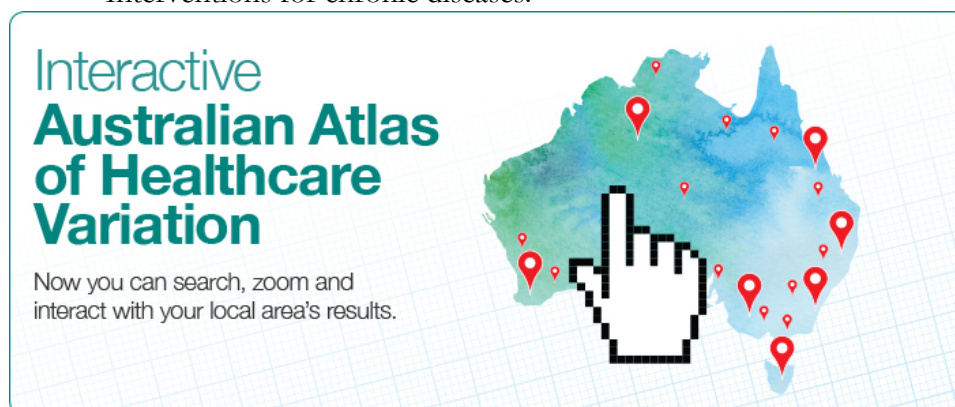
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#### *Interactive Australian Atlas of Healthcare Variation*

<http://www.safetyandquality.gov.au/atlas>

The Australian Commission on Safety and Quality in Health Care has developed an online interactive version of the *Australian Atlas of Healthcare Variation* following the launch of the hardcopy atlas in November 2015. The atlas covers the following clinical areas:

- Antimicrobial dispensing
- Diagnostic interventions
- Surgical interventions
- Interventions for mental health and psychotropic medicines
- Opioid medicines
- Interventions for chronic diseases.



The online interactive version provides users a new platform to interact and engage with the content and data in the atlas. The maps provide overlays of Primary Health Network and Local Hospital Network boundaries and pop-ups for each local area. The pop-ups depict graphically the local, state and national rate, and for some items, national and international comparison rates.

The online interactive atlas allows users to manipulate the maps, including being able to zoom in and out, move across the maps, and to interrogate the data behind the maps in various ways. The interactive atlas also allows users to examine and download or export the data in a range of formats.

## Reports

*Consent: Supported Decision-Making. A Guide to Good Practice*

Royal College of Surgeons of England

London: Royal College of Surgeons of England; 2016. p. 44.

URL	<a href="https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/consent-good-practice-guide/">https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/consent-good-practice-guide/</a>
Notes	<p>The Royal College of Surgeons of England has released a new guide <i>Consent: Supported Decision-Making</i> for surgeons on meeting the legal and regulatory requirements around the consent process.</p> <p>The guide references the UK Supreme Court’s landmark decision in 2015 which repositioned the focus of the legal requirements about what information should be provided to patients prior to making a decision about their care. This shifted the focus of consent from a paternalistic model where a doctor is the arbiter of determining what risks are material to their patients, towards consent a being patient-specific approach.</p> <p>The guide provides surgeons with practical advice on:</p> <ul style="list-style-type: none"> <li>• key principles of supported decision making</li> <li>• types of information that patients require to make an informed decision about treatment</li> <li>• 10 step process on working with patients to obtain valid consent.</li> </ul>

For information about the Commission’s work on shared decision making, see

<https://www.safetyandquality.gov.au/our-work/shared-decision-making/>

*Measuring Patient Harm in Canadian Hospitals*

Canadian Institute for Health Information and Canadian Patient Safety Institute

Ottawa: Canadian Institute for Health Information; 2016. p. 49.

URL	<a href="https://www.cihi.ca/en/health-system-performance/quality-of-care-and-outcomes/1-in-18-patients-experiences-harm-in-canadian-hospitals">https://www.cihi.ca/en/health-system-performance/quality-of-care-and-outcomes/1-in-18-patients-experiences-harm-in-canadian-hospitals</a>
Notes	<p>The Canadian Institute for Health Information and Canadian Patient Safety Institute have released this report into patient harm in Canadian (excluding Quebec) hospitals. The report suggests that in 2014–15 there were 138,000 patients ( or one in every 18 or 5.6%) admitted to a Canadian hospital who suffered some kind of harmful event that could potentially have been prevented. Of those 138,000 patients, about 30,000 had more than one adverse event that compromised their care. The report also reveals that those most at risk for hospital-related harms are patients with multiple conditions. Along with the report there are also a summary report, a technical report, technical backgrounder, an infographic, an FAQ, an information sheet, a data quality report and a <i>Hospital Harm Improvement Resource</i> that is an online compilation of resources provides evidence-based practices specific to the 31 different types of harm included in the measure and, as such, links measurement to improvement.</p>

*Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions* (Prepared by Collaborative Healthcare Strategies Inc. and John Snow Inc. under Contract No HHS290201000034I) AHRQ Publication No 16-0047-EF  
 Boutwell A, Bourgojn A, Maxwell J, DeAngelis K, Genetti S, Savuto M  
 Rockville, MD: Agency for Healthcare Research and Quality; 2016. p. 94.

URL	<a href="http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html">http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html</a>
Notes	The (US) Agency for Healthcare Research and Quality has updated its <i>Hospital Guide to Reducing Medicaid Readmissions</i> . This resource is designed to help hospitals design and deliver transitional care that addresses medical, social and behavioural needs for Medicaid and other vulnerable populations. The guide includes 13 customizable tools and content for six webinars to support training in use of the guide. The resource provides guidance through an easy-to-remember framework “ASPIRE”: <b>Analyse</b> your data to understand existing readmission patterns and root cause <b>Survey</b> your current readmission reduction efforts <b>Plan</b> a multi-faceted, data-informed portfolio of strategies <b>Implement</b> whole-person transitional care <b>Reach</b> out to collaborate with cross-setting partners, and <b>Enhance</b> services for high-risk patients.

## Journal articles

*Safety Lessons from the NIH Clinical Center*  
 Gandhi TK

New England Journal of Medicine. 2016;375(18):1705-7.

DOI	<a href="http://dx.doi.org/10.1056/NEJMp1609208">http://dx.doi.org/10.1056/NEJMp1609208</a>
Notes	Perspective piece recounting the identification, analysis and (possible) resolution of issues at the (US) National Institutes of Health Clinical Center. While specific to the specific institution many of the experiences and actions are germane to other hospitals and medical facilities. The author’s concluding paragraph: “The NIHCC crisis demonstrates how easy it is for safety to slip out of view. What happened there could happen in any health system: priorities can shift, whether to research, education, mergers, or finances. The lessons of the NIHCC are that <b>patient safety must be a core value</b> and that <b>health care organizations require a culture of safety, appropriate oversight and expertise, and key safety systems and structures. Patient safety should never take second place.</b> ”

*Building a Culture of Safety in Ophthalmology*

Custer PL, Fitzgerald ME, Herman DC, Lee PP, Cowan CL, Cantor LB, et al  
 Ophthalmology. 2016;123(9, Supplement):S40-S5.

DOI	<a href="http://dx.doi.org/10.1016/j.ophtha.2016.06.019">http://dx.doi.org/10.1016/j.ophtha.2016.06.019</a>
Notes	This paper, reflecting many of the same considerations as the previous, focuses on how a safety culture can be fostered in the specific domain of ophthalmology. Issues discussed include specifics such as error disclosure, teamwork, and failure analysis while also taking a broader view on safety culture, training and attributes of safe practice and the safe physician.

*Measures to Improve Diagnostic Safety in Clinical Practice*

Singh H, Graber ML, Hofer TP

Journal of Patient Safety. 2016 [epub].

DOI	<a href="http://dx.doi.org/10.1097/PTS.0000000000000338">http://dx.doi.org/10.1097/PTS.0000000000000338</a>
Notes	Further addition to the literature on diagnostic error (much of which these authors have been responsible for). This open access article canvasses the need to develop measures to improve diagnostic performance and the challenges and opportunities for developing potential measures of "diagnostic safety" related to clinical diagnostic errors and associated preventable diagnostic harm. The authors propose measurement concepts and argue that health-care systems should consider measurement and evaluation of diagnostic performance as essential to timely and accurate diagnosis and to the reduction of preventable diagnostic harm.

*Healthcare Quarterly*

Vol. 19 No. 3 2016

URL	<a href="http://www.longwoods.com/publications/healthcare-quarterly/24787">http://www.longwoods.com/publications/healthcare-quarterly/24787</a>
Notes	<p>A new issue of <i>Healthcare Quarterly</i> has been published with a special focus on global climate change. Articles in this special issue of <i>Healthcare Quarterly</i> include:</p> <ul style="list-style-type: none"> <li>• Developing <b>Indicators</b> for the <b>Child and Youth Mental Health</b> System in Ontario (Julie Yang, Paul Kurdyak and Astrid Guttmann)</li> <li>• Increasing Rates of <b>Kidney Failure Care</b> in Canada Strains Demand for Kidney Donors (Michael Terner, Noura Redding and Juliana Wu)</li> <li>• <b>Healthcare in the Anthropocene: Challenges and Opportunities</b> (Trevor Hancock)</li> <li>• Canadian Coalition for <b>Green Health Care</b> Leading the Evolution of Green (Kent Waddington and Linda Varangu)</li> <li>• <b>Recovering Plastics</b> in a Hospital Can Have Environmental, Social and Economic Benefits (Jérôme Ribesse and Nathalie Robitaille)</li> <li>• <b>Organic Waste Reduction</b> at Hamilton Health Sciences (Rosemary Van Oostrom)</li> <li>• <b>Healthcare and Climate Change: Do No Harm</b> (Deanna Fourt and Claudette Poirier)</li> <li>• Searching for <b>Best Direction in Healthcare: Distilling Opportunities, Priorities and Responsibilities</b> (Terrence Montague, Amédé Gogovor, Lucas Marshall, Bonnie Cochrane, Sara Ahmed, E Torr, J Aylen and J Nemis-White)</li> <li>• Using <b>System Maps</b> to Gain a System Perspective to Improve Outcomes (Faten Mitchell)</li> <li>• Canadian Cancer Programs Are Struggling to Invest in Development of <b>Future Leaders: Results of a Pan-Canadian Survey</b> (Nadir Khan, Lena Ghatage and Peter S. Craighead)</li> <li>• Increasing <b>Primary Care Access</b> Close to Home for Residents of <b>Remote Communities</b> in Northern Alberta (A Alison Ross, Tracey L Yap, Johan van der Nest, Keith Martin and Alison H Edie)</li> <li>• Evaluating Innovations in <b>Home Care for Performance Accountability</b> (Barbara Collister, Abram Gutscher and Jana Ambrogiano)</li> </ul>

URL	<a href="http://ajm.sagepub.com/content/31/6?etoc">http://ajm.sagepub.com/content/31/6?etoc</a>
Notes	<p>A new issue of the <i>American Journal of Medical Quality</i> has been published. Articles in this issue of the <i>American Journal of Medical Quality</i> include:</p> <ul style="list-style-type: none"> <li>• A Multidisciplinary <b>Sepsis Program</b> Enabled by a Two-Stage Clinical Decision Support System: Factors That Influence Patient Outcomes (Robert C Amland, James M Haley, and Jason J Lyons)</li> <li>• Together We Learn: Analyzing the Interprofessional Internal Medicine <b>Residents'</b> and Master of Public Health <b>Students' Quality Improvement Education Experience</b> (Gouri Gupte, Craig Noronha, Michal Horný, Karin Sloan, and Winnie Suen)</li> <li>• Partnering With a <b>Family Advisor</b> to Improve Communication in a <b>Pediatric Intensive Care Unit</b> (Laura Czulada, Patience Leino, and Tina Schade Willis)</li> <li>• Attitudes Toward <b>Collaboration</b> Among Practitioners in Newly Established <b>Medical Homes</b>: A Survey of Nurses, General Practitioners, and Specialists (Matthew Alcusky, Luciano Ferrari, Giuseppina Rossi, Mengdan Liu, Mohammadreza Hojat, and Vittorio Maio)</li> <li>• The VA Medical Foster Home Program, <b>Ambulatory Care Sensitive Conditions</b>, and <b>Avoidable Hospitalizations</b> (Etienne E. Pracht, Cari R Levy, Arthur Williams, Farrokh Alemi, and Allison E. Williams)</li> <li>• <b>Emergency Department Return Visits</b> Resulting in Admission: Do They Reflect Quality of Care? (John Cheng, Amita Shroff, Naghma Khan, and Shabnam Jain)</li> <li>• <b>Quality Improvement</b> Process in a Large <b>Intensive Care Unit</b>: Structure and Outcomes (Anita J. Reddy and Jorge A. Guzman)</li> <li>• One Size Does Not Fit All: <b>Pediatric Patient Satisfaction</b> Within an Integrated Health Network (Gang Ye, Paul Rosen, Brian Collins, and Stephen Lawless)</li> <li>• A Missed Opportunity to Improve Patient Satisfaction? Patient Perceptions of <b>Inpatient Communication</b> With Their <b>Primary Care Physician</b> (Dara R Adams, Andrea Flores, Ainoa Coltri, David O Meltzer, and V M Arora)</li> <li>• Achieving <b>Hand Hygiene</b> Success With a Partnership Between Graduate Medical Education, Hospital Leadership, and Physicians (Glenn Rosenbluth, Susan Garritson, Adrienne L Green, Dimiter Milev, Arpana R Vidyarthi, Andrew D Auerbach, and Robert B Baron)</li> <li>• <b>Operating Room Inefficiencies</b> Attributable to Errors in Surgical Case Scheduling and Surgeon Procedure Heterogeneity (Joseph J Pariser, Alanna J Diamond, Laura W Christianson, Brian A Mitchell, and A Langerman)</li> <li>• <b>Identifying Deteriorating Patients</b> Through Multidisciplinary Team Training (Abi Merriel, Helen van der Nelson, Sam Merriel, Joanne Bennett, Fiona Donald, Timothy Draycott, and Dimitrios Siassakos)</li> <li>• Changing <b>Physician Behavior</b> by Integrating a Risk-Adjusted Database Into a <b>Quality Improvement</b> Program (John R Stanford and D S Wilkins)</li> <li>• Department of Veterans Affairs <b>Chief Resident in Quality and Patient Safety</b> Program: A Model to Spread Change (Bradley V Watts, Douglas E Paull, Linda C Williams, Julia Neily, Robin R Hemphill, and J L Brannen)</li> <li>• <b>Student Perceptions of Clinical Quality and Safety</b> (Lakshmana Swamy, Colleen Badke, A Suguness, J McKeegan, K Kirkham, and N J Borges)</li> </ul>



URL	<a href="http://www.longwoods.com/publications/healthcarepapers/24655">http://www.longwoods.com/publications/healthcarepapers/24655</a>
Notes	<p>A special issue of <i>HealthcarePapers</i> has been published with the theme ‘Health System Transformation through Research Innovation’. Articles in this special issue of <i>HealthcarePapers</i> include:</p> <ul style="list-style-type: none"> <li>• The Continuing Relevance of <b>Academics</b> to <b>Health System Reform</b> (Adalsteinn D. Brown and Sabina Nuti)</li> <li>• <b>Health System Transformation</b> through <b>Research Innovation</b> (Robyn Tamblyn, Meghan McMahon, Jessica Nadigel, Beth Dunning and Elizabeth Drake with the Institute of Health Services and Policy Research Advisory Board)</li> <li>• The Necessary – but Not Sufficient – Leadership of <b>Research</b> to <b>Transform the Health Systems</b> (Denis A Roy, Bernard Candas, Eric Litvak and Luc Boileau)</li> <li>• “If You’re Riding a Horse and It Dies ...” A Commentary on <b>Health System Transformation</b> through <b>Research Innovation</b> (Chris Power)</li> <li>• Embedding <b>Research</b> in the <b>Learning Health System</b> (Robert J Reid)</li> <li>• <b>Digital Drivers</b> in a <b>Learning Health System</b>: Considerations for Research Innovation (Jennifer Zelmer)</li> <li>• <b>Community-Engaged Scholarship</b> to Catalyze Innovation: A Case Study of the Uptake of Metered-Dose Inhalers with Spacers to Deliver Respiratory Medication in a Pediatric Emergency Department in Nova Scotia (Ingrid Sketris, Barbara Hill Taylor, Joan Sargeant and Katrina Hurley)</li> <li>• Modernizing our <b>Doctoral and Postdoctoral Training</b> Programs: Bold New Initiatives (Stephen Bornstein)</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>Performance measures</b>, perceptions of quality and safety, and experience of adverse events (Usman Iqbal, Yu-Chuan (Jack) Li)</li> </ul>

**Online resources**

*Future Leaders Communiqué*

<http://www.vifmcommuniques.org>

The team behind the *Clinical Communiqué* are about to launch a new publication, *The Future Leaders Communiqué*. This new publication is an electronic publication containing narrative case reports about lessons learned from Coroners’ investigations into preventable deaths. These articles are written by healthcare graduates with a fresh take on current matters. To subscribe to any of the Communiqué series, visit [www.vifmcommuniques.org](http://www.vifmcommuniques.org)

*Medical Devices Safety Update*

<https://www.tga.gov.au/publication-issue/medical-devices-safety-update-volume-4-number-6-november-2016>

Volume 4, Number 6, November 2016

The Therapeutic Goods Administration (TGA) has released the latest edition of its medical device safety bulletin. Topics covered in this issue include:

- New insights into **orthopaedic implants** – the Australian Orthopaedic Association National Joint Replacement Registry annual reports offer insight into the performance of orthopaedic implants being used in this country
- Standard improves **heat pack safety** – The TGA has collaborated with Standards Australia to improve the safety of microwaveable heat packs
- Practice points: **Postoperative monitoring** – Understanding the time periods of highest risk and individual patient risk factors for respiratory depression may assist in efficient resource allocation in postoperative patients.
- **Recent safety alerts.**

*[UK] Choosing Wisely UK*

<http://www.choosingwisely.co.uk/>

As part of the continuing global reach of the Choosing Wisely movement, the UK's Academy of Medical Royal Colleges has produced a list of 40 treatments and procedures that have limited clinical value or impact. The campaign calls for doctors and patients to have a fully informed conversation about the risks and benefits of treatments and procedures. Apparently New Zealand will shortly join the growing list of countries with a Choosing Wisely program or similar.

*[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 CG155 **Psychosis and schizophrenia in children and young people: recognition and management** <https://www.nice.org.uk/guidance/cg155>
- NICE Guideline NG58 **Physical health of people in prison** <https://www.nice.org.uk/guidance/ng57>

*[USA] Nursing Home Antimicrobial Stewardship Guide*

<http://www.ahrq.gov/nhguide/index.html>

The (US) Agency for Healthcare Research and Quality have developed this resource that offers step-by-step instructions and materials to help nursing homes improve antibiotic use and decrease harms caused by inappropriate prescribing.

The guide includes four toolkits designed to

- implement, monitor, and sustain an antimicrobial stewardship program
- determine whether it is necessary to treat a potential infection with antibiotics
- help prescribing clinicians use an antibiogram to choose the right antibiotic to treat a particular infection
- educate and engage residents and family members.

[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:

- Video or Facebook pages describing normality seem to reduce **sexually transmitted infections in youth**
- Rapid blood test helps exclude **pulmonary embolism** for low risk patients
- Treating low grade **piles** with a newer surgical technique leads to less recurrence than rubber band ligation
- **Flu vaccine** reduces deaths for people with **type 2 diabetes**
- Home-based **cardiac rehabilitation** may be a convenient alternative to centre-based rehabilitation
- Acupuncture shows promise for preventing **episodic migraines**
- Flushing your nose with salt water may be moderately useful for symptoms of **sinusitis**
- Corticosteroid injections provide only short term relief for **rotator cuff disorders**
- Questionnaires directed at smokers improve detection of **chronic lung disease** in general practice
- Surgery to remove the thymus gland improves weakness for people with **myasthenia gravis**.

[USA] *Healthcare Simulation Dictionary*

<http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/research/simulation-dictionary/index.html>

The (US) Agency for Healthcare Research and Quality (AHRQ) has partnered with the Society for Simulation in Healthcare to produce the first comprehensive *Healthcare Simulation Dictionary*. With more than 100 health care simulation terms and definitions, the *Healthcare Simulation Dictionary* takes the first steps toward standardising the use of simulation terminology to enhance information sharing. The dictionary will support clear communication and improve awareness about lexicon use.

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