



On the Radar

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On the Radar

Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au

Contributors: Niall Johnson, Alice Bhasale

Consultation on draft Heavy Menstrual Bleeding Clinical Care Standard

www.safetyandquality.gov.au/ccs/consultation

In collaboration with consumers, clinicians, researchers and health service organisations, the Australian Commission on Safety and Quality in Health Care has developed the draft *Heavy Menstrual Bleeding Clinical Care Standard*. The development of a Clinical Care Standard on heavy menstrual bleeding (previously described as menorrhagia) was recommended in the first *Australian Atlas of Healthcare Variation*, in view of the observed variation in endometrial ablation and hysterectomy rates.

The Commission is seeking feedback on the draft Clinical Care Standard, which will be available for public consultation from **Wednesday 23 November 2016**.

Feedback is sought via an online survey or in writing by **11:59 pm, 11 January 2017**. Find out about the consultation process and access the draft *Heavy Menstrual Bleeding Clinical Care Standard*, related documents and the online survey at www.safetyandquality.gov.au/ccs/consultation

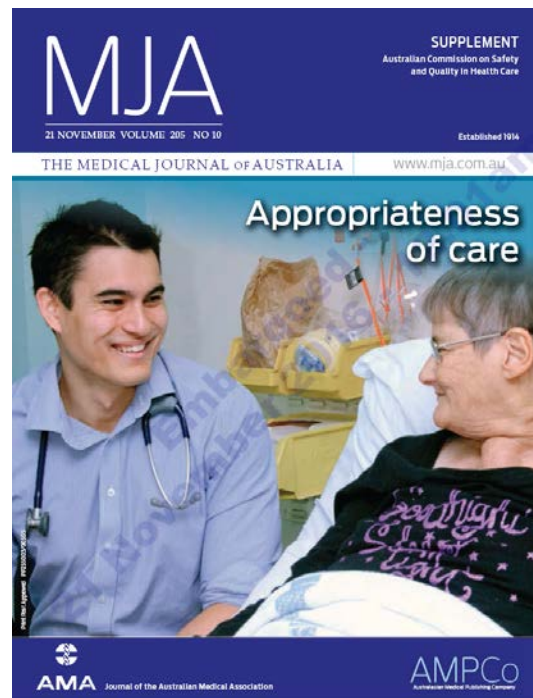
For information about the *Australian Atlas of Healthcare Variation*, see <http://www.safetyandquality.gov.au/atlas>

Appropriateness of Care

<https://www.mja.com.au/journal/2016/205/10/supplement>

<https://www.mja.com.au/journal/2016/205/10>

Efforts to understand and reduce unwarranted variations in healthcare is a priority for Australia's healthcare system as a means to improve the quality and appropriateness of health care, according to a series of articles published in a Supplement to the *Medical Journal of Australia*. The articles explore the evidence for atlases of healthcare variation to act as catalysts for improvements in care. Mechanisms to reduce unwarranted variation explored in the supplement include the establishment of clinical quality registries, which collect data and report on the appropriateness and effectiveness of care patients receive, and patient-reported outcomes measures. Other strategies discussed are Clinical Care Standards, which are small sets of concise recommendations that focus on known gaps in evidence-based care for a particular clinical condition. These aim to ensure that all patients with the same clinical condition are offered appropriate care, regardless of their location. They complement clinical practice guidelines and other initiatives for improving quality of health care.



Another paper in the supplement, by Buchan and colleagues, notes that while some variation is to be expected due to differences in the need for care, or patient preferences – researchers had detected “large and persistent variations in healthcare use, far beyond that explainable by patient need or preference, for many decades”.

The supplement that has been coordinated by the Australian Commission on Safety and Quality in Health Care. The supplement contains the following articles:

- *Clinical variation: why it matters.* Duggan A, Koff E, Marshall V
<http://dx.doi.org/10.5694/mja16.00819>
- *English lessons: can publishing an atlas of variation stimulate the discussion on appropriateness of care?* DaSilva P, Grey JAM <http://dx.doi.org/10.5694/mja15.00896>
- *Clinical care standards: appropriate care everywhere — acute coronary syndromes as an example.* Chew DP, Herkes R, Page MA <http://dx.doi.org/10.5694/mja15.00897>
- *Appropriate care for older people with cognitive impairment in hospital.* Kaplan GA, Kurrle SE, Cumming A <http://dx.doi.org/10.5694/mja15.00898>
- *Antimicrobial use in Australian hospitals: how much and how appropriate?* Turnidge JD, Thursky K, Chen CS, McNeil VR, Wilkinson IJ <http://dx.doi.org/10.5694/mja15.00899>
- *Clinical quality registries have the potential to drive improvements in the appropriateness of care.* Wilcox N, McNeil JJ <http://dx.doi.org/10.5694/mja15.00921>
- *Paying hospitals for quality: can we buy better care?* Hall JP, van Gool KC
<http://dx.doi.org/10.5694/mja15.01110>
- *Health care variation: time to act.* Buchan HA, Duggan A, Hargreaves J, Scott IA, Slawomirski L
<http://dx.doi.org/10.5694/mja15.01360>

Previous Supplements that the Commission coordinated:

- *Using what we gather - information for improved care*
<https://www.mja.com.au/journal/2010/193/8/supplement>
- *Clinical handover: critical communications*
<https://www.mja.com.au/journal/2009/190/11/supplement>

Reports

Realising the value: Ten key actions to put people and communities at the heart of health and wellbeing

Finnis A, Khan H, Ejbye J, Wood S, Redding D

London: Realising the value; 2016. p. 44.

URL	http://www.health.org.uk/publication/realising-value
Notes	<p>Realising the Value was an 18-month programme funded by NHS England that aimed to consolidate what is known about person- and community-centred approaches for health and wellbeing, and make recommendations on how they can have maximum impact. This final report from the programme draws together the key learning and recommendations from the programme. It puts forward ten key actions - focused both on what should be done and how people need to work differently.</p> <p>Ten key actions to put people and communities at the heart of health and wellbeing</p> <p>What needs to happen</p> <ol style="list-style-type: none"> 1. Implement person- and community-centred ways of working across the system, using the best available tools and evidence. 2. Develop a simplified outcomes framework, focused on what matters to people. 3. Continue to learn by doing, alongside further research. 4. Make better use of existing levers such as legislation, regulation and accountability. 5. Trial new outcomes-based payment mechanisms and implement them as part of wider national payment reform. <p>How people need to work differently</p> <ol style="list-style-type: none"> 6. Enable health and care professionals and the wider workforce to understand and work in person- and community-centred ways. 7. Develop strong and sustained networks as an integral part of implementation. 8. Value the role of people and communities in their health and wellbeing, including through co-production, volunteering and social movements for health. 9. Make greater use of behavioural insights to increase effectiveness and uptake. 10. Support a thriving and sustainable voluntary, community and social enterprise sector, working alongside people, families, communities and the health and care system.

For information about the Commission's work on patient and consumer centred care see, www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Journal articles

Core Elements of Outpatient Antibiotic Stewardship

Sanchez GV, Fleming-Dutra KE, Roberts RM, Hicks LA

Morbidity and Mortality Weekly Report. 2016;65(Recommendations and Reports 6):1-12.

DOI	http://dx.doi.org/10.15585/mmwr.rr6506a1
Notes	<p>Following the (US) Centers for Disease Control and Prevention's 2014 and 2015 release of <i>Core Elements of Hospital Antibiotic Stewardship Programs</i> and the <i>Core Elements of Antibiotic Stewardship for Nursing Homes</i>, comes this report providing a framework for antibiotic stewardship for outpatient clinicians and facilities that routinely provide antibiotic treatment. The authors identify the "four core elements of outpatient antibiotic stewardship are commitment, action for policy and practice, tracking and reporting, and education and expertise."</p>

For information about the Commission’s work on healthcare associated infection, including antimicrobial stewardship, see www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Perspectives: answering questions about quality improvement: suggestions for investigators

Øvretveit J

International Journal for Quality in Health Care. 2016.

DOI	http://dx.doi.org/10.1093/intqhc/mzw136
Notes	<p>In this Perspective piece the renowned John Øvretveit reflects on some of the questions that those seeking improvements ask when considering interventions. These questions (should) include: Does it work? Will it work here? What conditions are needed to implement and sustain it? Can we adapt it? How much will it cost and how much will it save? Is there enough evidence?</p> <p>The paper concludes with the ‘Features of the new quality improvement investigation movement’. These include:</p> <ul style="list-style-type: none"> • Takes a customer-centered approach using a broad range of methods to answer improver's questions. • Chooses the investigation method to suit the question, given the timescale and the resources available for the investigation. • Clearly states the limitations of the conclusions and gives implications for action. • Documents the intervention and the context, so as to answer improver's questions about what was implemented in the study and under which conditions. • Chooses measures of effectiveness, depending on the customers question, the validity of data available, and whether any changes in data collected using these measures can be attributed to the improvement change. • Views context not as background but as an active element in improvement, especially for sustainability. • Provides knowledge to enable improvers systematically to adapt the change to suit their context. • Estimates costs and savings over time, for the customer and other stakeholders.

Patient safety improvement interventions in children's surgery: A systematic review

Macdonald AL, Sevdalis N

Journal of Pediatric Surgery. 2016.

DOI	http://dx.doi.org/10.1016/j.jpedsurg.2016.09.058
Notes	<p>This systematic review examined the nature and quality of patient safety evidence relating to surgery on children, noting that when compared to adult surgery that there is a paucity of evidence. Indeed, the review focused on 20 studies and found that handover tools were the successful of the reported interventions. The authors noted that “Pediatric surgical patient safety evidence is in its early stages.” And that there “ought to be an onus on pediatric surgeons to develop and apply bespoke pediatric surgical safety interventions and generate an evidence base to parallel the adult literature.”</p>

Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care

Aiken LH, Sloane D, Griffiths P, Rafferty AM, Bruyneel L, McHugh M, et al
 BMJ Quality & Safety. 2016 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2016-005567
Notes	<p>Paper reporting on a European study that sought to examine the association of hospital nursing skill mix with patient mortality, patient ratings of their care and indicators of quality of care. The work involved a survey of adult acute care hospitals in Belgium, England, Finland, Ireland, Spain and Switzerland covering 13,077 nurses in 243 hospitals, and 18,828 patients in 182 of the same hospitals with discharge data for 275,519 surgical patients in 188 of these hospitals.</p> <p>From their analyses the authors report that a “Richer nurse skill mix (eg, every 10-point increase in the percentage of professional nurses among all nursing personnel) was associated with lower odds of mortality (OR=0.89), lower odds of low hospital ratings from patients (OR=0.90) and lower odds of reports of poor quality (OR=0.89), poor safety grades (OR=0.85) and other poor outcomes (0.80<OR<0.93), after adjusting for patient and hospital factors.”</p> <p>They conclude “A bedside care workforce with a greater proportion of professional nurses is associated with better outcomes for patients and nurses. Reducing nursing skill mix by adding nursing associates and other categories of assistive nursing personnel without professional nurse qualifications may contribute to preventable deaths, erode quality and safety of hospital care and contribute to hospital nurse shortages.”</p>

Opportunities to Enhance Laboratory Professionals’ Role On the Diagnostic Team

Taylor JR, Thompson PJ, Genzen JR, Hickner J, Marques MB
 Laboratory Medicine. 2016 [epub].

DOI	http://dx.doi.org/10.1093/labmed/lmw048
Notes	<p>Following a number of items on laboratory/pathology is this paper discussing how involving laboratory professionals with diagnostic challenges may improve diagnoses. Using survey responses from 1,768 American physicians the authors report that many physicians “reported using electronic resources because they find it difficult and time-consuming to contact the laboratory. Only 20% had an effective way to access laboratory professionals, mostly seeking help for logistical but less for clinical issues.”</p> <p>The authors argue that “Laboratory professionals have an opportunity to play a greater role in the diagnostic process by becoming active members of the clinical care team, beyond providing results.”</p>

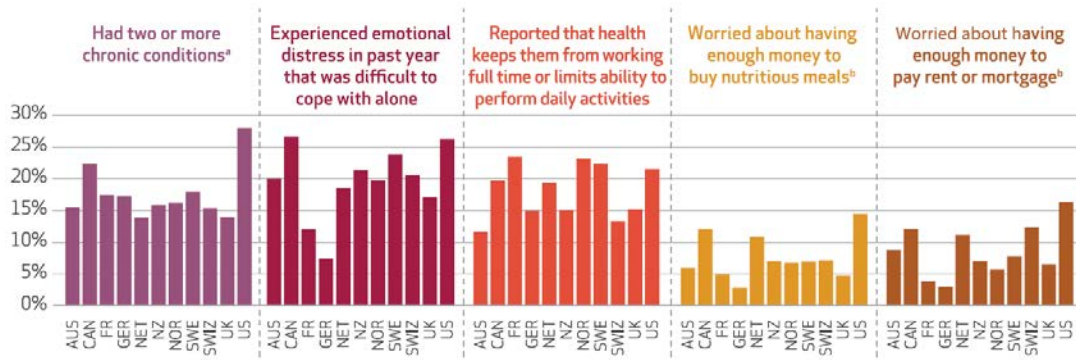
In New Survey Of Eleven Countries, US Adults Still Struggle With Access To And Affordability Of Health Care

Osborn R, Squires D, Doty MM, Sarnak DO, Schneider EC
 Health Affairs. 2016 [epub].

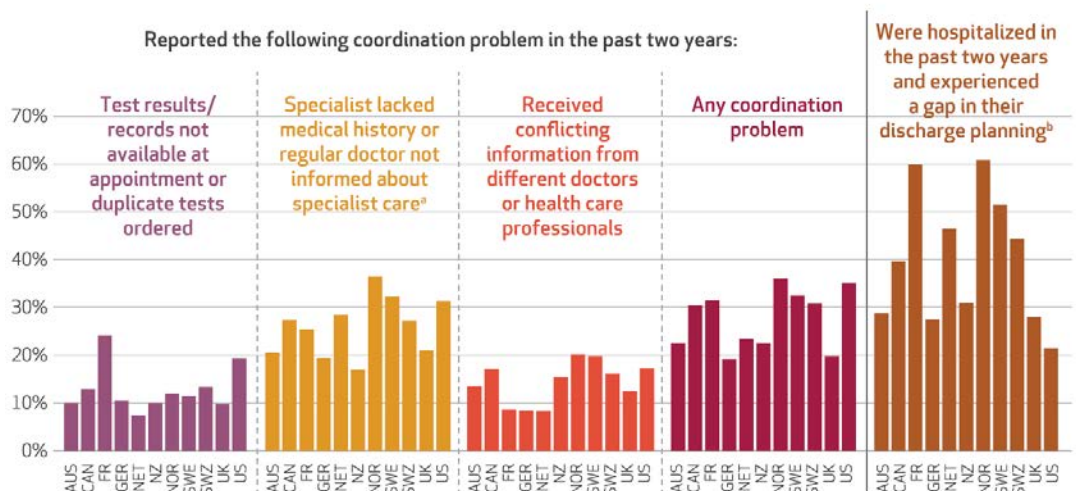
DOI	http://dx.doi.org/10.1377/hlthaff.2016.1088
Notes	<p>Each year the (US) Commonwealth Fund surveys various aspects of health care systems in the US and a group of comparable countries, including Australia. This article reports on the most recent survey that looked at issues of affordability. The authors report that from the eleven countries surveyed (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States) “US adults reported poor health and well-being and were the most likely to experience material hardship. The United States trailed other countries in making health care affordable and ranked poorly on providing timely access to medical care (except specialist care). In all countries, shortfalls in patient</p>

engagement and chronic care management were reported, and at least one in five adults experienced a care coordination problem. Problems were often particularly acute for low-income adults. Overall, the Netherlands performed at the top of the eleven-country range on most measures of access, engagement, and coordination.” In these surveys Australia has tended to poll quite well on outcomes and services but less well on affordability (out of pocket costs)) and a number of other aspects. In this survey Australia tended to again fall into the middle to better ratings depending on the specific topic. Australian respondents were the least likely (12%) to say that health prevented them from working full time or limited their ability to perform daily activities.

Percentages of adults in eleven countries who reported problems with health status and material hardship, 2016



Percentages of adults in eleven countries who reported having care coordination problems, 2016



In a related vein, the Australian Bureau of Statistics has released their *Patient Experiences in Australia: Summary of Findings, 2015-16*

(<http://abs.gov.au/ausstats/abs@.nsf/Lookup/4839.0main+features12015-16>).

While many of the results are positive or improved there were some issues identified. These included that about one in four (23%) people who saw a medical specialist waited longer than they felt acceptable to get an appointment, one in twelve people (8%) who needed to see a medical specialist delayed or did not go because of the cost and those living in areas of most socio-economic disadvantage were more likely to delay seeing or not see either a medical specialist due to cost (9%) compared with those living in areas of least disadvantage (6%) or a dental professional due to cost (27%) compared with those living in areas of least disadvantage (11%). The coordination of care for those with three or more health professionals for the same condition, saw one in eight (13%) reporting that there were issues caused by a lack of communication between the health professionals.

Individual surgeon mortality rates: can outliers be detected? A national utility analysis
Harrison EM, Drake TM, O'Neill S, Shaw CA, Garden OJ, Wigmore SJ
BMJ Open. 2016;6(10):e012471

DOI	http://dx.doi.org/10.1136/bmjopen-2016-012471
Notes	Paper reporting on the use of data in identifying exceptional performance for surgeons. The study sought to determine the likelihood that variation in surgeon performance will be detected using published outcome data for UK surgeons who performed colon cancer resection, oesophagectomy or gastrectomy, elective aortic aneurysm repair, hip replacement, bariatric surgery or thyroidectomy. The authors report that “overall mortality rates for the procedures ranged from 0.07% to 4.5% and mean/median surgeon volume was between 23 and 75 cases.” They concluded that “At present, surgeons with increased mortality rates are unlikely to be detected. Performance within an expected mortality rate range cannot be considered reliable evidence of acceptable performance. Alternative approaches should focus on commonly occurring meaningful outcome measures, with infrequent events analysed predominately at the hospital level.”

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	<i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including: <ul style="list-style-type: none"> • Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care (Linda H Aiken, Douglas Sloane, Peter Griffiths, Anne Marie Rafferty, Luk Bruyneel, Matthew McHugh, Claudia B Maier, Teresa Moreno-Casbas, Jane E Ball, Dietmar Ausserhofer, Walter Sermeus)

International Journal for Quality in Health Care online first articles

URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
Notes	<i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles, including: <ul style="list-style-type: none"> • The Outpatient Experience Questionnaire of comprehensive public hospital in China: development, validity and reliability (Yinhuan Hu, Zixia Zhang, Jinzhu Xie, Guanping Wang) • The effects of citizenship status on service utilization and general satisfaction with healthcare: a cross-cultural study (Salma M Khaled, Bethany Shockley, Hanan F Abdul Rahim) • Quality of child healthcare at primary healthcare facilities: a national assessment of the Integrated Management of Childhood Illnesses in Afghanistan (Ghulam Farooq Mansoor, Paata Chikvaidze, Sherin Varkey, Ariel Higgins-Steele, Najibullah Safi, Adela Mubasher, Khaksar Yusufi, Sayed Alisha Alawi) • Perspectives: answering questions about quality improvement: suggestions for investigators (John Øvretveit) • Quality agencies at the global level: characteristics and functions—a narrative review (Pedro J. Saturno Hernández, María Fernández Elorriaga, Ofelia Poblano Verástegui, José De Jesús Vértiz Ramírez) • Improving geriatric prescribing in the ED: a qualitative study of facilitators and barriers to clinical decision support tool use (Ann E Vandenberg, Camille P Vaughan, Melissa Stevens, Susan N Hastings, James Powers, Alayne Markland, Ula Hwang, William Hung, Katharina V Echt)

Online resources

[USA] *Top 10 Health Technology Hazards for 2017*

<https://www.ecri.org/Pages/2017-Hazards.aspx>

The ECRI Institute has released its annual list of the more significant hospital health technology hazards. This year's list includes:

1. **Infusion Errors** Can Be Deadly If Simple Safety Steps Are Overlooked
2. **Inadequate Cleaning** of Complex Reusable Instruments Can Lead to Infections
3. Missed **Ventilator Alarms** Can Lead to Patient Harm
4. Undetected **Opioid-Induced Respiratory Depression**
5. Infection Risks with **Heater-Cooler Devices** Used in Cardiothoracic Surgery
6. **Software Management** Gaps Put Patients, and Patient Data, at Risk
7. **Occupational Radiation** Hazards in Hybrid ORs
8. **Automated Dispensing Cabinet** Setup and Use Errors May Cause Medication Mishaps
9. **Surgical Stapler** Misuse and Malfunctions
10. **Device Failures** Caused by Cleaning Products and Practices

[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:

- Clinical Guideline CG190 ***Intrapartum care*** for healthy women and babies
<https://www.nice.org.uk/guidance/cg190>

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