On the Radar

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On the Radar
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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

Journal articles

Does quality improvement improve quality?
Dixon-Woods M, Martin GP
Future Hospital Journal. 2016 October 1, 2016;3(3):191-4.

DOI	http://futurehospital.rcpjournal.org/content/3/3/191.abstract http://dx.doi.org/10.7861/futurehosp.3-3-191
Notes	With this provocative title the authors pick up some of the issues raised in John Øvretveit's piece discussed in the last issue of *On the Radar*. This piece poses perhaps more fundamental questions about quality improvement (QI) in healthcare – as it has been practiced – and suggests ways in which QI may be improved. The authors describe the issue thus "Although quality improvement (QI) is frequently advocated as a way of addressing the problems with healthcare, evidence of its effectiveness has remained very mixed. The reasons for this are varied but the growing literature highlights particular challenges. Fidelity in the application of QI methods is often variable. QI work is often pursued through time-limited, small-scale projects, led by professionals who may lack the expertise, power or resources to instigate the changes required. There is insufficient attention to rigorous evaluation of improvement and to sharing the lessons of successes and failures. Too many QI interventions are seen as 'magic bullets' that will produce improvement in any situation, regardless of context. Too much improvement work is undertaken in isolation at a local level, failing to pool resources and develop collective solutions, and introducing new hazards in the process." The proposals for improving the quality of quality improvement include: 1. **Act like a sector** – many of the quality challenges that confront healthcare need to be solved at the level of entire systems 2. **Stop looking for magic bullets – focus on organisational strengthening and learn from positive deviance**. …Too little has been spent on the organisational strengthening needed to make improvement. …much can be learned from the characteristics, practices and behaviours that are implicated in the performance of demonstrably safe and high-quality settings. 3. **Build capacity for designing and testing solutions, and plan for replication and scaling from the start** – Developing solutions to many quality and safety problems may require high-level skills and expertise from multiple disciplines, and highly sophisticated development processes. …we need to get better at developing or selecting interventions that have a high likelihood of success, testing them rigorously in different contexts, and offering organisations solutions 4. **Think programmes and resources, not projects** – QI projects are sometimes the right answer … but where they are undertaken it should be with a commitment to sharing. … Healthcare needs to do for QI what it has done for research: build an infrastructure that enables learning about successful and less successful efforts to be curated and searched by others.

Inpatient notes: reducing diagnostic error—a new horizon of opportunities for hospital medicine
Singh H, Zwaan L
Annals of Internal Medicine. 2016;165(8):HO2-HO4.

DOI	http://dx.doi.org/10.7326/M16-2042
Notes	Further contribution to the literature on diagnostic error – this time addressing 'hospitalists'. This commentary piece discusses how hospitalists can prevent diagnostic errors and identifies some opportunities for improvement, including patient involvement and face-to-face team communication.

Adding Value by Talking More
Kaplan RS, Haas DA, Warsh J
New England Journal of Medicine. 2016;375(20):1918-20.

DOI	http://dx.doi.org/10.1056/NEJMp1607079
Notes	Fee-for-service payment models in the US have led to severe constraints on the time physicians spend speaking with patients. However, new value-based reimbursement models provide powerful incentives for physicians to regain control over the quantity and quality of time that they spend talking with patients. Kaplan and colleagues identify several benefits that talking more with patients can have on delivering better, higher-value patient care: - motivating patients to make earlier and better decisions can lead to reductions in harms and treatment costs - addressing patient's concerns about the management of their chronic conditions can lead to higher treatment adherence, averting complications and hospital admissions - discussing patient and physician expectations of outcomes of care can positively influence behaviour and recovery - actively engaging patients in treatment choices can lead to better outcomes and less expensive care.

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/

For information about the Commission's work on shared decision making, see
https://www.safetyandquality.gov.au/our-work/shared-decision-making/

Healthy life-years lost and excess bed-days due to 6 patient safety incidents: empirical evidence from English hospitals
Hauck KD, Wang S, Vincent C, Smith PC
Medical Care. 2016 [epub].

DOI	http://dx.doi.org/10.1097/MLR.0000000000000631
Notes	Paper reporting on a British study that attempted to estimate the number healthy life-years (HLYs) lost due to 6 incidents in English hospitals between the years 2005/2006 and 2009/2010. The study was cross-sectional analysis of the medical records of all inpatients treated in 273 English hospitals. The incidents included preventable pressure ulcers , deaths in low-mortality procedures, deep-vein thrombosis/pulmonary embolisms, postoperative sepsis, hip fractures, and central-line infections. The authors report that "The 6 incidents resulted in an annual loss of 68 HLYs and 934 excess bed-days per 100,000 population. Preventable pressure ulcers caused the loss of 26 HLYs and 555 excess bed-days annually. Deaths in low-mortality procedures resulted in 25 lost life-years and 42 bed-days. Deep-vein thrombosis/pulmonary embolisms cost 12 HLYs, and 240 bed-days. Postoperative sepsis, hip fractures, and central-line infections cost <6 HLYs and 100 bed-days each."

Multimethod study of a large-scale programme to improve patient safety using a harm-free care approach
Power M, Brewster L, Parry G, Brotherton A, Minion J, Ozieranski P, et al
BMJ Open. 2016;6(9):e011886.

DOI	http://dx.doi.org/10.1136/bmjopen-2016-011886
Notes	Paper evaluating the NHS (England) large-scale two-phase quality improvement programme. The programme sought to 1. develop a shared national, regional and locally aligned safety focus for 4 high-cost, high volume harms (venous thromboembolism (VTE), pressure ulcers, urinary tract infection in patients with urinary catheters and falls) 2. establish a new measurement system based on a composite measure of 'harm-free' care and 3. deliver improved outcomes, with a specific objective of ensuring that 95% of patients would be harm-free. These aims were only partially met or met in some places better than others. However, as the authors note external events, "A context of extreme policy-related structural turbulence impacted strongly". Many participants "saw the principles underlying the programme as attractive, useful and innovative" but "they often struggled to convert enthusiasm into change." The development of the measurement system was "arduous" and data submission rates were "patchy throughout phase I but improved in reach and consistency in phase II." Also reported was "Some evidence of improvement in clinical outcomes over time could be detected but was hard to interpret". The authors conclude that there are "important lessons for large-scale improvement programmes, particularly when they seek to develop novel concepts and measures. External contexts may exert far-reaching influence. The challenges of developing measurement systems should not be underestimated."

Measuring patient safety: the Medicare Patient Safety Monitoring System (past, present, and future)
Classen DC, Munier W, Verzier N, Eldridge N, Hunt D, Metersky M, et al
Journal of Patient Safety. 2016 [epub].

DOI	http://dx.doi.org/10.1097/pts.0000000000000322
Notes	The cautionary conclusion of the previous item has its echoes in this piece describing the development and evolution of the US Medicare Patient Safety Monitoring System (MPSMS) and its redevelopment as the Quality and Safety Review System (QSRS). The new system will aim to encourage the standardisation and usage of data.

Improving patient safety reporting with the common formats: common data representation for Patient Safety Organizations
Elkin PL, Johnson HC, Callahan MR, Classen DC
Journal of Biomedical Informatics. 2016;64:116-21.

DOI	http://dx.doi.org/10.1016/j.jbi.2016.09.020
Notes	The issues of standardisation and improvement through use of data also resonate in this piece. Based on the premise that the "first step on the path to improvement in patient safety is more comprehensive collection and analysis of patient safety events" and a belief "that this will enable safety improvements based on data showing the nature and frequency of events that occur, and the effectiveness of interventions", the US Agency for Healthcare Research and Quality (AHRQ) have developed Common Formats for Patient Safety data collection and reporting. The authors describe the development of patient safety reporting and learning through the Patient Safety Organizations (PSO) and the Common Formats and provide an overview of how the system is expected to function and the breadth of development of the Common Formats to date.

Patient safety in the emergency department
Farmer BM
Emergency Medicine. 2016;48(9):396-404.

A patient reported approach to identify medical errors and improve patient safety in the emergency department
Glickman SW, Mehrotra A, Shea CM, Mayer C, Strickler J, Pabers S, et al
Journal of Patient Safety. 2016 [epub].

DOI	Farmer http://dx.doi.org/10.12788/emed.2016.0052 Glickman et al https://dx.doi.org/10.1097/PTS.0000000000000287
Notes	A pair of items looking at aspects of care in emergency departments. Farmer describes some aspects of patient safety in this particular setting, including medication safety, clinical handovers/ handoffs or transitions of care, discharge processes, and electronic health records. For each of these possible strategies for addressing the risks are also discussed. Glickman et al look at how patient observation and reporting may help identify issues and improve patient safety in emergency departments. In this study 52,683 surveys were distributed to patients in a large, academic emergency department over a 1-year period. Using the 7,103 responses (including 2,836 free text comments), the researchers classified 242 (8.5%) of 2836 comments as potential safety issues, including 12 adverse events, 40 near-misses, 23 errors with minimal risk of harm, and 167 general safety issues (e.g., gaps in care transitions). Of the 40 near misses, 35 (75.0%) of 40 were preventable. Of the 52 adverse events or near misses, 5 (9.6%) were also identified via an existing patient occurrence reporting system. These lead the authors to argue that "A patient-reported approach to assess ED-patient safety yields important, complementary, and potentially actionable safety information."

Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates
Dowell D, Zhang K, Noonan RK, Hockenberry JM
Health Affairs. 2016;35(10):1876-83.

DOI	http://dx.doi.org/10.1377/hlthaff.2016.0448
Notes	Paper describing the impact of some US states having mandated provider review of drug monitoring data. In states with mandated review, opioid prescribers must check whether patients are receiving opioids from multiple prescribers and identify the total prescribed opioid dose. According to this study, states with mandated review policies had fewer opioid overdose deaths and lower amounts of opioids prescribed than states without mandated prescriber review.

For information about the Commission's work on medication safety, including medication reconciliation, see www.safetyandquality.gov.au/our-work/medication-safety/

Economic value of pharmacist-led medication reconciliation for reducing medication errors after hospital discharge
Najafzadeh M, Schnipper JL, Shrank WH, Kymes S, Brennan TA, Choudhry NK
American Journal of Managed Care. 2016;22(10):654-61.

URL	http://www.ajmc.com/journals/issue/2016/2016-vol22-n10/Economic-Value-of-Pharmacist-Led-Medication-Reconciliation-for-Reducing-Medication-Errors-After-Hospital-Discharge
Notes	Paper reporting on a modelling study that sought to estimate the economic value of 'non-targeted' and 'targeted' medication reconciliation conducted by pharmacists and pharmacy technicians at hospital discharge versus usual care. The authors suggest that if medication discrepancies were reduced by 10% then the medication reconciliation would be cost neutral. Thus, if pharmacist-led medication reconciliation improves accuracy to the extent has been suggested by other studies, then implementing it at hospital discharge should save costs when compared with usual care.

BMJ Quality and Safety
December 2016, Vol. 25, Issue 12

URL	http://qualitysafety.bmj.com/content/25/12
Notes	A new issue of *BMJ Quality and Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality and Safety* include: • Editorial: **Patient-centred care**: confessions of a pragmatist (Kenneth EF Sands) • Editorial: **Video transparency**: a powerful tool for patient safety and quality improvement (Sarah Joo, Tim Xu, Martin A Makary) • Editorial: Does it matter how much **physician trainees** work anymore? (Kathlyn E Fletcher, Sumant R Ranji) • Fake and expired **medications in simulation-based education**: an underappreciated risk to patient safety (Jane Torrie, David Cumin, Janie Sheridan, Alan F Merry) • Effect of **patient-centred bedside rounds** on hospitalised **patients' decision control, activation and satisfaction** with care (Kevin J O'Leary, Audrey Killarney, Luke O Hansen, Sasha Jones, Megan Malladi, Kelly Marks, Hiren M Shah) • Lost information during the **handover of critically injured trauma patients**: a mixed-methods study (Tanya Liv Zakrison, Brittany Rosenbloom, Amanda McFarlan, Aleksandra Jovicic, Sophie Soklaridis, Casey Allen, Carl Schulman, Nicholas Namias, Sandro Rizoli) • The **Healthcare Complaints Analysis Tool**: development and reliability testing of a method for service monitoring and organisational learning (Alex Gillespie, Tom W Reader) • **Remote video auditing** with **real-time feedback** in an academic surgical suite improves safety and efficiency metrics: a cluster randomised study (Frank J Overdyk, Oonagh Dowling, Sheldon Newman, David Glatt, Michelle Chester, Donna Armellino, B Cole, G S Landis, D Schoenfeld, J F DiCapua) • Comparing **NICU teamwork and safety climate** across two commonly used survey instruments (Jochen Profit, Henry C Lee, Paul J Sharek, Peggy Kan, Courtney C Nisbet, Eric J Thomas, Jason M Etchegaray, Bryan Sexton)

	- Impact of the 2011 ACGME **resident duty hour reform** on hospital patient experience and processes-of-care (Ravi Rajaram, Lily Saadat, Jeanette Chung, Allison Dahlke, Anthony D Yang, David D Odell, Karl Y Bilimoria) - A 'paperless' wall-mounted **surgical safety checklist** with migrated leadership can improve compliance and team engagement (Aaron Pin Chien Ong, Daniel A Devcich, Jacqueline Hannam, Tracey Lee, Alan F Merry, Simon J Mitchell) - Displaying **radiation exposure and cost** information at order entry for outpatient diagnostic imaging: a strategy to inform **clinician ordering** (Jenna F Kruger, Alice Hm Chen, Alex Rybkin, Kiren Leeds, David Guzman, Eric Vittinghoff, L Elizabeth Goldman) - SQUIRE 2.0 (**Standards for QUality Improvement Reporting Excellence**): revised publication guidelines from a detailed consensus process (Greg Ogrinc, Louise Davies, Daisy Goodman, Paul Batalden, Frank Davidoff, David Stevens) - Explanation and elaboration of the SQUIRE (**Standards for Quality Improvement Reporting Excellence**) Guidelines, V.2.0: examples of SQUIRE elements in the healthcare improvement literature (Daisy Goodman, Greg Ogrinc, Louise Davies, G Ross Baker, Jane Barnsteiner, Tina C Foster, Kari Gali, Joanne Hilden, Leora Horwitz, Heather C Kaplan, Jerome Leis, John C Matulis, Susan Michie, Rebecca Miltner, Julia Neily, William A Nelson, Matthew Niedner, Brant Oliver, Lori Rutman, Richard Thomson, Johan Thor) - Abstracts: 22nd Annual IHI Scientific Symposium on Improving the Quality and Value of Health Care (Gareth Parry)

Health Expectations
December 2016, Volume 19, Issue 6

URL	http://onlinelibrary.wiley.com/doi/10.1111/hex.2016.19.issue-6/issuetoc
Notes	A new issue of *Health Expectations* has been published. Articles in this issue of *Health Expectations* include: - Editorial: **Public and patient involvement in health policy**: A continuously growing field (Kyriakos Souliotis) - **Conflicting health information**: a critical research need (Delesha M Carpenter, Lorie L Geryk, Annie T Chen, Rebekah H Nagler, Nathan F Dieckmann and Paul K J Han) - **Patient and family involvement in adult critical and intensive care settings**: a scoping review (Michelle Olding, Sarah E McMillan, Scott Reeves, Madeline H Schmitt, Kathleen Puntillo and Simon Kitto) - **Public preferences** for **communicating personal genomic risk** information: a focus group study (Amelia K Smit, Louise A Keogh, Jolyn Hersch, Ainsley J Newson, Phyllis Butow, Gabrielle Williams and A E Cust) - Building intentions with the **theory of planned behaviour**: a qualitative assessment of salient beliefs about pharmacy value added services in Malaysia (Christine Liang Hoay Tan, Mohamed Azmi Hassali, Fahad Saleem, Asrul Akmal Shafie, Hisham Aljadhay and Vincent B Y Gan) - **Treatment-related experiences and preferences** of patients with lung cancer: a qualitative analysis (Ines Aumann, Kristine Kreis, Kathrin Damm, Heiko Golpon, Tobias Welte and J Matthias Graf von der Schulenburg) - Let's talk about sex: older people's views on the **recognition of sexuality and sexual health** in the health-care setting (Michael Bauer, Emily Haesler and Deirdre Fetherstonhaugh)

	- We are not all coping: a cross-sectional investigation of **resilience** in the **dementia care workforce** (Kate-Ellen J Elliott, Christine M Stirling, Angela J Martin, Andrew L Robinson and Jennifer L Scott) **Citizens' preferences on healthcare expenditure allocation**: evidence from Greece (Sofia Xesfingi, Athanassios Vozikis and Yannis Pollalis) - Healthcare providers' experiences screening for **intimate partner violence** among migrant and seasonal farmworking women: A phenomenological study (Jonathan B Wilson, Damon L Rappleyea, Jennifer L Hodgson, Andrew S Brimhall, Tana L Hall and Alyssa P Thompson) - Facilitating **psychosexual adjustment** for women undergoing pelvic radiotherapy: pilot of a novel patient psycho-educational resource (Franchelle Lubotzky, Phyllis Butow, Kathryn Nattress, Caroline Hunt, Susan Carroll, Andrew Comensoli, Shannon Philp and Ilona Juraskova) - A devolved model **for public involvement** in the field of **mental health research**: case study learning (Pam Moule and Rosie Davies) **Knowledge, attitudes and beliefs** regarding **colorectal cancer screening** among ethnic minority groups in the Netherlands – a qualitative study (Anke J Woudstra, Evelien Dekker, Marie-Louise Essink-Bot and Jeanine Suurmond) **Young adults' experiences** of **seeking online information** about diabetes and mental health in the age of social media (Gillian Fergie, Shona Hilton and Kate Hunt) **Public involvement in research within care homes**: benefits and challenges in the APPROACH study (Katherine Froggatt, Claire Goodman, Hazel Morbey, Sue L Davies, Helen Masey, Angela Dickinson, Wendy Martin and Christina Victor) **Trial participation as avoidance strategy**: a qualitative study (Natalie Armstrong, Elizabeth Shaw, Elaine McColl, Douglas G Tincello and P Hilton)

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: Remembering to learn: the overlooked role of **remembrance in safety improvement** (Carl Macrae)

Online resources

[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:

- New summaries for treating low back pain
  For clinicians: *Noninvasive Treatments for* **Low Back Pain:** *Current State of the Evidence* summarises the benefits and harms of non-invasive treatments for acute, subacute and chronic low back pain. https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2327
  The publication summarizes findings in a systematic review that examined interventions including exercise, medications, acupuncture and superficial heat. The publication also evaluates the strength of evidence for each finding. Also available is a new continuing education module based on the evidence review. http://www.baylorcme.org/trans/cme.cfm?activityID=394
  For patients: *Noninvasive Treatments for* **Low Back Pain** *– A Summary of the Research for Adults* https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2326
- *Strategies for Improving the Lives of* **Women** *Aged 40 and Above* **Living With HIV/AIDS** https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2328

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