



On the Radar

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On the Radar

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Reports

Treat as One: Bridging the gap between mental and physical healthcare in general hospitals
National Confidential Enquiry into Patient Outcome and Death
London. 2017. p. 112.

URL	http://www.ncepod.org.uk/2017mhgh.html
Notes	<p>People with experience of mental health issues have reported receiving sub-optimal care when they attend health services for physical health concerns. It is estimated that people with serious mental illness die 15 years earlier than members of the general population, from preventable physical health problems.</p> <p>This report provides detailed information about systematic factors that influence the care provided to people with known mental health conditions when they enter hospital for treatment of physical illness. A team of clinical researchers reviewed admission notes for 552 people over one month in 2014 throughout general hospitals in the United Kingdom. They also conducted a survey with over 1300 healthcare professionals.</p> <p>Key findings include:</p> <ul style="list-style-type: none"> • 21% of patients did not have their mental health history recorded at admission • 71% of patients had medicines reconciliation at initial assessment • 28% of discharge summaries lacked mental health diagnoses and details of mental health medications, and there was no evidence that discharge summaries were copied to relevant mental health consultants, even where

these were named

- 11% of healthcare professionals had no basic training in mental health awareness, and 39% had no training dealing with patients who had self-harmed

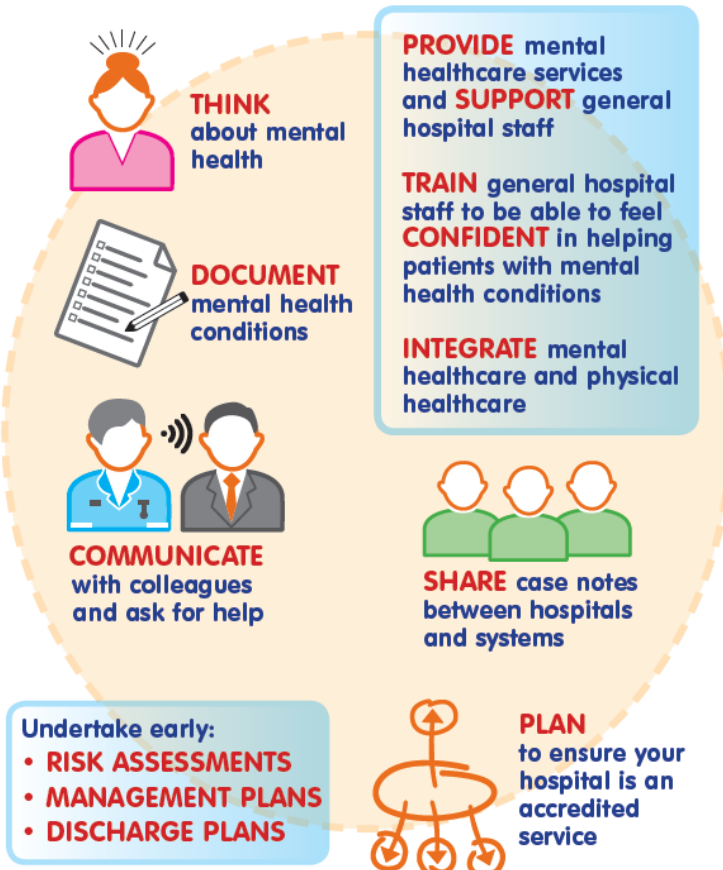
The report also includes a number of case studies that starkly illustrate the negative outcomes for individuals behind these statistics.


The report recommends:

- Patients who present with known co-existing mental health conditions should have them documented and assessed along with any other clinical conditions that have brought them to hospital.
- National guidelines should be developed outlining the expectations of general hospital staff in the management of mental health conditions
- All hospital staff who have interaction with patients, including clinical, clerical and security staff, should receive training in mental health conditions in general hospitals.

The Commission has previously begun work on integrated resources that align with the recommendations arising from this report. Version 2 of the *National Safety and Quality Health Service Standards* includes a Comprehensive Care Standard that sets out screening and assessment protocols for physical, mental and cognitive health problems. The Commission has also developed a draft *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*. Check the website for information on these later in the year, or sign up to our Twitter feed for advance notice.

TO IMPROVE THE PROVISION OF MENTAL HEALTHCARE IN GENERAL HOSPITALS WE NEED TO:



URL	http://www.ihl.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx
Notes	<p>The (US) Institute for Healthcare Improvement (IHI) and Safe & Reliable Healthcare (SRH) have collaborated to develop this framework that seeks to offer “direction to health care organisations on key strategic, clinical, and operational components involved in achieving safe and reliable operational excellence — a ‘system of safety,’ not just a collection of stand-alone safety improvement projects.”</p> <p>According to the IHI, the framework:</p> <ul style="list-style-type: none"> • Describes the framework's two foundational domains — culture and the learning system — outlining what is involved with each and how they interact • Provides definitions and implementation strategies for nine interrelated components: leadership, psychological safety, accountability, teamwork and communication, negotiation, transparency, reliability, improvement and measurement, and continuous learning • Discusses engagement of patients and their families, the core of the framework — the engine that drives the focus of the work to create safe, reliable, and effective care.  <p>© Institute for Healthcare Improvement and Safe & Reliable Healthcare</p>

Journal articles

Surgical decision making: Challenging dogma and incorporating patient preferences

Chhabra KR, Sacks GD, Dimick JB

Journal of the American Medical Association. 2017;317(4):357-8.

DOI	http://dx.doi.org/10.1001/jama.2016.18719
Notes	<p>In this opinion piece Chhabra and colleagues discuss three recently published randomised trials which compare three commonly used operations (appendectomy for appendicitis, colectomy for diverticulitis and knee replacement for osteoarthritis) with less invasive or non-operative alternatives.</p> <p>In all three trials, the less invasive treatments were found to be safe, effective and though less definitive, may be preferred by some patients, thus challenging the dogma of long-established surgical gold standard treatments.</p> <p>The authors suggest that in situations where no treatment option is clearly superior, the determination about which treatment is ‘best’ should be guided by how the patient values the different outcomes and trade-offs through the process of shared decision making.</p>

The Commission is developing an online training module for doctors on the effective communication of risks and benefits with patients. A version for general practitioners is currently available for RACGP members at www.racgp.org.au/. A specialist college version will be released in mid-2017.

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

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

Parent Preferences for Medical Error Disclosure: A Qualitative Study

Coffey M, Espin S, Hahmann T, Clairman H, Lo L, Friedman JN, et al

Hospital Pediatrics. 2017;7(1):24-30.

DOI	http://dx.doi.org/10.1542/hpeds.2016-0048
Notes	<p>Paper reporting on a qualitative study that interviewed 15 parents of hospitalised children to examine their preferences about disclosure of errors, near misses, and the degree to which they were willing for their children to participate in disclosure processes. In the scenarios where harm occurred the parents uniformly wanted disclosure, but not necessarily for the child informed. For non-harmful errors, most parents wanted disclosure for themselves but few for their children. As the authors concluded “Parents have mixed expectations regarding disclosure. Although survey studies indicate a stronger desire for disclosure of nonharmful events than for adult patients, this qualitative study revealed a greater degree of hesitation and complexity. Parents have a great need for reassurance and consistently wish to act as a buffer between the health care team and their children.”</p>

For information about the Commission’s work on open disclosure, including the national *Australian Open Disclosure Framework*, see <https://www.safetyandquality.gov.au/our-work/open-disclosure/>

Transmission of Staphylococcus aureus between health-care workers, the environment, and patients in an intensive care unit: a longitudinal cohort study based on whole-genome sequencing

Price JR, Cole K, Bexley A, Kostiou V, Eyre DW, Golubchik T, et al
The Lancet Infectious Diseases. 2017;17(2):207-14.

Effects of control interventions on Clostridium difficile infection in England: an observational study

Dingle KE, Didelot X, Quan TP, Eyre DW, Stoesser N, Golubchik T, et al
The Lancet Infectious Diseases. 2017

Effect of a national 4C antibiotic stewardship intervention on the clinical and molecular epidemiology of Clostridium difficile infections in a region of Scotland: a non-linear time-series analysis

Lawes T, Lopez-Lozano J-M, Nebot CA, Macartney G, Subbarao-Sharma R, Wares KD, et al
The Lancet Infectious Diseases. 2017;17(2):194-206.

Clostridium difficile infection: stewardship's lowest hanging fruit?

Graber CJ

The Lancet Infectious Diseases. 2017;17(2):123-4.

DOI	<p>Price et al http://dx.doi.org/10.1016/s1473-3099(16)30413-3 Dingle et al http://dx.doi.org/10.1016/s1473-3099(16)30514-x Lawes et al http://dx.doi.org/10.1016/S1473-3099(16)30397-8 Graber http://dx.doi.org/10.1016/s1473-3099(16)30416-9</p>
Notes	<p>The journal <i>Lancet Infectious Diseases</i> had a number of articles on two important infections, <i>Staphylococcus aureus</i> and <i>Clostridium difficile</i>.</p> <p>Price et al report on a study that looked at transmission of <i>Staphylococcus aureus</i> between health workers, patients and the intensive care unit (ICU) environment. This was longitudinal cohort study in which health-care workers, the environment, and patients were systematically sample over 14 months at the ICU and high dependency unit (HDU) of the Royal Sussex County Hospital, Brighton, England. Nasal swabs were taken from health-care workers every 4 weeks, bed spaces were sampled monthly, and screening swabs were obtained from patients at admission, weekly thereafter, and at discharge. 198 health-care workers, 40 environmental locations, and 1854 patients were sampled; 1819 isolates were sequenced. While <i>S aureus</i> was routinely found, with 605 genetically distinct subtypes identified the analysis found only 25 instances of transmission to patients (seven from health-care workers, two from the environment, and 16 from other patients). This led to the conclusion that “In the presence of standard infection control measures, health-care workers were infrequently sources of transmission to patients. <i>S aureus</i> epidemiology in the ICU and HDU is characterised by continuous ingress of distinct subtypes rather than transmission of genetically related strains.”</p> <p>The remaining three papers all looked at <i>Clostridium difficile</i> – all with reasonably positive news.</p> <p>Dingle et al examined how the incidence of <i>C difficile</i> in England declined by roughly 80% after 2006, following the implementation of national control policies. They sought to test two hypotheses: if <i>C difficile</i> infection declines were driven by reductions in use of particular antibiotics; and if <i>C difficile</i> infection declines were driven by improvements in hospital infection control. Their analyses led the authors to conclude that “Restricting fluoroquinolone prescribing appears to explain the decline in incidence of <i>C difficile</i> infections, above other measures, Antimicrobial stewardship should be a central component of <i>C difficile</i> infection control programmes.”</p> <p>Lawes et al also looked at the role of antimicrobial stewardship on <i>C difficile</i> incidence. This study looked at national antibiotic stewardship intervention limiting the use of 4C</p>

	<p>antibiotics (fluoroquinolones, clindamycin, co-amoxiclav, and cephalosporins) and other infection prevention and control strategies in northeast Scotland. This study also found a significant impact as the authors reported “Limiting population use of 4C antibiotics reduced selective pressures favouring multidrug-resistant epidemic ribotypes and was associated with substantial declines in total <i>C difficile</i> infections in northeast Scotland.” They also noted that “Efforts to control <i>C difficile</i> through antibiotic stewardship should account for ribotype distributions and non-linear effects.”</p> <p>These articles contribute to Graber’s discussion as to whether ameliorating or preventing <i>Clostridium difficile</i> may be one of the more readily achievable goals of antimicrobial stewardship. “Reduction of inappropriate use of antibiotics, particularly those associated with high <i>C difficile</i> infection risk, thus represents one of the clearest opportunities for antimicrobial stewardship programmes to demonstrate their benefit, not only at an individual medical centre level but also at a system or population level.”</p>
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For information about the Commission’s work on healthcare associated infection, including antimicrobial stewardship, see <https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/>

Australian Health Review
Volume 41(1) 2017

URL	http://www.publish.csiro.au/ah/issue/8486
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"> • Costs of paying higher prices for equivalent effects on the Pharmaceutical Benefits Scheme (Jonathan Karnon, Laura Edney and Michael Sorich) • Effect of a smoke-free policy on staff attitudes and behaviours within an Australian metropolitan health service: a 3 year cross-sectional study (Nicole Hale, Andrea M Murphy, Jon R Adams and Cylie M Williams) • Using a community of practice to evaluate falls prevention activity in a residential aged care organisation: a clinical audit (Jacqueline Francis-Coad, Christopher Etherton-Ber, Caroline Bulsara, Debbie Nobre and A-M Hill) • Health technology assessment in Australia: a role for clinical registries? (Anna Mae Scott) • Steam sterilisation’s energy and water footprint (Forbes McGain, Graham Moore and Jim Black) • Platelet-rich plasma: a case study for the identification of disinvestment opportunities using horizon scanning (Linda Mundy) • Integrated mental health atlas of the Western Sydney Local Health District: gaps and recommendations (Ana Fernandez, James A Gillespie, Jennifer Smith-Merry, Xiaoqi Feng, Thomas Astell-Burt, Cailin Maas and Luis Salvador-Carulla) • Organisational benefits of a strong research culture in a health service: a systematic review (Katherine Harding, Lauren Lynch, J Porter and N F Taylor) • Stranded: causes and effects of discharge delays involving non-acute in-patients requiring maintenance care in a tertiary hospital general medicine service (Armi Salonga-Reyes and Ian A Scott) • Private general paediatric care availability in Melbourne (Marina Kunin, Amy R Allen, Caroline Nicolas and Gary L Freed)

	<ul style="list-style-type: none"> • Community views and perspectives on public engagement in health technology assessment decision making (Sally Wortley, Allison Tong and Kirsten Howard) • Western Australia's rural surgical workforce going to sustain the future? A quantitative and qualitative analysis (Sharanyaa Shanmugakumar, Denese Playford, Tessa Burkitt, Marc Tennant and Tom Bowles) • Costs and returns on training investment for empirically supported psychological interventions (Erica Crome, Joanne Shaw and Andrew Baillie) • How do we capture the emergency nurse practitioners' contribution to value in health service delivery? (Natasha Jennings, Matthew Lutze, Stuart Clifford and Michael Maw) • Roles and competencies of the Support Facilitator in Australia's recovery-oriented mental health initiative: a qualitative study from Gippsland, Victoria (Keith Sutton, Anton N Isaacs, Kim Dalziel and Darryl Maybery) • Should the healthcare compass in Australia point towards value-based primary healthcare? (Jodie Oliver-Baxter, Lynsey Brown and Paresh Dawda) • Screening for important unwarranted variation in clinical practice: a triple-test of processes of care, costs and patient outcomes (Andrew Partington, Derek P. Chew, David Ben-Tovim, M Horsfall, P Hakendorf and J Karnon) • Urban Australian general practitioners' perceptions of falls risk screening, falls risk assessment, and referral practices for falls prevention: an exploratory cross-sectional survey study (Kajtek Kielich, Lynette Mackenzie, Meryl Lovarini and Lindy Clemson)
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Healthcare Quarterly
Vol. 19 No. 4, 2017

URL	http://www.longwoods.com/publications/healthcare-quarterly/24901
Notes	<p>A new issue of <i>Healthcare Quarterly</i> has been published. Articles in this issue of <i>Healthcare Quarterly</i> include:</p> <ul style="list-style-type: none"> • Pediatric Insulin Pump Therapy: Reflecting on the First 10 Years of a Universal Funding Program in Ontario (Rayzel Shulman, Fiona A Miller, Thérèse A Stukel, Denis Daneman and Astrid Guttman) • A Snapshot of Advance Directives in Long-Term Care: How Often Is "Do Not" Done? (Sheril Perry and Christina Lawand) • Open Innovation Prizes and Challenges: Learnings from the ImagineNation Series (Jennifer Zelmer, Fraser Ratchford and Justin Noble) • Principles for Health System Capacity Planning: Insights for Healthcare Leaders (James Shaw, Ivy Wong, Bailey Griffin, Michael Robertson and R Sacha Bhatia) • Comparing the Health of Canadian Hospitals: Paying Attention to the Mix of Planned and Unplanned Admissions (Les Vertesi) • How Appropriate Is All This Data Sharing? Building Consensus Around What We Need to Know About Shared Electronic Health Records in Extended Circles of Care (Josephine McMurray, Kelly A Grindrod and Catherine Burns) • The Development of a Quality Management Framework for Evaluating Medical Device Reprocessing Practice in Healthcare Facilities (Bailey Lory, Robin Horodyski, Cynthia Welton, John Vail, Luca Simonetto, Danilo Jokanovic, Richa Sharma, Angela Rea Mahoney, Shay Savoy-Bird and S Bains)

	<ul style="list-style-type: none"> • Key Advantages of a Targeted Incident Reporting System for Severe and Critical <i>Clostridium difficile</i> Infection Incidents (Hibak Mahamed, Camille Lemieux and Susy Hota) • Emergency Department Use: Influence of Connection to a Family Physician on ED Use and Attempts to Avoid Presentation (Lynette D Krebs, Scott W Kirkland, Cristina Villa-Roel, Alan Davidson, Britt Voaklander, Taylor Nickel, Rajiv Chetram, Stephanie Couperthwaite, Garnet Cummings and B H Rowe) • Primary Care Collaborative Memory Clinics: Building Capacity for Optimized Dementia Care (Linda Lee, Loretta M Hillier, Frank Molnar and M J Borrie) • Lessons Learned from an Advanced Access Trial Within a Canadian Armed Forces Primary Care Clinic (P Tony Singh) • Strategies For Challenging Behaviours: Implementation of Behavioural Supports Ontario (BSO): An Evaluation of Three Models of Care (Michelle Grouchy, Nancy Cooper and Tommy Wong) • Longitudinal Evaluation of a Parent and School Team-Mediated Workshop Intervention for Reducing Challenging Behaviours in Children with Autism Spectrum Disorder (Brea Chouinard and Shawn Reynolds)
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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"> • Our current approach to root cause analysis: is it contributing to our failure to improve patient safety? (Kathryn M Kellogg, Zach Hettinger, Manish Shah, Robert L Wears, Craig R Sellers, Melissa Squires, Rollin J Fairbanks) • Deaths from preventable adverse events originating in hospitals (John T James) • Getting to grips with the beast: the potential of multi-method operational research approaches (Jenni Burt) • Estimating preventable hospital deaths: the authors reply (Kaveh G Shojanian, Mary Dixon-Woods)

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"> • Quality of antenatal care and client satisfaction in Kenya and Namibia (Mai Do; Wenjuan Wang; John Hembling; Paul Ametepi) • Evaluation of a novel mentor program to improve surgical care for US hospitals (Julia R Berian; Juliana M Thomas; Christina A Minami; Paula R Farrell; Kevin J O'Leary) • A flowchart for building evidence-based care bundles in intensive care: based on a systematic review (Marjon Borgert; Jan Binnekade; Frederique Paulus; Astrid Goossens; Dave Dongelmans) • Reliability of clinical impact grading by healthcare professionals of common prescribing error and optimisation cases in critical care patients (Richard S Bourne; Rob Shulman; Mark Tomlin; Mark Borthwick; Will Berry; G H Mills)

Online resources

[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:

- Quality Standard QS86 *Falls in older people* <https://www.nice.org.uk/guidance/qs86>
- Quality Standard QS21 *Stable angina* <https://www.nice.org.uk/guidance/qs21>

[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:

- *Modeling and Simulation in the Context of Health Technology Assessment: Review of Existing Guidance, Future Research Needs, and Validity Assessment*
<https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2425>
- For clinicians: *Diagnosis and Management of Gout: Current State of the Evidence*
<https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2323>
- A plain-language publication for patients: *Managing Gout – A Review of the Research for Adults*
<https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2324>

[USA] Making Informed Consent an Informed Choice: Training Modules for Health Care Leaders and Professionals

<https://www.ahrq.gov/professionals/systems/hospital/informedchoice/index.html>

The (US) Agency for Healthcare Research and Quality (AHRQ) has developed two new continuing education activities (and an accompanying implementation guide) to improve the informed consent process, one for hospital executives and the other for health care professionals.

- *Making Informed Consent an Informed Choice: Training Module for Health Care Leaders* provides guidance on developing informed consent policies and securing organizational support to ensure best practices in informed consent are consistently practiced.
- *Making Informed Consent an Informed Choice: Training Module for Professionals* teaches clinicians a set of strategies to communicate clearly, present choices, and confirm and document informed consent.

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