AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Reports

National guidelines for on-screen presentation of discharge summaries
Australian Commission on Safety and Quality in Health Care
Sydney: ACSHQC; 2016. 56 p.

URL	https://www.safetyandquality.gov.au/publications/national-guidelines-for-on-screen-presentation-of-discharge-summaries/
Notes	The *National guidelines for on-screen presentation of discharge summaries* specify the sequence, layout and format of the core elements of hospital discharge summaries, as displayed in clinical information systems. The guidelines were developed through extensive research, consultation and iterative testing with more than 70 clinicians. The guidelines are intended to be adopted by vendors of medical software, and health services which procure and implement systems which generate and present discharge summaries. National guidelines for on-screen presentation of discharge summaries August 2016 AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE
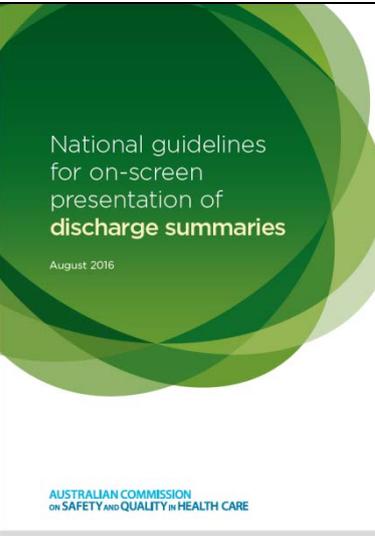
Journal articles

Exploring the roots of unintended safety threats associated with the introduction of hospital ePrescribing systems and candidate avoidance and/or mitigation strategies: a qualitative study
Mozaffar H, Cresswell KM, Williams R, Bates DW, Sheikh A
BMJ Quality & Safety. 2017 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2016-005879
Notes	Paper describing a number of the types of safety issues that can arise from the implementation and adoption of hospital ePrescribing systems and some possible technological and organisational strategies. Based on studies of the implementation and adoption of such systems in six English hospitals that included 214 interviews, 24 observations and a range of documents, the authors categorised the factors underlying unintended safety threats into various categories: 1. **suboptimal system design**, including lack of support for complex medication administration regimens, lack of effective integration between different systems, and lack of effective automated decision support tools; 2. **inappropriate use of systems**—in particular, too much reliance on the system and introduction of workarounds; and 3. **suboptimal implementation strategies** resulting from partial roll-outs/dual systems and lack of appropriate training.

For information about the Commission's work on safety in e-health, including electronic medication management systems in hospitals, see https://www.safetyandquality.gov.au/our-work/safety-in-e-health/

Integrated Approach to Reduce Perinatal Adverse Events: Standardized Processes, Interdisciplinary Teamwork Training, and Performance Feedback
Riley W, Begun JW, Meredith L, Miller KK, Connolly K, Price R, et al.
Health Services Research. 2016;51:2431-52.

DOI	http://dx.doi.org/10.1111/1475-6773.12592
Notes	This paper reports on a study that examined the impact of an intervention aimed at improving safety practices and reducing adverse events in perinatal units. The study used data from perinatal units of 14 hospitals participating in the intervention between 2008 and 2012 involving 342,754 deliveries to examine the quality improvement collaborative that supported three primary interventions. Primary measures include adoption of three standardized care processes and four measures of outcomes. The perinatal units increased use of all three care processes, while harms measured by the Adverse Outcome Index decreased 14 percent.

Patient safety in community dementia services: what can we learn from the experiences of caregivers and healthcare professionals?
Behrman S, Wilkinson P, Lloyd H, Vincent C
Age and Ageing [epub].

DOI	https://doi.org/10.1093/ageing/afw220
Notes	Safety and quality issues can affect any patients. However, some patients may be more vulnerable. One such group may be patients with dementia. That paper reports on a qualitative study that interviewed 20 caregivers and health care workers. These interviews identified a range of issues including medication errors, miscommunication between professionals, unclear service pathways and the effects of stress on caregivers' behaviour. The authors noted that caregivers and professionals differed in their attitudes to balancing safety with patient autonomy and who is responsible for managing safety.

A randomized trial to determine the impact of a 5 moments for patient hand hygiene educational intervention on patient hand hygiene

Rai H, Knighton S, Zabarsky TF, Donskey CJ

American Journal of Infection Control. 2017 [epub].

DOI	http://dx.doi.org/10.1016/j.ajic.2016.12.022
Notes	The 5 Moments for Hand Hygiene has been used to encourage and promote effective hand hygiene by clinicians. This paper describes a study that looked at a 5 moments for hand hygiene for patients. The authors suggest that their intervention led to "a significant increase in patient hand hygiene."

For information about the Commission's work on healthcare associate infections, including the National Hand Hygiene Initiative, see https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Public Health Research & Practice

February 2017, Volume 27, Issue 1

URL	http://www.phrp.com.au/issues/february-2017-volume-27-issue-1-2/
Notes	A new issue of *Public Health Research & Practice* has been published. This issue is a special edition examining the theme of knowledge translation to support public health policy and practice. Articles in this issue of *Public Health Research & Practice* include: • Editorial: **Knowledge translation** – evidence into action (Don Nutbeam and Andrew J Milat) • Interview with the Hon. Nicola Roxon: getting **evidence into health policy** (Nicola Roxon) • A long-term, strategic approach to **evidence generation and knowledge translation** in NSW, Australia (Sarah Thackway, Danielle Campbell, Tina Loppacher) • **Alliance for Health Policy and Systems Research**: aims, achievements and ambitions (Adbul Ghaffar, NhanTran, Etienne Langlois, Z Shroff, D Javadi) • Narrative review of frameworks for **translating research evidence into policy and practice** (Andrew Milat, Ben Li) • Qualitative investigation of the reasons behind opposition to **water fluoridation** in regional NSW, Australia (Matthew C Knox, Alexander Garner, Alan Dyason, Thomas Pearson, Sabrina W Pit) • A new model of **collaborative research**: experiences from one of Australia's **NHMRC Partnership Centres for Better Health** (Sonia Wutzke, Sally Redman, Adrian Bauman, Penelope Hawe, Alan Shiell, S Thackway, A Wilson) • **Dynamic simulation modelling of policy responses** to reduce alcohol-related harms: rationale and procedure for a participatory approach (Jo-An Atkinson, Eloise O'Donnell, John Wiggers, Geoff McDonnel, Jo Mitchell, Louise Freebairn, Devon Indig, Lucie Rychetnik) • The use of **secondments** as a tool to increase **knowledge translation** (Lily O'Donoughue Jenkins, Kaarin Anstey) • **Communicating about risk**: strategies for situations where public concern is high but the risk is low (Claire Hooker, Adam Capon, Julie Leask)

International Journal for Quality in Health Care online first articles

URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Examining the nature of **interprofessional interventions** designed to promote **patient safety**: a narrative review (Scott Reeves; Emma Clark; Sally Lawton; Melissa Ream; Fiona Ross) • Factors constraining **patient engagement** in implantable medical device discussions and **decisions**: interviews with physicians (Anna R Gagliardi, Pascale Lehoux, Ariel Ducey, Anthony Easty, Sue Ross, Chaim M Bell, Patricia Trbovich, Julie Takata and David R Urbach) • Experimenting the hospital survey on **patient safety culture** in prevention facilities in Italy: psychometric properties (Carmen Tereanu; Scott A Smith; Giuseppe Sampietro; Francesco Sarnataro; Giuliana Mazzoleni; Bruno Pesenti; Luca C Sala; Roberto Cecchetti; Massimo Arvati; Dania Brioschi; Michela Viscardi; Chiara Prati; Giorgio G Barbaglio)

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:
- Clinical Guideline CG74 **Surgical site infections**: *prevention and treatment* https://www.nice.org.uk/guidance/cg74
- Clinical Guideline CG139 **Healthcare-associated infections**: *prevention and control in primary and community care* https://www.nice.org.uk/guidance/cg139

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