



On the Radar

Issue 315

20 March 2017

On the Radar is a summary of some of the recent publications in the areas of safety and quality in health care. Inclusion in this document is not an endorsement or recommendation of any publication or provider. Access to particular documents may depend on whether they are Open Access or not, and/or your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

On the Radar is available online, via email or as a PDF or Word document from <http://www.safetyandquality.gov.au/publications-resources/on-the-radar/>

If you would like to receive *On the Radar* via email, you can subscribe on our website <http://www.safetyandquality.gov.au/> or by emailing us at mail@safetyandquality.gov.au. You can also send feedback and comments to mail@safetyandquality.gov.au.

For information about the Commission and its programs and publications, please visit <http://www.safetyandquality.gov.au>
You can also follow us on Twitter @ACSQHC.

On the Radar

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

Contributors: Niall Johnson, Alice Bhasale

Reports

The Economics of Patient Safety : Strengthening a value-based approach to reducing patient harm at national level
Slawomirski L, Auraaen A, Klazinga N
Paris: OECD Publishing; 2017. p. 65.

URL	https://www.bundesgesundheitsministerium.de/health/patient-safety-summit-2017.html
Notes	<p>This OECD-authored report was prepared for a workshop at the Second Global Ministerial Summit on Patient Safety to be held in Germany this month.</p> <p>The report focuses on the economics of patient safety and has two major sections:</p> <ol style="list-style-type: none"> 1. The cost of failure. Estimating the costs of lapses in patient safety. 2. Reducing harm effectively and efficiently. Exploring a value-based approach to investing in patient safety in a resource-constrained context. The relative costs and impact of various interventions (and combinations thereof) targeting patient harm across healthcare systems are estimated using a snapshot survey of international patient safety experts and policy makers. <p>The key messages from this report include:</p> <ul style="list-style-type: none"> • Patient safety is a critical policy issue. Patient harm is estimated to be the 14th leading cause of the global disease burden. • The cost to patients, healthcare systems and societies is considerable. Patient harm imparts a high financial cost. Overall, the available evidence

	<p>suggests that 15% of hospital expenditure and activity in OECD countries can be attributed to treating safety failures. Patient harm is felt in the broader economy through lost capacity and productivity of patients and their carers. It is estimated that the aggregate costs amount to trillions of dollars each year.</p> <ul style="list-style-type: none"> • Most of the burden is associated with a few common adverse events. The most burdensome include healthcare-associated infections (HAI), venous thromboembolism (VTE), pressure ulcers, medication error and wrong or delayed diagnosis. For example, it is estimated that every adult in the United States will experience a diagnostic error at least once during their life time. The annual cost of common adverse events in England is equivalent to 2,000 GPs or 3,500 hospital nurses • Greater investment in prevention is justified. Many adverse events can be systematically prevented through better policy and practice, with the cost of prevention typically much lower than the cost of harm. • Solid foundations for patient safety need to be in place. A national value-based approach – where harm is reduced using limited resources – should begin with investing in fundamental system-level initiatives such as professional education and training, safety standards and a solid information infrastructure. • Active engagement of providers and patients is critical. Organisational-level initiatives such as clinical governance frameworks, patient–engagement and building a positive safety culture also form an important part of an integrated patient safety strategy. • Innovation at the clinical level is enhanced through national leadership. Emphasis should broaden from safety in hospital settings to primary care and long term care. Vision and leadership at the highest levels of government is required to operationalise a systems approach to improving patient safety and ensure that healthcare is a high-reliability industry. • Practical approaches exist to identify national priorities for action. A system-wide priority setting exercise with broad range of stakeholders can build consensus and inform safety strategies.
--	--

Journal articles

Patient safety incidents are common in primary care: A national prospective active incident reporting survey

Michel P, Brami J, Chanelière M, Kret M, Mosnier A, Dupie I, et al

PLoS ONE. 2017;12(2):e0165455.

DOI	http://dx.doi.org/10.1371/journal.pone.0165455
Notes	<p>Historically, much of the focus of the safety and quality movement in healthcare has been on the acute sector, the care taking place in hospitals. It has been understood that primary care – where the majority of care is undertaken – was something of an unknown for the scale and nature of safety and quality issues. This French study asked GPs to report any incidents observed each day over a one-week period between May and July 2013. An incident was an event or circumstance that could have resulted, or did result, in harm to a patient, which the GP would not wish to recur. The 127 GPs reported 317 incidents of which 270 were deemed to be preventable, among 12,348 encounters. 77% had no consequences for the patient. The incidence of reported PSIs was 26 per 1000 patient encounters per week. The authors concluded that “Patient safety incidents (PSIs) occurred in mean once every two days in the sampled GPs and 2% of them were associated with a definite possibility for harm.”</p>

Variation in outpatient consultant physician fees in Australia by specialty and state and territory

Freed GL, Allen AR

Medical Journal of Australia. 2017;206(4):176-80.

Variation in the fees of medical specialists: problems, causes, solutions

McRae IS, van Gool KC

Medical Journal of Australia. 2017;206(4):162-3.

Variation in the costs of surgery: seeking value

Hillis DJ, Watters DAK, Malisano L, Bailey N, Rankin D

Medical Journal of Australia. 2017;206(4):153-4.

DOI	Freed and Allen http://dx.doi.org/10.5694/mja16.00653 McRae and van Gool http://dx.doi.org/10.5694/mja16.01297 Hillis et al http://dx.doi.org/10.5694/mja16.01161
Notes	<p>The issue of variation has become quite prominent. Three articles in the latest <i>MJA</i> discuss the considerable variation in fees for surgery, noting the considerable out-of-pocket (OOP) costs for patients, and the possible consequences for sustainability. Hillis et al use hip fracture surgery as an example, with varying costs in terms of hospital length of stay, the costs of prostheses and OOP costs. For the 299 surgeons who performed at least five hip replacements, 142 (47%) did not charge any OOP. The OOP charged ranged from none to \$4057.</p> <p>Freed and Allen compare bulk-billing rates across 11 major specialties, finding considerable variation, and that only haematology and medical oncology showed bulk-billing for more than half of initial consultations. Out-of-pocket payments varied more than fivefold in some specialties.</p> <p>McRae and van Gool describe causes and potential solutions, with transparency of information about costs and fees being a key theme.</p>

Use of standard risk screening and assessment forms to prevent harm to older people in Australian hospitals: a mixed methods study

Redley B, Raggatt M

BMJ Quality & Safety. 2017.

DOI	http://dx.doi.org/10.1136/bmjqs-2016-005867
Notes	<p>This study of standardised patient risk screening and assessment tools in 11 Victorian health services reported finding that in this small selection of health services there were 52 standard assessment forms in use (the abstract says 152). The paper goes on to discuss many of the implications of such a range of ‘standard’ forms. These include the range of items covered (and not covered such as frailty, nutrition and cognitive impairment) by these forms, the burdens on staff and patients, the difficulty of converting information into appropriate care, poor integration with technology, and others. The author’s offer a set of key recommendations:</p> <ul style="list-style-type: none"> • Bundle interventions to address multiple risks: Explore use of global triggers and intervention bundles to address multiple risks, for example, frailty, vulnerability, cognitive impairment. • Combine and streamline assessment tools to reduce burden on patients and staff. • Support individualised care and clinical judgement in complexity: Include the patient's voice and support iterative decision-making. • Build resilience in front-line clinical governance: Shift focus of quality monitoring from error and form compliance to recognising good practice and effectiveness of patient-centred intervention.

Thirty years of the World Health Organization's target caesarean section rate: time to move on

Robson SJ, de Costa CM

Medical Journal of Australia. 2017;206(4):181-5.

DOI	http://dx.doi.org/10.5694/mja16.00832
Notes	The authors discuss the WHO's target caesarean rate of 15% and ask whether an international rate is realistic. They describe the differences in demographics, and particularly the increasing average maternal age in Australia, as well as the long-term negative impacts of vaginal birth.

Understanding 30-day re-admission after hospitalisation of older patients for diabetes: identifying those at greatest risk

Caughey GE, Pratt NL, Barratt JD, Shakib S, Kemp-Casey AR, Roughead EE

Medical Journal of Australia. 2017;206(4):170-5.

DOI	http://dx.doi.org/10.5694/mja16.00671
Notes	<p>This Australian study used Department of Veterans' Affairs administrative data for all patients hospitalised for diabetes and discharged alive during the period 1 January – 31 December 2012 in order to identify factors that contribute to older Australians hospitalised with diabetes being re-hospitalised within 30 days of discharge.</p> <p>The data revealed 848 people hospitalised for diabetes (median age 87 years (interquartile range, 77–89 years) and 60% were men) of whom 209 (24.6%) were re-hospitalised within 30 days of discharge, with most of these (77.5%) re-admitted within 14 days of discharge.</p> <p>The authors report that those patients with “comorbid heart failure, multiple recent hospitalisations, and multiple prescribers involved in their care are at greatest risk of being re-admitted to hospital within 30 days.” They suggest that “Targeted follow-up during the initial 14 days after discharge may facilitate appropriate interventions that avert re-admission of these at-risk patients.”</p>

American Journal of Medical Quality

Volume: 32, Number: 2 (March/April 2017)

DOI	http://journals.sagepub.com/toc/ajmb/32/2
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"> • Practical Approaches for Achieving Integrated Behavioral Health Care in Primary Care Settings (Anna Ratzliff, Kathryn E Phillips, Jonathan R Sugarman, Jürgen Unützer, Edward H Wagner) • Incorporating Patient Acuity Rating Score Into Patient Handoffs and the Correlation With Rapid Responses and Unexpected ICU Transfers (Christopher O'Donnell, Samantha Thomas, Crystal Johnson, Lalit Verma, Jonathan Bae, David Gallagher) • Patient Safety Indicators for Judging Hospital Performance (John C Kubasiak, Amanda B Francescatti, Raj Behal, Jonathan A Myers) • Heart Failure Readmission Reduction (Joseph P Drozda, Donna A Smith, Paul C Freiman, Janet Pursley, Jeffrey A VanSlette, Timothy R Smith) • Adding Laboratory Data to Hospital Claims Data to Improve Risk Adjustment of Inpatient/30-Day Postdischarge Outcomes (Michael Pine, Donald E Fry, Edward L Hannan, James M Naessens, Kay Whitman, Agnes Reband, Feng Qian, Joseph Schindler, Mark Sonneborn, Jaclyn Roland, Linda Hyde, Barbara A Dennison) • An Organizational Learning Framework for Patient Safety (Marc T Edwards)

	<ul style="list-style-type: none"> • The Burden of Burnout (Hany Elmariah, Samantha Thomas, Joel C Boggan, Aimee Zaas, Jonathan Bae) • Admission Laboratory Results to Enhance Prediction Models of Postdischarge Outcomes in Cardiac Care (Michael Pine, Donald E Fry, Edward L Hannan, James M Naessens, Kay Whitman, Agnes Reband, Feng Qian, Joseph Schindler, Mark Sonneborn, Jaclyn Roland, Linda Hyde, Barbara A Dennison) • Rapid Process Optimization (Jennifer L Wiler, Kelly Bookman, Derek B Birznieks, Robert Leeret, April Koehler, Shauna Planck, Richard Zane) • Enhancing the Safe and Effective Management of Chronic Pain in Accountable Care Organization Primary Care Practices in Kentucky (Selam Wubu, Laura Lee Hall, Paula Straub, Matthew J Bair, Jill A Marsteller, Yea-Jen Hsu, Doron Schneider, Gregory A Hood) • Handoffs in the Intensive Care Unit (Beth R Hochman, Mark E Barry, Meghan B Lane-Fall, Steven R Allen, Daniel N Holena, Brian P Smith, Lewis J Kaplan, Jose L Pascual) • A Plan-Do-Study-Act Approach to Improving Bowel Preparation Quality (Audrey H Calderwood, Elaine M Mahoney, Brian C Jacobson) • Interrater Reliability of Hospital Readmission Evaluations for Surgical Patients (Amber W Trickey, Jeffrey M Wright, Jean Donovan, H David Reines, Jonathan M Dort, Heather A Prentice, Paula R Graling, John J Moynihan) • Comparing the Treatment Algorithm and Complications for Patients Undergoing an Anterior Cervical Discectomy and Fusion at a Physician-Owned Specialty Hospital and a University-Owned Tertiary Care Hospital (Gregory D Schroeder, Mark F Kurd, Christopher K Kepler, Kris E Radcliff, Jeffery A Rihn, D Greg Anderson, Alan S Hilibrand, Alexander R Vaccaro) • Technology Development in Health Care Is Broken (Peter J Pronovost, Joe Powers, Walter Jin) • Improving Timeliness of Discharge Summaries at an Academic Affiliated Veterans Administration Hospital (Blake John Anderson, Krysta Johnson-Martinez, Benjamin Flink, Jonathan Gandhi, Anne Tomolo)
--	--

Health Expectations

Volume 20, Issue 2 Pages 185 -368, April 2017

URL	http://onlinelibrary.wiley.com/doi/10.1111/hex.2017.20.issue-2/issuetoc
Notes	<p>A new issue of <i>Health Expectations</i> has been published. Articles in this issue of <i>Health Expectations</i> include:</p> <ul style="list-style-type: none"> • Engaging patients and public in decision-making: approaches to achieving this in a complex environment (Mary Chambers) • Why do pregnant women participate in research? A patient participation investigation using Q-Methodology (Riwa Meshaka, Stephen Jeffares, Farah Sadrudin, Nicole Huisman and Ponnusamy Saravanan) • ‘Who is on your health-care team?’ Asking individuals with heart failure about care team membership and roles (Kori A LaDonna, Joanna Bates, Glendon R Tait, Allan McDougall, Valerie Schulz, Lorelei Lingard and For the Heart Failure/Palliative Care Teamwork Research Group) • Cancer screening in Portugal: sex differences in prevalence, awareness of organized programmes and perception of benefits and adverse effects (Ana Rute Costa, Susana Silva, Pedro Moura-Ferreira, Manuel Villaverde-Cabral,

	<p>Osvaldo Santos, Isabel do Carmo, Henrique Barros and Nuno Lunet)</p> <ul style="list-style-type: none"> • The use of decision aids on early detection of prostate cancer: views of men and general practitioners (Annelies Engelen, Joke Vanderhaegen, Hendrik Van Poppel and Chantal Van Audenhove) • Sensitivity to scale of willingness-to-pay within the context of menorrhagia (Sabina Sanghera, Emma Frew, Janesh Kumar Gupta, Joe Kai and Tracy Elizabeth Roberts) • We need to talk about purpose: a critical interpretive synthesis of health and social care professionals' approaches to self-management support for people with long-term conditions (Heather May Morgan, Vikki A Entwistle, Alan Cribb, Simon Christmas, John Owens, Zoë C Skea and Ian S Watt) • End-of-life care decisions for haemodialysis patients – ‘We only tend to have that discussion with them when they start deteriorating’ (Sophia Lazenby, Adrian Edwards, Raymond Samuriwo, Stephen Riley, Mary Ann Murray and Andrew Carson-Stevens) • Involving self-help groups in health-care institutions: the patients' contribution to and their view of ‘self-help friendliness’ as an approach to implement quality criteria of sustainable co-operation (Stefan Nickel, Alf Trojan and Christopher Kofahl) • Patient involvement in the development of a handbook for moderate rheumatoid arthritis (Louise Prothero, Sofia Georgopoulou, Savia de Souza, Ailsa Bosworth, Lindsay Bearne and Heidi Lempp) • Process and impact of patient involvement in a systematic review of shared decision making in primary care consultations (Catherine Hyde, Kate M Dunn, Adele Higginbottom and Carolyn A Chew-Graham) • Drug breakthrough offers hope to arthritis sufferers: qualitative analysis of medical research in UK newspapers (Helen Hanson, Nicola O'Brien, Paul Whybrow, John D Isaacs and Tim Rapley) • Validation of a new measure of availability and accommodation of health care that is valid for rural and urban contexts (Jeannie L Haggerty and Jean-Frédéric Levesque) • Agreeing the content of a patient-reported outcome measure for primary care: a Delphi consensus study (Mairead Murphy, Sandra Hollinghurst and Chris Salisbury) • Communicating with parents of obese children: which channels are most effective? (Melanie Randle, Anthony D Okely and Sara Dolnicar) • Public consultation changes guidance on the use of health-care interventions. An observational study (Bruce Campbell, Jeffrey Tabiri-Essuman, Helen Gallo, Vassilia Verdiel, Lakshmi Mandava, Mohamed Ansaf Azhar and John Powell)
--	--

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"> • Use of standard risk screening and assessment forms to prevent harm to older people in Australian hospitals: a mixed methods study (Bernice Redley, Michelle Raggatt)

URL	https://academic.oup.com/intqhc/advance-access?papetoc
Notes	<p>International Journal for Quality in Health Care has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none">• Patient reporting of undesirable events: a pilot study in China (Jia Yan; Ke Liu; Lifeng Zhang; Ting Chu; Xuehua Wang)• The proportion of errors in medical prescriptions and their executions among hospitalized children before and during accreditation (Tal Margalit Mekory; Hilla Bahat; Benjamin Bar-Oz; Orna Tal; Matitiah Berkovitch; Eran Kozer)

Online resources

[UK] *Options in the care of people with depression*

<http://www.dc.nihr.ac.uk/highlights/options-for-depression/>

The UK’s National Institute for Health Research (NIHR) has produced this ‘Highlights’ web page drawing together NIHR research into different ways of managing the care of people with depression and treating the condition. The NIHR observes that as much as 90% of patients with depression are treated in primary care, but care can be complex, involving a number of different specialists and requiring access to different forms of treatment. There is also high demand for these treatments. The Highlight explores **collaborative care** – coordinating care through a care manager, and **behavioural activation** – a simple psychological therapy that could be cheaper to deliver than current options.

[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:

- *First- and Second-Generation Antipsychotics in Children and Young Adults: Systematic Review Update* <http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2437>

[USA] *Toolkit To Reduce CAUTI and Other HAIs in Long-Term Care Facilities*

<https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/cauti-ltc/index.html>

The (US) Agency for Healthcare Research and Quality (AHRQ) has produced this toolkit to assist long-term care facilities to facilities reduce catheter-associated urinary tract infections (CAUTIs) and other healthcare associated infections.

The toolkit is based on the experiences of more than 450 long-term care facilities across the USA that participated in an AHRQ-funded project and reported significant CAUTI rate reductions. The new toolkit uses strategies from AHRQ’s Comprehensive Unit-based Safety Program (CUSP), which has reduced CAUTI as well as central line-associated bloodstream infections in hospitals.

The toolkit combines clinical interventions and best practices for infection prevention with behaviour change elements that promote leadership involvement, improvement in safety culture, teamwork, and communication, and sustainability. Its user-friendly educational modules, guides, and tools can help your facility advance from the "what to do" to the "how to do it." The modules are customizable to local needs. They include: Using the Comprehensive Long-Term Care Safety Toolkit; Senior Leader Engagement; Staff Empowerment; Teamwork and Communication; Resident and Family Engagement; and Sustainability.

For information on the Commission’s work on healthcare associated infection, see

<https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/>

Disclaimer

On the Radar is an information resource of the Australian Commission on Safety and Quality in Health Care. The Commission is not responsible for the content of, nor does it endorse, any articles or sites listed. The Commission accepts no liability for the information or advice provided by these external links. Links are provided on the basis that users make their own decisions about the accuracy, currency and reliability of the information contained therein. Any opinions expressed are not necessarily those of the Australian Commission on Safety and Quality in Health Care.