AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Second Australian Atlas of Healthcare Variation

Australian Commission on Safety and Quality in Health Care and Australian Institute for Health and Welfare
Sydney: ACSQHC; 2017. 332 p.

URL	http://www.safetyandquality.gov.au/atlas
Notes	The *Second Australian Atlas of Healthcare Variation* shows large variations in the provision of common health treatments across the country – giving health experts and clinicians valuable new information that will help to ensure more patients get the most effective and appropriate care. The Atlas shows variation in the use of specific types of health care across more than 300 local areas nationally, with chapters on women's health, cardiovascular conditions, surgical interventions and chronic disease and infection. Types of care examined include hysterectomy, cataract surgery, knee replacement and potentially preventable hospitalisations for selected conditions, including diabetes complications. Hysterectomy is generally becoming less common in developed countries, following the introduction of less invasive but still highly effective treatment options. The Atlas shows rates are up to seven times as high in the area with the highest rate compared to the area with the lowest rate. Endometrial ablation is often a preferred alternative to hysterectomy for abnormal uterine bleeding. Endometrial ablation shows even higher variation than hysterectomy, with rates nearly 21 times as high in the highest compared to the lowest areas.

	Access to effective secondary prevention programs can significantly reduce the need for hospitalisation for many chronic conditions. The new Atlas finds up to 16-fold variations in the rates of hospitalisations for some chronic conditions. The Atlas includes the Commission's recommendations for action across the health system to address variation where this appears to be unwarranted. The Atlas also provides information about hospitalisation rates for Aboriginal and Torres Strait Islander Australians, about the percentage of services funded publicly and privately, and includes analysis by socioeconomic status. The Commission collaborated with the Australian Government, state and territory governments, specialist medical colleges, clinicians and consumer representatives, and the Australian Institute of Health and Welfare to develop the Atlas. All the content, with additional functionality, and the data for this Atlas and the previous one are available from the interactive atlas via http://www.safetyandquality.gov.au/atlas 

Reports

Final Report: Sentinel Event Research Project. Australian Patient Safety Foundation A report submitted to the Victorian Department of Health and Human Services
Hibbert P, Thomas MJW, Deakin A, Runciman W, Braithwaite J
Melbourne: Victorian Department of Health and Human Services; 2016. p. 44.

URL	https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management/sentinel-event-program
Notes	Report from the Australian Patient Safety Foundation commissioned by the Victorian Department of Health and Human Services looking into "sentinel events". Currently there are eight sentinel events and Victoria has an additional category of "Other catastrophic: Incident severity rating one (ISR1)". This report describes a project that included: • Classification and descriptive analysis of Root Cause Analysis (RCA) reports based on a set of 227 sentinel events; • Analysis of conformity to best practice in the conduct of these RCAs; • Classification and analysis of 478 claims related to healthcare; and • Stakeholder feedback on the strengths and weaknesses of the RCA process. The authors' analysis of the 227 RCA reports and assessment of the strength of recommendations found just 8% were deemed to be "strong". The report also made a number of recommendations around the training for and conduct of RCAs, various other tools and for safety and quality, including greater involvement of consumers.

Journal articles

Improving Care Teams' Functioning: Recommendations from Team Science
Fiscella K, Mauksch L, Bodenheimer T, Salas E
The Joint Commission Journal on Quality and Patient Safety. 2017 [epub].

DOI	https://doi.org/10.1016/j.jcjq.2017.03.009
Notes	Health care is a team game. This piece reviews how elements of team behaviour can contribute to primary care and teams within the primary care setting. The authors describe six elements of teams that thy consider particularly relevant to primary care: • practice **conditions** that support or hinder effective teamwork • team **cognition**, including shared understanding of team goals, roles, and how members will work together as a team • **leadership and coaching**, including mutual feedback among members that promotes teamwork and moves the team closer to achieving its goals • **cooperation** supported by an emotionally safe climate that supports expression and resolution of conflict and builds team trust and cohesion • **coordination**, including adoption of processes that optimize efficient performance of interdependent activities among team members • **communication**, particularly regular, recursive team cycles involving planning, action, and debriefing. The piece also discusses how these elements may be configured for varying forms of teams in primary care.

Patient-reported safety incidents in older patients with long-term conditions: a large cross-sectional study
Panagioti M, Blakeman T, Hann M, Bower P
BMJ Open. 2017;7(5):e013524.

DOI	http://dx.doi.org/10.1136/bmjopen-2016-013524
Notes	Paper reporting on a study that looked at patient-reported safety incidents in a group of older patients. Of the 3378 **patients aged 65 years and over** who had a long-term condition **11% reported safety incidents**. The authors concluded that "older patients with multimorbidity and depression are more likely to report experiences of patient safety incidents. Improving perceived support and involvement of patients in their care may help prevent patient-reported safety incidents."

Challenges and opportunities from the Agency for Healthcare Research and Quality (AHRQ) research summit on improving diagnosis: a proceedings review
Henriksen K, Dymek C, Harrison MI, Brady PJ, Arnold SB
Diagnosis. 2017;4(2):57-66.

DOI	https://doi.org/10.1515/dx-2017-0016
Notes	Issues around diagnosis, including diagnostic error, over-diagnosis, etc., have been rising in prominence in the last few years. This piece provides a review of a research summit on diagnosis that was convened by the (US) Agency for Healthcare Research and Quality. Topics covered include calls for rigorous definitions of diagnostic error, the role of technology in diagnostic improvement, and organisational factors that contribute to issues with diagnoses.

Does a checklist reduce the number of errors made in nurse-assembled discharge prescriptions?
Byrne C, Sierra H, Tolhurst R
British Journal of Nursing. 2017;26(8):464-7.

DOI	https://dx.doi.org/10.12968/bjon.2017.26.8.464
Notes	Checklists have spread across many aspects of healthcare. This article looks at the introduction of checklist to aid nurses preparing medications for patients being discharged. The paper reports that the **checklist** was associated with a **reduction in errors**. This was a relatively small study and it would be useful to know more about the sustainability and longer term efficacy of the intervention.

Tools and methods for quality improvement and patient safety in perinatal care
Nathan AT, Kaplan HC
Seminars in Perinatology. 2017.

DOI	https://doi.org/10.1053/j.semperi.2017.03.002
Notes	Safety and quality efforts can be applied at various scales. Context is always an important consideration for the transferability and scalability. Consequently such efforts need to be tailored for the context. This paper describes some of the approaches that may be considered in the realm of perinatal care. This is more about the model for improvement and QI tools than specific interventions.

Healthcare Policy
Vol. 12 No. 4, 2017

URL	http://www.longwoods.com/publications/healthcare-policy/25096
Notes	A new issue of *Healthcare Policy* has been published. Articles in this issue of *Healthcare Policy* include: • The Sociopolitical Context of Canada's **National Standard for Psychological Health and Safety in the Workplace**: Navigating Policy Implementation (Cindy Malachowski, Bonnie Kirsh and Ellen McEachen) • What Do We Know and Not Know about the **Professional Integration of International Medical Graduates** (IMGs) in Canada? (Elena Neiterman, Ivy Lynn Bourgeault and Christine L Covell) • Retention Patterns of Canadians Who Studied Medicine Abroad and Other **International Medical Graduates** (Maria Mathews, Rima Kandar, Steve Slade, Yanqing Yi and Ivy Lynn Bourgeault) • Reforming **Refugee Healthcare** in Canada: Exploring the Use of Policy Tools (Ethan Holtzer, Alicia Moore-Dean, A Srikanthan and K Kuluski) • **Public Health Policy** in Support of Insurance Coverage for **Smoking Cessation Treatment** (Robert Schwartz, Farzana Haji, Alexey Babayan, Christopher Longo and Roberta Ferrence) • **Bifurcation of Health Policy Regimes**: A Study of Sleep Apnea Care and Benefits Coverage in Saskatchewan (Gregory P. Marchildon, Caroline A. Beck, Tarun R. Katapally, Sylvia Abonyi, James A. Dosman and Jo-Ann Episkenew)

BMJ Quality and Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Editorial: **Preventing hospital readmissions**: the importance of considering 'impactibility,' not just predicted risk (Adam Steventon, John Billings) • Advancing **infection prevention** and **antimicrobial stewardship** through improvement science (Jerome A Leis) • International comparison of **emergency hospital use for infants**: data linkage cohort study in Canada and England (Katie Harron, Ruth Gilbert, David Cromwell, Sam Oddie, Astrid Guttmann, Jan van der Meulen) • Engaging patients and the public in **Choosing Wisely** (Karen B Born, Angela Coulter, Angela Han, Moriah Ellen, Wilco Peul, Paul Myres, Robyn Lindner, Daniel Wolfson, R. Sacha Bhatia, Wendy Levinson) • Are **Facebook** user ratings associated with **hospital cost, quality and patient satisfaction**? A cross-sectional analysis of hospitals in New York State (Lauren Campbell, Yue Li)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-access?papetoc
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Lessons learned for reducing the negative **impact** of **adverse events** on **patients, health professionals and healthcare organizations** (Jose Joaquin Mira, Susana Lorenzo, Irene Carrillo, Lena Ferrús, Carmen Silvestre, Pilar Astier Fuencisla Iglesias-Alonso, Jose Angel Maderuelo Pastora Pérez-Pérez, Maria Luisa Torijano, Elena Zavala, Susan D Scott on behalf of the Research Group on Second and Third Victims)

Online resources

[UK] NICE Guidelines and Quality Standards
https://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 reviews or updates are:

- Quality Standard QS24 ***Nutrition*** *support in adults* https://www.nice.org.uk/guidance/qs24
