



## On the Radar

Issue 330  
17 July 2017

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### On the Radar

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### Reports

*The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization*  
Patient-Centered Primary Care Collaborative and Robert Graham Center  
Washington D.C.: Milbank Memorial Fund; 2017. p. 40.

URL	<a href="https://www.milbank.org/publications/patient-centered-primary-care-collaborative-publishes-new-evidence-report/">https://www.milbank.org/publications/patient-centered-primary-care-collaborative-publishes-new-evidence-report/</a>
Notes	<p>The (US) Patient-Centered Primary Care Collaborative has released this report examining the links the patient-centred medical home (PCMH) and other forms of advanced primary care with improved outcomes in many studies. The report highlights findings from 45 newly released peer-reviewed reports and additional government and state evaluations.</p> <p>It is claimed that this report demonstrates that positive outcomes associated with high-performing primary care continue to increase, even while the PCMH model evolves.</p> <p>Report findings include :</p> <ul style="list-style-type: none"> <li>• The longer a practice had been transformed, and the higher the risk of the patient pool in terms of comorbid conditions, the more significant the positive effect of practice transformation, especially in terms of cost savings.</li> <li>• Peer-reviewed data, both federal and state-specific, showed either a trend towards a positive effect on quality, or no impact on quality, though few results were statistically significant.</li> <li>• All studies that reported on patient satisfaction showed positive results.</li> </ul>

For information the Commission’s work on patient and consumer centred care, see <https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/>

*Discharge Instructions for Venous Thromboembolism (VTE): A Comprehensive Approach to Medication Management. Compendium of resources*

The Joint Commission

Oakbrook Terrace, IL: The Joint Commission; 2017. p. 16.

URL	<a href="https://www.jointcommission.org/discharge-instructions-for-venous-thromboembolism-vte/">https://www.jointcommission.org/discharge-instructions-for-venous-thromboembolism-vte/</a>
Notes	The Joint Commission in the USA has compiled this compendium so as to provide clinicians and other health care educators with education and discharge materials for venous thromboembolism (VTE) patients discharged on anticoagulants. This resource document contains descriptions of resources and websites that provide patient education materials related to the use of anticoagulants for VTE.

## Journal articles

*When “patient centred” is no longer enough: the challenge of collaborative health: an essay by Michael L Millenson*

Millenson ML

BMJ. 2017;358:j3048.

DOI	<a href="http://dx.doi.org/10.1136/bmj.j3048">http://dx.doi.org/10.1136/bmj.j3048</a>
Notes	<p>Patient-centredness has become a focus for much of healthcare delivery. In this short essay there is a call to move beyond patient-centred or focused care to what’s termed <b>collaborative care</b>. This requires not just a focus on the patient or even a move to shared decision making but to a collaborative and shared care experience. This would see a deeper engagement on both the part of the patient and the clinician and it would shift the locus of power/decision-making and make for a much more dynamic or fluid relationship as that locus or balance may move depending on context, need and capacity. In this piece three core sharing principles are described:</p> <ul style="list-style-type: none"> <li>• Shared information – ‘Opening the complete electronic health record for patients to read, comment on, and share improves their ability to manage their health.<sup>20</sup> Moreover, by making the sharing of information the default, the profession sweeps away a critical information asymmetry...’</li> <li>• Shared engagement– ‘Collaborative health is multidirectional and multidimensional... Collaboration also means accommodating varying engagement preferences. ... those who may want or need the doctor to guide prevention or care, those in the do-it-yourself health movement, those who prefer shared decision making, and those whose preferences may shift because of illness or a new life situation. It’s also a model that sometimes allows one partner to say, “I want you to decide.”’</li> <li>• Shared accountability – ‘Shared accountability may pose the greatest challenge. Hierarchies have clear lines; shared power is more complex, particularly among diverse individuals and organisations.’</li> </ul> <p>In a related editorial in the <i>BMJ</i> (<a href="https://doi.org/10.1136/bmj.j325">https://doi.org/10.1136/bmj.j325</a>), Fiona Godlee noted that ‘Millenson ends on a positive note, however. The world will still need doctors, he says, and there remains great value in professional expertise rooted in ethical and legal traditions. “Accepting a less central role may feel at first as if collaborative health is shrinking the profession’s importance. In reality, accepting true partnership will profoundly expand the profession’s influence in the days to come.”’</p>

For information the Commission’s work on patient and consumer centred care, see <https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/>

*Preventing Harm in the ICU-Building a Culture of Safety and Engaging Patients and Families*  
 Thornton KC, Schwarz JJ, Gross AK, Anderson WG, Liu KD, Romig MC, et al.  
 Critical Care Medicine. 2017 [epub].

DOI	<a href="http://dx.doi.org/10.1097/CCM.0000000000002556">http://dx.doi.org/10.1097/CCM.0000000000002556</a>
Notes	The Intensive Care Unit (ICU) may often be better-resourced than other units, but it also has particular pressures and issues including vulnerable patients and complex issues. This piece reports on a literature review of the evidence on safety culture and sought to provide practical guidance on implementing initiatives aimed at improving safety culture and more effectively integrate patients and families in such efforts. The authors report that ‘A <b>strong safety culture is associated with reduced adverse events, lower mortality rates, and lower costs.</b> Quality improvement efforts have been shown to be more effective and sustainable when paired with a strong safety culture.’

*Missed Nursing Care in Pediatrics*

Lake ET, de Cordova PB, Barton S, Singh S, Agosto PD, Ely B, et al.  
 Hospital Pediatrics. 2017;7(7):378-84.

DOI	<a href="http://dx.doi.org/10.1542/hpeds.2016-0141">http://dx.doi.org/10.1542/hpeds.2016-0141</a>
Notes	This article reports on a study that surveyed paediatric nursing staff so as to determine the frequency and patterns of missed nursing care in inpatient paediatric settings and to determine whether missed nursing care is associated with unfavourable work environments and high nurse workloads. This cross-sectional study used survey data collected in 2006 to 2008 from 2187 NICU, PICU, and general paediatric nurses in 223 hospitals in 4 US states. It is report that ‘ <b>More than half</b> of pediatric nurses had <b>missed care on their previous shift.</b> ’ Further, missed care was more common in work environments considered poor. The authors concluded that ‘Nurses in inpatient pediatric care settings that care for <b>fewer patients</b> each and practice in a professionally <b>supportive work environment miss care less often, increasing quality</b> of patient care.’

*Journal of Health Services Research & Policy*

Volume: 22, Number: 3 (July 2017)

URL	<a href="http://journals.sagepub.com/toc/hsrb/22/3">http://journals.sagepub.com/toc/hsrb/22/3</a>
Notes	A new issue of the <i>Journal of Health Services Research &amp; Policy</i> has been published. Articles in this issue of <i>Journal of Health Services Research &amp; Policy</i> include: <ul style="list-style-type: none"> <li>• Editorial: A thing called Q (Catherine Pope)</li> <li>• <b>Partnering to improve care:</b> the case of the Veterans’ Health Administration’s Quality Enhancement Research Initiative (Alicia A Bergman, Deborah M Delevan, Isomi M Miake-Lye, Lisa V Rubenstein, David A Ganz)</li> <li>• <b>Dying in hospital:</b> socioeconomic inequality trends in England (Helen Barratt, Miqdad Asaria, Jessica Sheringham, Patrick Stone, Rosalind Raine, Richard Cookson)</li> <li>• Have <b>individual medical savings accounts</b> accumulated meaningful balances after 10 years of enrolment? Empirical evidence from China (Hao Yu, Jiaying Chen)</li> <li>• <b>Attitude</b> of US obstetricians and gynaecologists to <b>global warming and medical waste</b> (Cassandra Thiel, Paula Duncan, Noe Woods)</li> </ul>

	<ul style="list-style-type: none"> <li>• The impact of <b>adverse childhood experiences</b> on <b>health service use</b> across the <b>life course</b> using a retrospective cohort study (Mark Bellis, Karen Hughes, Katie Hardcastle, Kathryn Ashton, Kat Ford, Zara Quigg, Alisha Davies)</li> <li>• Seeking consensus on <b>universal health coverage</b> indicators in the <b>sustainable development goals</b> (Jennifer Reddock)</li> <li>• Impact case studies: <b>palliative</b> and <b>end of life care</b></li> <li>• Maimonides’ middle path in the use of health care (Moriah Ellen, Gabi Bin Nun, Ruth Shach)</li> <li>• Beyond <b>integrated care</b> (Thomas Plochg, Stefania Ilinca, Mirko Noordegraaf)</li> <li>• <b>Personalized medicine</b>: what are the challenges for health services? (Walter Ricciardi)</li> </ul>
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*BMJ Quality and Safety* online first articles

URL	<a href="https://qualitysafety.bmj.com/content/early/recent">https://qualitysafety.bmj.com/content/early/recent</a>
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• Anticipation, teamwork and cognitive load: chasing <b>efficiency</b> during <b>robot-assisted surgery</b> (Kevin Sexton, Amanda Johnson, Amanda Gotsch, Ahmed A Hussein, Lora Cavuoto, Khurshid A Guru)</li> <li>• Utilizing a transfer of care bundle to reduce <b>unplanned readmissions</b> to the <b>cardiac intensive care unit</b> (Jean Storey, Jonathan W Byrnes, Jeffrey Anderson, James Brown, Katherine Clarke-Myers, Melissa Kimball, Candice Meyer, Laurie Mustin, Gina Schoenling, Nicolas Madsen)</li> <li>• How do hospital boards <b>govern</b> for <b>quality improvement</b>? A mixed methods study of 15 organisations in England (Lorelei Jones, Linda Pomeroy, Glenn Robert, Susan Burnett, Janet E Anderson, Naomi J Fulop)</li> <li>• Reasons for <b>computerised provider order entry</b> (CPOE)-based <b>inpatient medication ordering errors</b>: an observational study of voided orders (Joanna Abraham, Thomas G Kannampallil, Alan Jarman, Shivy Sharma, Christine Rash, Gordon Schiff, William Galanter)</li> <li>• Patients’ and providers’ perceptions of the <b>preventability of hospital readmission</b>: a prospective, observational study in four European countries (Louise S van Galen, Mikkel Brabrand, Tim Cooksley, Peter M van de Ven, Hanneke Merten, Ralph KL So, Loes van Hooff, Harm R Haak, Rachel M Kidney, Christian H Nickel, John TY Soong, Immo Weichert, Mark HH Kramer, Christian P Subbe, Prabath WB Nanayakkara)</li> </ul>

**Online resources**

*Medical Devices Safety Update*

<https://www.tga.gov.au/publication-issue/medical-devices-safety-update-volume-5-number-4-july-2017>

Volume 5, Number 4, July 2017

The Therapeutic Goods Administration (TGA) has released the latest edition of its medical device safety bulletin. Topics covered in this issue include:

- **Intravenous solution bags** are for single use only –there are no circumstances where they should be reconnected (re-spiked) after first use
- Zoll upgrade to counter **AED PRO clock drift** – internal clocks on some Zoll AED PRO devices have been identified as having larger-than-expected drift
- **Hysteroscope cleaning advice** updated – Hologic Australia has issued a safety alert updating the Instructions for Use supplied with the MyoSure XL Rod Lens Hysteroscope following reports of various types of contamination.

- **Mitroflow valves** – the UK’s Medicines and Healthcare products Regulatory Agency (MHRA) has issued an alert for the Mitroflow LX biological replacement pericardial aortic heart valve due to the risk of early structural valve deterioration with smaller sizes (19 and 21 mm)
- **Recent safety alerts.**
- **What to report?** Please report adverse events, as well as near misses.

[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:

- Clinical Guideline CG99 **Constipation** in children and young people: diagnosis and management  
<https://www.nice.org.uk/guidance/cg99>

[USA] ASP Clinical Tools

<http://www.cidrap.umn.edu/asp/clinicaltools>

The Center for Infectious Disease Research and Policy at the University of Minnesota has compiled this database of publicly available tools for implementing or enhancing antimicrobial stewardship programs in medical, dental, veterinary, and agricultural practices. They include a variety of materials (e.g., administrative policies and procedures, dosing protocols, treatment guidelines, educational tools) applicable to different clinical settings (e.g., paediatrics, long-term care, outpatient clinics, emergency departments). The database is updated regularly.

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