AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state

The Australian Commission on Safety and Quality in Health Care has developed the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* (the Consensus Statement).

The Consensus Statement aligns with the National Safety and Quality Health Service (NSQHS) Standards (second edition) as recommended best practice. It is intended that the Consensus Statement is applied in conjunction with the existing *National Consensus Statement: essential elements for recognising and responding to acute physiological deterioration* (second edition).

The Consensus Statement is available on the Commission's website at https://www.safetyandquality.gov.au/publications/national-consensus-statement-essential-elements-for-recognising-and-responding-to-deterioration-in-a-persons-mental-state/

Books

Optimal Resources for Surgical Quality and Safety
Hoyt DB, Ko CY, editors
Chicago: American College of Surgeons; 2017.

URL	https://www.facs.org/quality-programs/about/optimal-resources-manual
Notes	The American College of Surgeons has published this edited volume. The book discusses the range of technical and organisational factors that can contribute to safety and quality lapses and how to address these issues and weaknesses. Topics covered include patient-centredness, high reliability, teamwork, communication, and culture.

Reports

Patient Safety in the Home: Assessment of Issues, Challenges, and Opportunities
Carpenter D, Famolaro T, Hassell S, Kaeberle B, Reefer S, Robins C, et al
Cambridge MA: Institute for Healthcare Improvement; 2017. p. 54.

An Overview of Home-Based Primary Care: Learning from the Field. Issue Brief
Klein S, Hostetter M, McCarthy D
New York: The Commonwealth Fund; 2017. p. 20.

URL	Carpenter et al http://www.ihi.org/resources/Pages/Publications/Patient-Safety-in-the-Home.aspx Klein at el http://www.commonwealthfund.org/publications/issue-briefs/2017/jun/overview-home-based-primary-care
Notes	The (US) Institute for Healthcare Improvement has published this report examining patient safety in the home, including challenges, funding mechanisms, and conceptual frameworks. The challenges found are wide ranging and include fragmentation of care; household hazards; ill-prepared family caregivers; limited training and regulation of home care workers; inadequate communication among patients, caregivers, and providers; and misaligned payment incentives. The report examined the challenges using four dimensions: • Physical – including environmental hazards such as home layout and infrastructure, clutter, and unsanitary conditions • Processes of care – including medication management, infection control, nutrition, fall prevention, complex clinical care, and care coordination • Emotional – involves stress, trauma, and discomfort related to receiving and providing care., and • Social and functional – covering the community and the network of support, and the effects of health conditions on activities of daily living. The (US) Commonwealth Fund has also produced as Issue Brief *An Overview of Home-Based Primary Care* based on the experience of a number of home-based primary care services. Their analysis found interdisciplinary teams, incorporating behavioural care and social supports into primary care, responding rapidly to urgent and acute care needs, offering palliative care, and supporting family members and caregivers were all key. Savings were produced due to reducing hospital use. Challenges to making "effective home-based primary care more widely available would require a better-prepared workforce, appropriate financial incentives to encourage more clinicians to provide house calls to their home-limited patients, and relevant quality measures to ensure that value-based payment is calibrated to meet the needs of patients and their families."

Improving the Working Environment For Safe Surgical Care
The Royal College of Surgeons of Edinburgh
Edinburgh: The Royal College of Surgeons of Edinburgh; 2017. p. 38.

URL	https://www.rcsed.ac.uk/news-public-affairs/news/2017/july/rcsed-publishes-plan-for-safer-working-environment
Notes	This report from the Royal College of Surgeons of Edinburgh focuses on how to improve safety in the delivery of surgical treatment and patient care in the UK's National Health Service. The report suggests a number of relatively simple measures that they argue have a cumulative effect for the better. A number of these echo some of the recent material on addressing burnout and staff engagement. The recommendations include: • Establish structured senior support by re-establishing the traditional team structure • Reintroducing a communal area • Streamline and reorganise the overall workload to prioritise core clinical duties and create an integrated multidisciplinary surgical team • Promote human factors training to help ensure a safety-centred team approach from the early stages of medical training • Recognise that better training delivers better care • Minimising use of shift systems • Intelligent design of rotas by providing rotas 6–8 weeks in advance • Support and training of t by providing recognition and job-planning for trainers • Providing a better title for 'junior doctors'.

Surgical Variance Report 2017: Urology
Royal Australasian College of Surgeons, Medibank
Melbourne: Royal Australasian College of Surgeons and Medibank; 2017. p. 36.

URL	https://www.surgeons.org/policies-publications/publications/surgical-variance-reports/
Notes	The latest report from the Royal Australasian College of Surgeons and Medibank's surgical variance work focuses on urology. This report looks at variation in de-identified Medibank claims data from the two most recent financial years (2015 and 2016). Topics covered in this report include cystoscopy with and without resection procedures and endoscopic and radical prostatectomy procedures. For each of these, variation in aspects such as length of stay, 30 day readmissions, re-operations within 6 months, average cost, average out-of-pocket cost, complication rates are described.

For information on the Commission's work on healthcare variation, including the *Australian atlas of healthcare variation*, see https://www.safetyandquality.gov.au/atlas/

Complexity Science in Healthcare – Aspirations, Approaches, Applications and Accomplishments
A White Paper
Braithwaite J, Churruca K, Ellis LA, Long J, Clay-Williams R, Damen N, et al
North Ryde: Australian Institute of Health Innovation, Macquarie University; 2017. p. 129.

URL	https://aihi.mq.edu.au/resource/complexity-science-healthcare-white-paper
Notes	The Australian Institute of Health Innovation group at Macquarie University has produced this 'white paper' that seeks to describe and understand how a complexity science approach to healthcare can aid our understanding, analysis and responses to health care (a complex adaptive system).

Chartbook on Patient Safety: National Healthcare Quality and Disparities Report
Agency for Healthcare Quality and Research
Rockville, MD: Agency for Healthcare Research and Quality; 2017. p. 39.

URL	https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/patientsafety/index.html
Notes	The (US) Agency for Healthcare Research and Quality (AHRQ) has released this chartbook as a companion volume to its annual *National Healthcare Quality and Disparities Report* . The chartbook includes a summary of trends across measures of patient safety from the *National Healthcare Quality and Disparities Report* and has figures illustrating select measures of patient safety. A PowerPoint version is also available that can downloaded for presentations.

Journal articles

The burden of healthcare-associated infection in Australian hospitals: A systematic review of the literature
Mitchell BG, Shaban RZ, Macbeth D, Wood C-J, Russo PL
Infection, Disease & Health. 2017 [epub].

DOI	http://dx.doi.org/10.1016/j.idh.2017.07.001
Notes	Review article that attempts to estimate the incidence of healthcare-associated infection (HAI) in Australian hospitals. On their review of the literature the authors suggest that the literature is a "very large underestimate" due to the "lack of or incomplete data on common infections such as pneumonia, gastroenterological and bloodstream infection". This leads them to suggest that "the **incidence of HAIs in Australia may be closer to 165,000 per year**." The lead author has also penned a companions opinion piece on The Conversation website at https://theconversation.com/heres-how-many-people-get-infections-in-australian-hospitals-every-year-82309

For information on the Commission's work on healthcare associated infection, including hand hygiene, see https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Pharmacist-led admission medication reconciliation before and after the implementation of an electronic medication management system
Sardaneh AA, Burke R, Ritchie A, McLachlan AJ, Lehnbom EC
International Journal of Medical Informatics. 2017;101:41-9.

DOI	https://doi.org/10.1016/j.ijmedinf.2017.02.001
Notes	Medication reconciliation is recognised as an important medication safety process. This paper describes how the implementation of an electronic medication management (EMM) system in an Australian hospital contributed to changes in medication reconciliation. **EMM implementation** led to both an **increased rate of and more timely medication reconciliation** on hospital admission. High-risk patients, such as older patients and those using than five prescription medications, were more likely to receive medication reconciliation after implementation of the EMM.

For information on the Commission's work on medication safety, including medication reconciliation, see https://www.safetyandquality.gov.au/our-work/medication-safety/

Identifying high-alert medications in a university hospital by applying data from the medication error reporting system
Tyynismaa L, Honkala A, Airaksinen M, Shermock K, Lehtonen L
Journal of Patient Safety. 2017 [epub].

DOI	Http://dx.doi.org/10.1097/PTS.0000000000000388
Notes	This paper provides a practical example of a learning health system. In this case it was using the errors captured in a reporting system to improve their recognition of medications that needed alerts to assist healthcare workers to avoid those errors in future. The authors believe their approach is "applicable for **compiling a hospital-specific high-alert medication list** and related analysis of key process safety risks".

Impact of a restraint management bundle on restraint use in an intensive care unit
Hall DK, Zimbro KS, Maduro RS, Petrovitch D, Ver Schneider P, Morgan M
Journal of Nursing Care Quality. 2017 [epub].

DOI	http://dx.doi.org/10.1097/NCQ.0000000000000273
Notes	The use of restraint in various settings is contentious and can be a safety risk in and of itself. This paper examined how the implemented of a 'bundle' for restraint use influenced the use of restraints in one hospital's intensive care unit (ICU). The authors report that "the proportion of intensive care unit **patients restrained decreased** significantly (24.3% vs 20.9%)" after the restraint management bundle was introduced. They speculate that the bundle management provided "a framework for guiding the process to reduce restraint use, minimize harm, and improve patient safety."

A multi-state, multi-site, multi-sector healthcare improvement model: implementing evidence for practice
Edward K-L, Walker K, Duff J
International Journal for Quality in Health Care. 2017 [epub].

DOI	https://doi.org/10.1093/intqhc/mzx099
Notes	Paper reporting on a project undertaken in nine Australian hospitals seeking to improve the management of inadvertent peri-operative hypothermia. This paper focuses less on the intervention and more the approach or model adopted (or more accurately, adapted). The authors discuss taking the models developed by the Institute of Healthcare Improvement and the Johns Hopkins Quality and Safety Group and developing a 'hybrid model'. This model focused on engaging those most affected by the intervention so as "to engage the hearts and minds of healthcare clinicians, and others in order to empower them to make the necessary improvements to enhance patient care quality and safety." In a sense this is an example not so much of developing models but being aware of the **importance of context**. Transferability is often not so much a case of simply importing a solution but understanding the local context and making adjustments and modifications to suit the local setting.

High reliability leadership: a conceptual framework
Martínez-Córcoles M
Journal of Contingencies and Crisis Management. 2017 [epub].

DOI	http://dx.doi.org/10.1111/1468-5973.12187
Notes	The goal of a highly reliable and resilient health system has been discussed for some time. This paper describes a conceptual framework for leadership of high reliability systems (in areas other than health).

The relationship between patient safety climate and occupational safety climate in healthcare—a multi-level investigation
Pousette A, Larsman P, Eklöf M, Törner
Journal of Safety Research. 2017;61:187-98.

DOI	http://dx.doi.org/10.1016/j.jsr.2017.02.020
Notes	A safe environment can help ensure safety for both patients and the clinical workforce. This study sought to examine the relationship between patient safety climate and occupational safety climate by surveying 1154 nurses, 886 assistant nurses, and 324 physicians, organized in 150 work units, within hospitals (117 units), primary healthcare (5 units) and elderly care (28 units) in Sweden. From their analyses, the authors found that **patient safety climate and occupational safety climate were "strongly positively related at the unit level"** and believe that "Safety improvement interventions should be planned so that both patient safety and staff safety are considered concomitantly."

Mapping the drivers of overdiagnosis to potential solutions
Pathirana T, Clark J, Moynihan R
BMJ. 2017;358:j3879.

Overdiagnosis, ethics, and trolley problems: why factors other than outcomes matter—an essay by Stacy Carter
Carter SM
BMJ. 2017;358: j3872.

DOI	Carter https://doi.org/10.1136/bmj.j3872 Pathirana et al https://doi.org/10.1136/bmj.j3879
Notes	A pair of items published in the last few days by the BMJ looking at aspects of overdiagnosis. Pathirana and colleagues describe the issue of overdiagnosis (AKA 'too much medicine') and possible strategies to address it. They suggest that the drivers – and possible solutions – "arise across five inter-related domains: culture, the health system, industry and technology, healthcare professionals, and patients and the public." They consider information and education is the "most urgent need" and that we need "to generate accessible evidence based information and educational materials about overdiagnosis for the public, professionals, and decision makers—both general information and condition specific." Carter takes a more philosophical approach in examining how different views on the issue emerge and influence our thinking. Her key messages include that: • Overdiagnosis occurs because the standards in healthcare systems are set at the wrong point—excessive screening targets, a condition too broadly defined, a diagnostic threshold set too low. If the problem is with the system, perhaps we should not expect individual clinicians or patients to fix it, even if armed with better information. • Decision makers may stop a screening programme, or move a diagnostic boundary, to improve outcomes overall. But a few people are likely to be worse off as a result, and the new policy may seem to disregard their suffering. • Decision-makers should not just focus on overall utility but also publicly acknowledge that a minority might be worse off and communicate how they will be cared for.

Healthcare Quarterly
Vol. 20 No. 2, 2017

URL	http://www.longwoods.com/publications/healthcare-quarterly/25217
Notes	A new issue of *Healthcare Quarterly* has been published. Articles in this issue of *Healthcare Quarterly* include: • The **Delivery of Palliative and End-of-Life Care** in Ontario (Amy T Hsu and Peter Tanuseputro) • New Tools for **Measuring and Improving Patient Safety** in Canadian **Hospitals** (Jennifer D'Silva, Joseph Emmanuel Amuah, Vanessa Sovran, Anne MacLaurin, Jennifer Rodgers, Tracy Johnson, Kira Leeb and S Kossey) • Public and Professional Insights on **End-of-Life Care**: Results of the 2016 Health Care in Canada Survey (Terrence Montague, Joanna Nemis-White, John Aylen, Sara Ahmed, Sharon Baxter, L Martin, O Adams and A Gogovor) • **Second Medical Opinions in End-of-Life Disputes** in Critical Care: An Ethics-Based Approach (Sally Bean, Phil Shin, B Henry and B H Cuthbertson) • A Survey of **Hospital Ethics Structures** in Ontario (Jonathan Breslin) • Persistent and Non-Persistent **High-users of Acute Care Resources**: A Deeper Dive into the Patient and System Factors (Arpita Gantayet, Michelle Ang, Xingshan Cao and Ilana Halperin) • Six Change Ideas that Significantly Minimize **Alternative Level of Care** (ALC) Days in Acute Care Hospitals (Paula Chidwick, Jill Oliver, Daniel Ball, Christopher Parkes, Terri Lynn Hansen, Francesca Fiumara, Kiki Ferrari, Cindy Hawkswell and Karyn Lumsden) • Leading Practices in **Alternate Levels of Care** (ALC) Avoidance: A Standardized Approach (Elaine Burr and Sandra Dickau) • Conserving Quality of Life through **Community Paramedics** (Christopher Ashton, Denise Duffie and Jeffrey Millar) • **Medication Incidents** Involving **Antiepileptic Drugs** in Canadian Hospitals: A Multi-Incident Analysis (Roger Cheng, Yu Daisy Yang, Matthew Chan and Tejal Patel) • Sustainable Benefits of a **Community Hospital-based Pediatric Asthma Clinic** (Brian A Kuzik, Chee P Chen, Miriam J Hansen and P L Montgomery) • Strategic Change in Surgical Quality Improvement: The Ottawa **Hospital Comprehensive Unit-Based Safety Program Experience** (Caitlin Champion, Joseph Sadek and Husein Moloo)

Pediatric Quality & Safety
July/August 2017 - Volume 2 - Issue 4

URL	http://journals.lww.com/pqs/toc/2017/07000
Notes	A new issue of *Pediatric Quality & Safety* has been published. Articles in this issue of *Pediatric Quality & Safety* include: • Feasibility of **Episode-Based Bundled Payment** for a Pediatric Surgical Condition: Posterior Spinal Fusion (Shaughnessy, Erin E.; Sturm, Peter; Sitzman, Thomas J.) • Application of Conjoint Analysis to Improve Reliability of Dietician Consultation in **Pediatric Celiac Disease** (Kulkarni, Sakil; Liss, Kim; Samson, Charles M.) • Effects of Skin-to-Skin Care on Late Preterm and Term Infants At-Risk for **Neonatal Hypoglycemia** (Chiruvolu, Arpitha; Miklis, Kimberly K.; Stanzo, Karen C.; Petrey, Barbara; Groves, Chelsey G.; McCord, Kari; Qin, Huanying;

	Desai, Sujata; Tolia, Veeral N.) • Increasing **Physical Exam Teaching** on Family-Centered Rounds Utilizing a Web-Based Tool (Patel, Aarti; Unaka, Ndidi; Holland, Deborah; Schuler, Christine; Mangeot, Colleen; Sucharew, Heidi; Younts, Angela; Maag, Logan; Treasure, Jennifer; Sobolewski, Brad; Statile, Angela) • **Emergency Department Asthma Medication** Delivery Program: An Initiative to Provide Discharge Prescriptions and Education (Durkin, Kayla; Montgomery, Tricia; Lamberjack, Kristen; Hafer, Cindy C.; Naprawa, James; Yarosz, Shannon) • Impact of a Successful **Speaking Up** Program on **Health-Care Worker Hand Hygiene** Behavior (Linam, W. Matthew; Honeycutt, Michele D.; Gilliam, Craig H.; Wisdom, Christy M.; Deshpande, Jayant K.) • Deployment of a **Second Victim Peer Support Program**: A Replication Study (Merandi, Jenna; Liao, Nancy; Lewe, Dorcas; Morvay, Shelly; Stewart, Barb; Catt, Charline; Scott, Susan D.) • Identification of **Critical to Quality** Elements for **Intensive Care** Rounds by Kano Analysis (Tripathi, Sandeep; Henrekin, Lamonica L.; Read, Cynthia D.; Welke, Karl F.) • **Quality Improvement Leadership** in Academic Children's Hospitals (Barnard, John A.; Davis, J. Terrance)

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: • **Rehabilitative post-acute care for stroke patients** delivered by per-diem payment system in different hospitalization paths: A Taiwan pilot study (Chung-Yuan Wang; Yu-Ren Chen; Jia-Pei Hong; Chih-Chun Chan; Long-Chung Chang; Hon-Yi Shi) • A multi-state, multi-site, multi-sector healthcare improvement model: **implementing evidence for practice** (Karen-Leigh Edward; Kim Walker; Jed Duff)

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:

- Clinical Guideline CG81 ***Advanced breast cancer:*** *diagnosis and treatment* https://www.nice.org.uk/guidance/cg81
- Clinical Guideline CG192 ***Antenatal and postnatal mental health:*** *clinical management and service guidance* https://www.nice.org.uk/guidance/cg192