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On the Radar

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On the Radar
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Reports

Communicating Clearly About Medicines: Proceedings of a Workshop
National Academies of Sciences, Engineering, Medicine
Alper J, editor
Washington, DC: The National Academies Press; 2017. 124 p.

URL	https://www.nap.edu/catalog/24814/communicating-clearly-about-medicines-proceedings-of-a-workshop
Notes	The Roundtable on Health Literacy of the (US) National Academies of Sciences, Engineering, and Medicine convened a workshop on communicating clearly about medicines. The workshop focused on the clarity of written information given to patients and consumers. The workshop explored the design of health-literate written materials. The workshop rapporteurs have prepared this summary of the discussions.

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

Journal articles

Frequency and Nature of Medication Errors and Adverse Drug Events in Mental Health Hospitals: a Systematic Review
Alshehri GH, Keers RN, Ashcroft DM
Drug Safety. 2017 [epub].

DOI	http://dx.doi.org/10.1007/s40264-017-0557-7
Notes	In mental health care the focus is (obviously) on the mental health aspects, but this can create a gap in which other issues may arise. This can include lack of attention to other conditions, physical health and medications (both those for mental health care and others). This review sought to understand the scale of the medication errors (MEs) and adverse drug events (ADEs) in the mental health hospital setting. The review found that such errors "**occur frequently in mental health hospitals** and are associated with risk of patient harm". From the 20 studies that the review focused upon: • rate of **MEs** ranged from **10.6 to 17.5 per 1000 patient-days** • rate of **ADEs** ranged from **10.0 to 42.0 per 1000 patient-days** • **13.0–17.3%** of **ADEs** found to be **preventable** • ADEs were rated as clinically significant (66.0–71.0%), serious (28.0–31.0%), or life threatening (1.4–2.0%) • **prescribing errors** occurred in **4.5–6.3%** of newly written or omitted prescription items • **dispensing errors** occurred in 4.6% of opportunities for error and in 8.8% of patients **medication administration errors** occurred in 3.3–48.0% of opportunities for error • MEs and ADEs were frequently associated with psychotropics, with atypical antipsychotic drugs commonly involved.

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

Major health service transformation and the public voice: conflict, challenge or complicity?
Martin GP, Carter P, Dent M
Journal of Health Services Research & Policy. 2017 [epub].

Is There a Mismatch Between the Perspectives of Patients and Regulators on Healthcare Quality? A Survey Study
Bouwman R, Bomhoff M, Robben P, Friele R
Journal of Patient Safety. 2017 [epub].

When Patients and Their Families Feel Like Hostages to Health Care
Berry LL, Danaher TS, Beckham D, Awdish RLA, Mate KS
Mayo Clinic proceedings. 2017;92(9):1373-81.

DOI	Martin et al https://doi.org/10.1177/1355819617728530 Bouwman et al http://dx.doi.org/10.1097/PTS.0000000000000413 Berry et al http://dx.doi.org/10.1016/j.mayocp.2017.05.015
Notes	That patients should be engaged in (their) health care is now regarded as standard and appropriate. These papers all, in their own way, look at issues that problematize the engagement of patients with either involvement in their (or their family member's) care, the transformation of care at the system or service level and what they perceive as important to the quality of care as compared with the views of regulators.

	Martin et al examined the extent and nature, including design and function, of public involvement in two reconfiguration projects within the English NHS. As they note, "public involvement is fraught with challenges, and little research has focused on involvement in the health service transformation initiatives". Using qualitative data, including interviews, observation and documents, the authors found that "Public involvement …was extensive but its terms of reference, and the individuals involved, were **restricted by policy pressures and programme objectives**. The degree to which participants descriptively or substantively represented the wider public was limited; participants sought to 'speak for' this public but their views on **what was 'acceptable'** and likely to influence decision-making led them to **constrain their contributions**." Bouwman et al report on a survey that contacted 996 people who had registered a complaint with the Dutch Healthcare Inspectorate. The survey sought to measure their expectations of and experiences with the Inspectorate. 54% responded and from their responses the authors found that complaints about clinical issues (56%) were more likely to be investigated by the regulator than complaints about organizational (37%) and relational issues (51%). These, and other survey responses, led the authors to conclude "The predominant clinical **approach taken by regulators does not match the patients' perspective of what is relevant for healthcare quality**. In addition, patients seem to be more tolerant of what they perceive to be clinical or management errors than of perceived relational deficiencies in care providers. If regulators want to give patients a voice, they should expand their horizon beyond the medical framework." Berry et al focused more at the clinical interaction for the individual patient and their family, where there is an often a marked asymmetry in information, agency and power. The authors suggest that this can lead to patients being "susceptible to "**hostage bargaining syndrome**" (HBS), whereby they behave as if negotiating for their health from a position of fear and confusion. It may manifest as understating a concern, asking for less than what is desired or needed, or even remaining silent against one's better judgment." They suggest that to avert this, "**clinicians** must aim to be sensitive to the power imbalance inherent in the **clinician-patient relationship**. They should then actively and mindfully pursue **shared decision making** by helping patients trust that it is safe to **communicate** their concerns and priorities, ask questions about the available **clinical options**, and contribute knowledge of self to clinical decisions about their care."

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

For information on the Commission's work on shared decision making, see https://www.safetyandquality.gov.au/our-work/shared-decision-making/

Clinician-targeted interventions to influence antibiotic prescribing behaviour for acute respiratory infections in primary care: an overview of systematic reviews
Tonkin-Crine SKG, Tan PS, van Hecke O, Wang K, Roberts NW, McCullough A, et al.
Cochrane Database of Systematic Reviews. 2017 (9).

DOI	http://dx.doi.org/10.1002/14651858.CD012252.pub2
Notes	This Cochrane Review sought to "systematically review the existing evidence from systematic reviews on the effects of interventions aimed at influencing clinician antibiotic prescribing behaviour for ARIs [acute respiratory infections] in primary care". The review identified moderate quality evidence for three clinician-focused strategies that may reduce prescribing

	• encouraging the use of shared decision making between doctors and their patients • C-reactive protein tests (CRP) point-of-care testing • procalcitonin-guided management (both tests that measure the amount of proteins in the blood, which may be raised in the case of infection). These strategies probably reduce antibiotic prescribing for patients with ARIs, and therefore may reduce overall antibiotic consumption. However, the overall effect of these interventions was small, but the impact is likely to be clinically important. They also noted none of the reviewed studies compared these interventions against one another and consequently cannot say which are most effective.

Impact of clinical registries on quality of patient care and clinical outcomes: A systematic review
Hoque DME, Kumari V, Hoque M, Ruseckaite R, Romero L, Evans SM
PLoS ONE. 2017;12(9):e0183667.

DOI	https://doi.org/10.1371/journal.pone.0183667
Notes	Clinical quality registries have the potential to provide high-quality real-world information that can be used in a range of ways to improve and monitor the safety and quality of care. However, a lot of that potential has yet to be resolved, with some nations and some domains much further advanced than others. This review attempted to determine the impact of clinical quality registries to date. The authors found that while there is a volume of literature using data and information from clinical quality registries, there is explicitly considering or evaluating "the impact of the registry as an intervention on improving health outcomes. Those that have evaluated this impact have mostly found a positive impact on healthcare processes and outcomes."

For information on the Commission's work on clinical quality registries, see
https://www.safetyandquality.gov.au/our-work/information-strategy/clinical-quality-registries/

Guideline: Recommendations on screening for abdominal aortic aneurysm in primary care
Canadian Task Force on Preventive Health Care
Canadian Medical Association Journal. 2017 September 11, 2017;189(36):E1137-E45.

DOI	http://dx.doi.org/10.1503/cmaj.170118
Notes	This guideline from the Canadian Task Force on Preventive Health Care on screening for abdominal aortic aneurysm (AAA) {weakly) recommends screening men aged 65 to 80. The key points include: • Pooled analyses from four population-based RCTs with men older than 65 years show that **one-time screening** with ultrasonography for AAA **reduces the risk of aneurysm-related death, rupture and emergency repair**. • Screening leads to identification of aneurysms that would not dilate or rupture, and increases the likelihood of elective repair procedures for these patients. • A weak recommendation in favour of screening suggests the **importance of shared decision-**making with the primary care provider and patient, with discussion of patient preferences for screening. • The prevalence of AAA in screened populations has declined since the RCTs were conducted, reducing the absolute benefit of screening. • Women have much lower rates of AAA than men, and there is **no direct evidence that screening women has a positive impact** on their health. • Evidence on the impact of AAA screening on **men older than 80** years of age is indirect, meaning **any potential benefit is uncertain**.

Hospital-Readmission Risk — Isolating Hospital Effects from Patient Effects
Krumholz HM, Wang K, Lin Z, Dharmarajan K, Horwitz LI, Ross JS, et al
New England Journal of Medicine. 2017;377(11):1055-64.

DOI	http://dx.doi.org/10.1056/NEJMsa1702321
Notes	Rates of readmission are not uncommonly suggested or used as measures of hospital performance and/or quality. This US study examined readmission outcomes among patients who had multiple admissions for a similar diagnosis at more than one hospital within a given year in order to attempt to isolate hospital effects on risk-standardized hospital-readmission rates. The study used data on (US) Medicare patients (≥ 65 years of age). Data were used to calculate the risk-standardised readmission rate within 30 days for each hospital, and hospitals were classified into performance groups. A study sample included 37,508 patients who had two admissions for similar diagnoses at a total of 4272 different hospitals and was used to compare the observed readmission rates among patients who had been admitted to hospitals in different performance quartiles. From these analyses, the authors concluded "there was a **significant difference in rates of readmission** within 30 days. The findings suggest that **hospital quality contributes in part to readmission rates independent of factors involving patients**".

Why do surgeons receive more complaints than their physician peers?
Tibble HM, Broughton NS, Studdert DM, Spittal MJ, Hill N, Morris JM, et al
ANZ Journal of Surgery. 2017 [epub].

DOI	http://dx.doi.org/10.1111/ans.14225
Notes	This study started with the compilation of a national data set of complaints about surgeons and physicians lodged with medical regulators in Australia from 2011 to 2016. This database was then used to study the frequency and nature of complaints involving surgeons compared with physicians. The authors report that "The rate of complaints was 2.3 times higher for surgeons than physicians (112 compared with 48 complaints per 1000 practice years, $P < 0.001$). Two-fifths (41%) of the higher rate of complaints among surgeons was attributable to issues other than **treatments** and **procedures**, including **fees** (IRR = 2.68), **substance use** (IRR = 2.10), **communication** (IRR = 1.98) and **interpersonal behaviour** (IRR = 1.92). **Male surgeons** were at a higher risk of complaints, as were specialists in **orthopaedics**, **plastic surgery** and **neurosurgery**."

Understanding middle managers' influence in implementing patient safety culture
Gutberg J, Berta W
BMC Health Services Research. 2017 August 22;17(1):582.

DOI	https://doi.org/10.1186/s12913-017-2533-4
Notes	Culture change is often discussed in terms of 'top down' or 'bottom up'. This paper looks at the role some of those in the middle, the middle managers, can play. The authors argue that "**middle managers** can capitalize on their **unique position** between upper and lower levels in the organization and engage in 'ambidextrous' learning that is critical to implementing and sustaining radical change. This organizational learning perspective offers an innovative way of framing the mid-level managers' role, through both explorative and exploitative activities, which further considers the necessary organizational context in which they operate." Ultimately though, culture is everyone's business, the culture of an organisation is the culture that is lived and demonstrated every day throughout an organisation.

Post-operative mortality, missed care and nurse staffing in nine countries: A cross-sectional study
Ball JE, Bruyneel L, Aiken LH, Sermeus W, Sloane DM, Rafferty AM, et al
International Journal of Nursing Studies. 2017 [epub].

DOI	http://dx.doi.org/10.1016/j.ijnurstu.2017.08.004
Notes	The importance of nursing care is not always appreciated, while the importance of nurse staffing is contentious. This study sought to examine if missed nursing care mediates the previously observed association between nurse staffing levels and mortality. The study combined data on 422,730 surgical patients from 300 general acute hospitals in 9 countries, with survey data from 26,516 registered nurses, to examine any associations between nurses' staffing, missed care and 30-day in-patient mortality. The authors report finding that **nurse staffing** and **missed nursing care** were **significantly associated with 30-day case-mix adjusted mortality**, with an increase in a nurse's workload by one patient and a 10% increase in the percent of missed nursing care were associated with a 7% and 16% increase in the odds of a patient dying within 30 days of admission respectively.

Frequency of low-value care in Alberta, Canada: a retrospective cohort study
McAlister FA, Lin M, Bakal J, Dean S
BMJ Quality & Safety. 2017 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2017-006778
Notes	This Canadian retrospective cohort study used routinely collected health data from five linked data sets from 2012 to 2015 in order to estimate how frequently 10 low-value services highlighted by the Choosing Wisely campaign are done and what factors influence their provision. In the period 2002 to 2015, 162 143 people (**4%** of all adults in the province of Alberta and 5% of the people who saw a physician at least once) **received at least one of the 10 low-value services**, including 29.8% of Albertans older than 75 years. The proportion receiving low-value services ranged from carotid artery imaging in 0.1% of asymptomatic adults without cerebrovascular disease, to prostate-specific antigen **(PSA) testing in 55.5%** of men 75 years or older without a history of prostate cancer. The low-value services which resulted in the **greatest costs** to the healthcare system were **cervical cancer screening** in women older than 65 without history of cervical dysplasia or genital cancer, **PSA testing** in men older than 75 without history of prostate cancer and **preoperative stress testing/cardiac imaging** before non-cardiac surgery. The authors conclude that "Even within a universal coverage healthcare system, the proportion of patients receiving low-value services varied widely (from <0.1% to 56%). Increased use was associated with higher socioeconomic status, increased frequency of specialist contact and higher ratio of specialists to primary care physicians."

HealthcarePapers
Vol. 16, No. 4, 2017

URL	http://www.longwoods.com/publications/healthcarepapers/25197
Notes	A new issue of *HealthcarePapers* has been published, with the theme 'Enabling Evolving Practice for Healthcare Professionals: A Regulator's Journey'. Articles in this issue of *HealthcarePapers* include: • Defining **Health Profession Regulators' Roles** in the Canadian Healthcare System (Joshua Tepper, Humayun Ahmed and Adalsteinn D. Brown) • Enabling **Evolving Practice for Healthcare Professionals**: A Regulator's Journey (Kathy Wilkie and John Tzountzouris)

	• **Professional Healthcare Regulation and Practice**: The Case of Medicine in Britain (Mike Saks) • **Evolving Professional Regulation**: Keeping up with Health System Evolution (Elizabeth F. Wenghofer and Sophia M Kam) • Medical **Laboratory Technologists** as Positive **Quality Improvement Team Members** (Dennis Kendel) • Using Trends to **Inform Regulatory Practices** (Christine Penney and Alison Wainwright) • Ensuring Proactive **Regulatory Initiatives** Align with the **Public Interest** (Kathleen Leslie and Sioban Nelson) • Enhancing the **Relationship Between Regulators** and Their **Profession** (Zubin Austin) • Acting in the **Public Interest**: The Heart of **Professional Regulation** (Heidi M Oetter and Cynthia Johansen) • **Regulatory Models** and **Model Behaviours** (Kathy Wilkie and John Tzountzouris)

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: **Handoffs**: what's good for residents is good for nurses…so what's next? (Rebecca R Kitzmiller, Sim B Sitkin, Arpana R Vidyarthi) • Do the stars align? **Distribution of high-quality ratings** of healthcare sectors across US markets (Jose Figueroa, Yevgeniy Feyman, Daniel Blumenthal, Ashish Jha) • **Frequency of low-value care** in Alberta, Canada: a retrospective cohort study (Finlay A McAlister, Meng Lin, Jeff Bakal, Stafford Dean) • **Standard admission order sets** promote **ordering of unnecessary investigations**: a quasi-randomised evaluation in a simulated setting (Benjamin Leis, Andrew Frost, Rhonda Bryce, Kelly Coverett)

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: • Comparative epidemiology of ***Clostridium difficile*** infection: England and the USA (Alice King; Benjamin H. Mullish; Horace R.T. Williams; Paul Aylin) • **Senior services** in US hospitals and **readmission risk** in the Medicare population (Alicia I. Arbaje; Qilu Yu; Jiangxia Wang; Bruce Leff) • Physicians' and pharmacists' perceptions on **real-time drug utilization review system**: a nationwide survey (Seung-Mi Lee; Soo-Ok Lee; Dong-Sook Kim) • The role of patient perception of crowding in the determination of **real-time patient satisfaction at Emergency Department** (Hao Wang; Jeffrey A Kline; Bradford E Jackson; Richard D Robinson; Matthew Sullivan; Marcus Holmes; Katherine A Watson; Chad D Cowden; Jessica Laureano Phillips; Chet D Schrader; JoAnna Leuck; Nestor R Zenarosa)

Online resources

[UK] Guides to help staff support people with access needs
https://www.england.nhs.uk/publication/guides-to-help-staff-support-people-with-access-needs/
NHS England has produced this set of guides to help GP practice staff support people with access needs to use online services. The guides include:

- *How to support people with learning disabilities - A guide for GP practice staff*
- *How to support autistic people - A guide for GP practice staff*
- *How to support people who are blind or have sight loss - A guide for GP practice staff*
- *How to support people with hearing loss - A guide for GP practice staff Patient.*

[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 QS159 ***Transition between inpatient mental health*** *settings and community or care home settings* https://www.nice.org.uk/guidance/qs159
- Quality Standard QS160 ***End of life care*** *for infants, children and young people* https://www.nice.org.uk/guidance/qs160
- Quality Standard QS161 **Sepsis** https://www.nice.org.uk/guidance/qs161
