AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

Issue 341
Tuesday 3 October 2017

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On the Radar
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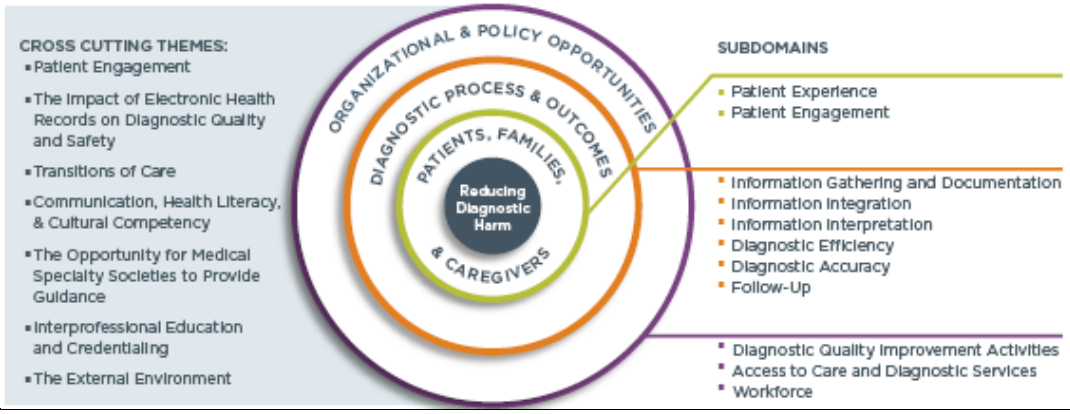
Books

Health Systems Improvement Across the Globe: Success Stories from 60 Countries
Braithwaite J, Mannion R, Matsuyama Y, Shekelle P, Whittaker S, Al-Adawi S, editors
Abingdon: Taylor & Francis; 2017.

URL	https://www.routledge.com/Health-Systems-Improvement-Across-the-Globe-Success-Stories-from-60-Countries/Braithwaite-Mannion-Matsuyama-Shekelle-Whittaker-Al-Adawi/p/book/9781472482044
Notes	Following on their 2015 book *Healthcare Reform, Quality and Safety: Perspectives, Participants, Partnerships and Prospects in 30 Countries*, this group of editors and authors have produced this new work seeking to identify and describe salient factors in success stories from healthcare systems worldwide. As with their earlier book, they have produced a summary paper for the *International Journal for Quality in Health Care* (https://doi.org/10.1093/intqhc/mzx122). In this paper they noted that "**Common factors** linked to **success** included the **'acorn-to-oak tree' principle** (a small scale initiative can lead to system-wide reforms); the **'data-to-information-to-intelligence' principle** (the role of IT and data are becoming more critical for delivering efficient and appropriate care, but must be converted into useful intelligence); the **'many-hands' principle** (concerted action between stakeholders is key); and the **'patient-as-the-pre-eminent-player' principle** (placing patients at the centre of reform designs is critical for success)."

Reports

Improving Diagnostic Quality and Safety Final Report
National Quality Forum
Washington D.C. : National Quality Forum; 2017. p. 79.

URL	http://www.qualityforum.org/Publications/2017/09/Improving_Diagnostic_Quality_and_Safety_Final_Report.aspx
Notes	The (US) National Quality Forum convened an expert Committee to develop a conceptual framework for measuring diagnostic quality and safety and to identify priorities for future measure development. The Committee's seven themes and recommendations are intended to apply broadly to those researching or wishing to develop measures related to reducing diagnostic harm: • **Patient Engagement**: Engaging patients and using their knowledge of their own medical histories is a critical aspect of the diagnostic process. • **Impact of Electronic Health Records** (EHR): Diagnostic quality and safety can be advanced significantly if EHRs have the capacity to collect key information related to diagnosis and are fully interoperable. • **Transitions of Care**: Transitions of care and errors during care transitions can have a significant impact on diagnostic quality and safety. • **Communication**: Communication—between the provider and the patient, and between providers—is a key issue in diagnostic quality and safety. When communicating with patients about their diagnoses, healthcare professionals should be sensitive to the patients' health literacy and cultural needs or preferences. • **Engagement with Medical Specialty Societies**: Improving diagnostic quality and safety will require medical specialty societies to engage and provide guidance as diagnostic measures are developed, in particular for conditions that are frequently misdiagnosed or can lead to serious harm in the event of a diagnostic error. • **Inter-professional Education and Credentialing**: Diagnostic quality and safety should become an important component of professional education, and credentialing organisations should ensure that their reviews emphasize diagnostic quality and safety. • **External Environment**: Issues related to the external environment, such as the alignment of payment incentives to promote timely and correct diagnosis, are less amenable to quality measurement but will have a significant impact on diagnostic quality and safety. **FIGURE 1. DIAGNOSTIC QUALITY AND SAFETY FRAMEWORK** 

Healthcare in Focus 2016
Bureau of Health Information
Sydney; BHI; 2017. p. 146.

URL	www.bhi.nsw.gov.au/BHI_reports/healthcare_in_focus/2016/
Notes	The New South Wales Bureau of Health Information has released their latest report comparing the performance of the NSW health system with those of a number of OECD nations. The measures are arranged according to a conceptual framework that views performance in terms of six dimensions: accessibility; appropriateness; effectiveness; efficiency; equity; and sustainability. There are sections reflecting each of these dimensions. Among the key messages is that the NSW healthcare system performs well, is considered accessible, largely patient-focused, safe, and cost-effective. Less positive findings include some inconsistency in communication, post-surgical complication rates, the levels of variation in a number of measures, including rates of unplanned readmission, emergency department re-presentations and re-fracture, identification of areas where better value could be achieved, such as reducing falls in hospital and more appropriate use of knee arthroscopy and that patients from low socioeconomic status (SES) groups had less positive experiences of care and longer median waiting times for elective surgery.

Journal articles

Patient-reported safety incidents as a new source of patient safety data: an exploratory comparative study in an acute hospital in England
Armitage G, Moore S, Reynolds C, Laloë P-A, Coulson C, McEachan R, et al
Journal of Health Services Research & Policy. 2017 [epub].

DOI	http://dx.doi.org/10.1177/1355819617727563
Notes	Paper reporting on an English study that compared a novel patient incident reporting tool with three established methods of detecting patient safety incidents to see if they same incidents were identified across the different methods. The study involved 329 patients in nine wards at a university teaching hospital. 77 patients provided 155 patient reports, with 68 patient safety incidents identified. The patient reports covered a range of events from their immediate environment, involving different health professionals and spanning the entire spectrum of care. This is a further addition to the literature that argues patients offer a valuable perspective – and potential source –safety incidents in health facilities. The authors concluded that the "**Patient safety incidents reported by patients are unlikely to be found through other established methods of incident detection**. When hospitalized patients are asked about their care, they can provide a **unique perspective** on patient safety. Co-designed, real-time reporting could be a helpful addition to existing methods of gathering patient safety intelligence."

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/

Wisdom of patients: predicting the quality of care using aggregated patient feedback
Griffiths A, Leaver MP
BMJ Quality & Safety. 2017.

DOI	http://dx.doi.org/10.1136/bmjqs-2017-006847
Notes	Also looking at value or utility of using patient's views and reports is this British paper. In this study the Care Quality Commission (CQC) sought to examine if automated collection and aggregation of multiple sources of patient feedback could be complied into a 'collective judgement' that accurately identifies risks to the quality of care. The CQC also sought to determine if such a tool could be used to prioritise their inspections of health facilities. The CQC's *Patient Voice Tracking System* combines patient feedback from NHS Choices, Patient Opinion, Facebook and Twitter to form a near real-time collective judgement score for acute hospitals and trusts on any given date. The authors report a positive association between the collective judgement score and subsequent inspection outcomes. This led to the conclusion that "The **collective judgement** score can successfully **identify a high-risk group** of organisations for inspection, is available in near real time and is available at a more granular level than the majority of existing data sets. The collective judgement score could therefore be used to help prioritise inspections."

Pennsylvania Patient Safety Advisory
September 2017, Vol. 14, No. 3

URL	http://patientsafety.pa.gov/ADVISORIES/Pages/201709_home.aspx
Notes	The Pennsylvania Patient Safety Authority has published their latest *Pennsylvania Patient Safety Advisory*. Topics in this issue include: • Treating **Hyperkalemia**: Avoid Additional Harm When Using Insulin and Dextrose • Promote a Culture of Safety with **Good Catch Reports** • Optimal Use of Antibiotics for **Urinary Tract Infections** in Long-Term Care Facilities: Successful Strategies Prevent Resident Harm • **Legionella**: Could This Potentially Deadly Bacteria Be Lurking in Your Facility's Water Distribution System? • Data Snapshot: **Dislodged Tubes and Lines** • **Workarounds**: Trash or Treasure? • **Saves, System Improvements, and Safety-II**

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: • **Psychotropic medications** prescribing trends in adolescents: A nationwide population-based study in Taiwan (Chin-Yen Tsai; Hsuan-Chia Yang; Mohaimenul Islam; Wan-Shan Hsieh; Shing-Hwa Juan; Jiang-Chen Chen; Hafsah Arshed Ali Khan; Wen-Shan Jian) • **Accomplishing reform**: **successful case studies** drawn from the health systems of 60 countries (Jeffrey Braithwaite; Russell Mannion; Yukihiro Matsuyama; Paul Shekelle; Stuart Whittaker; Samir Al-Adawi; Kristiana Ludlow; Wendy James; Hsuen P Ting; Jessica Herkes; Louise A Ellis; Kate Churruca; Wendy Nicklin; Clifford Hughes)

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: **Remediation and rehabilitation programmes for health professionals**: challenges for the future (François Goulet, Johanne Thiffault, Roger Ladouceur) • Comparison of **control charts** for **monitoring clinical performance** using binary data (Jenny Neuburger, Kate Walker, Chris Sherlaw-Johnson, Jan van der Meulen, David A Cromwell) • **Interprofessional collaboration** among care professionals in **obstetrical care**: are perceptions aligned? (Anita Romijn, Pim W Teunissen, Martine C de Bruijne, Cordula Wagner, Christianne J M de Groot) • Editorial: Unpacking **quality indicators**: how much do they reflect differences in the **quality of care**? (Jill Tinmouth) • Evaluation of the association between **Nursing Home Survey on Patient Safety culture** (NHSOPS) measures and **catheter-associated urinary tract infections**: results of a national collaborative (Shawna N Smith, M Todd Greene, Lona Mody, Jane Banaszak-Holl, Laura D Petersen, Jennifer Meddings) • Wisdom of patients: predicting the **quality of care** using aggregated **patient feedback** (Alex Griffiths, Meghan P Leaver) • Framework for direct **observation of performance and safety in healthcare** (Ken Catchpole, David M Neyens, James Abernathy, David Allison, Anjali Joseph, Scott T Reeves) • **Compassionate care**: not easy, not free, not only nurses (Roberta Bivins, Stephanie Tierney, Kate Seers)

Online resources

[USA] Fall Prevention in Hospitals Training Program
https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/index.html
The US Agency for Healthcare Research and Quality (AHRQ) has produced this training program (an implementation guide) to help acute care hospitals prevent patient falls. The training is designed for hospital quality improvement staff, patient safety officers and others staff who seek to reduce falls via a structured fall prevention initiative base on quality improvement principles. Data from 10 hospitals that used the program showed a 14 percent decrease in the average number of falls and a 20 percent decrease in falls-with-injury during the one-year period post implementation. Reductions were significantly greater for rehabilitation and geriatric/psychiatric units.

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

[UK] Digital skills
https://www.rcn.org.uk/clinical-topics/ehealth/digital-skills
The UK's Royal College of Nursing has produced this training resource on digital literacy. Digital literacies are the capabilities which fit someone for living, learning, working, participating and thriving in a digital society. Becoming a digitally-literate person involves developing those skills, attitudes, values and behaviours that can be categorised under the following headings:

- digital identity, well-being and safety
- communication, collaboration and participation
- teaching, learning and self-development
- technical proficiency
- information, data and media literacies
- digital creation, innovation and scholarship.

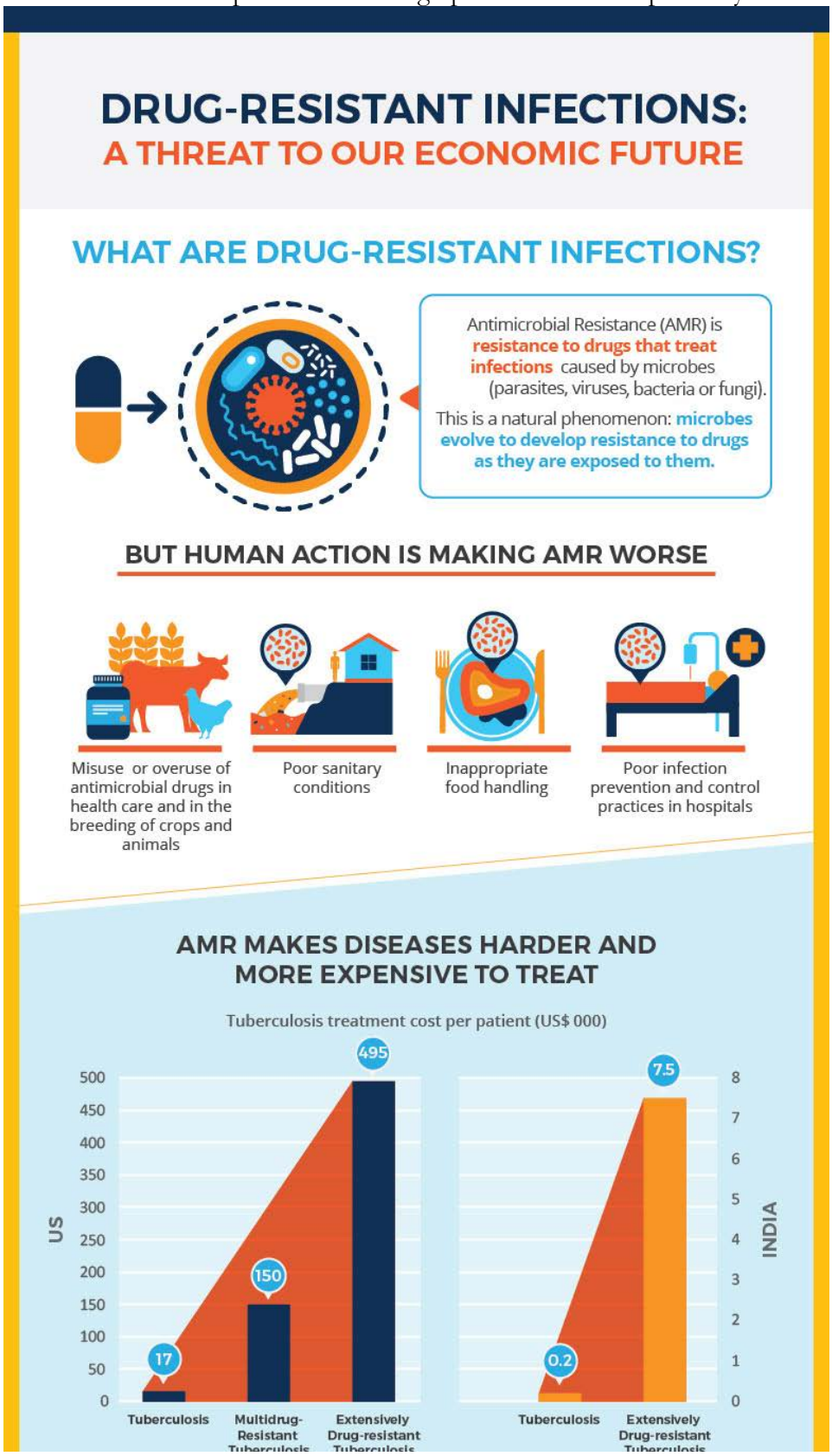
[UK] NICE Guidelines and Quality Standards
https://www.nice.org.uk
The UK's National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest reviews or updates are:

- Clinical Guideline CG54 ***Urinary tract infection*** *in under 16s: diagnosis and management* https://www.nice.org.uk/guidance/cg54
- Quality Standard QS36 ***Urinary tract infection*** *in children and young people* https://www.nice.org.uk/guidance/qs36
- NICE Guideline NG75 ***Faltering growth*** https://www.nice.org.uk/guidance/ng75

[UK] National Institute for Health Research
https://discover.dc.nihr.ac.uk/portal/search/signals
The UK's National Institute for Health Research (NIHR) Dissemination Centre has released the latest 'Signals' research summaries. This latest release includes:

- **Local nerve blocks** can improve outcomes for people with **hip fracture**
- Heel casts do not improve **heel ulcers** in **diabetes**
- Self-guided therapy for people with **obsessive-compulsive disorder** did not improve symptoms
- Intensive lifestyle interventions can help **obese young people** lose weight
- 52-week programme leads to more **weight loss** than 12-week
- **Group rehabilitation** activities improve walking after **stroke**
- A range of **anti-epilepsy drugs** are effective as first-line treatment
- Blood test and ECG may safely rule out **heart attack**
- Use of public **defibrillators** linked to out-of-hospital **cardiac arrest survival**
- Comprehensive assessment may reduce risk of **delirium** after **hip fracture**.

World Bank: Drug Resistant Infections: A Threat to Our Economic Future
http://www.worldbank.org/en/news/infographic/2016/09/18/drug-resistant-infections-a-threat-to-our-economic-future
The World Bank has produced an infographic on the threat posed by antimicrobial resistance.



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