AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

Books

WHO Guidelines on Integrated Care for Older People (ICOPE)
World Health Organization
Geneva: World Health Organization; 2017. 60 p.

URL	http://www.who.int/ageing/publications/guidelines-icope/en/
Notes	The World Health Organization has published this guideline encompassing evidence-based recommendations for health care professionals to prevent, slow or reverse declines in the physical and mental capacities of older people. These recommendations require countries to place the needs and preferences of older adults at the centre and to coordinate care. The ICOPE Guidelines will allow countries to improve the health and well-being of their older populations, and to move closer to the achievement of universal health coverage for all at all ages. The recommendations cover issues including mobility loss, malnutrition, visual impairment, hearing loss, cognitive impairment, depressive symptoms, urinary incontinence, falls risks and supporting caregivers. However, the reports notes that "The **recommendations** now formed in these guidelines **are interrelated**, and aim to produce synergistic effects on the intrinsic capacities and functional abilities of individuals. Although recommendations were made on the separate interventions, it was recognized that these would be **best implemented** in the context of a **comprehensive needs assessment** and an **integrated care plan**."

Reports

Active disinvestment in low-value care in Australia will improve patient outcomes and reduce waste
McCreanor V
Deeble Institute Issues Brief No 23
Canberra: Australian Healthcare and Hospitals Association; 2017. p. 27.

URL	https://ahha.asn.au/publication/issue-briefs/deeble-issues-brief-no-23-active-disinvestment-low%E2%80%90value-care-australia
Notes	The Australian Healthcare and Hospitals Association's Deeble Institute has released a new Issues Brief. This brief looks at steps toward disinvestment in 'low value' care in Australia and makes suggestions are to these could be extended so at to make health care more appropriate, cost-effective and equitable. The suggestions as to which actors undertake certain activities may need further consideration as to who may be best placed to take responsibility for these actions. The recommendations include: • Improving the disinvestment potential of the Medical Services Advisory Committee (MSAC) and the Pharmaceutical Benefits Advisory Committee (PBAC) • Collection of health outcomes data • Data sharing and reporting to support disinvestment • Better information for consumer decision-making • Private health insurers to promote use of high-value care only • Outcomes-based funding.

Making the case for quality improvement: lessons for NHS boards and leaders
Alderwick H, Charles A, Jones B, Warburton W
London: The King's Fund and The Health Foundation; 2017.

URL	https://www.kingsfund.org.uk/publications/making-case-quality-improvement
Notes	The King's Fund (and the Health Foundation) in the UK have produced this briefing that makes the case for quality improvement to be at the heart of local plans for health services. They defined quality improvement as "the use of methods and tools to try to continuously improve quality of care and outcomes for patients". The briefing draws on both literature and examples of where quality has been improved and describing how this was done. It describes the potential benefits from investing in quality improvement – including for patients, staff and the financial sustainability of the system. The primary audience for this briefing is senior leaders, given the need for new approaches within organisations and across local systems to improve quality of care. Leadership and management practices are strongly related to performance on quality, and there is a well-established relationship between board commitment to quality improvement and quality of care within their organisations. The author's offer ten lessons for health leaders. These are: • Make quality improvement a leadership priority for boards. • Share responsibility for quality improvement with leaders at all levels. • Don't look for magic bullets or quick fixes. • Develop the skills and capabilities for improvement. • Have a consistent and coherent approach to quality improvement. • Use data effectively. • Focus on relationships and culture. • Enable and support frontline staff to engage in quality improvement. • Involve patients, service users and carers. • Work as a system.

Americans' Experiences With Medical Errors and Views on Patient Safety
NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute
Chicago: NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute; 2017. p. 38.

URL	http://www.ihi.org/about/news/Pages/New-Survey-Looks-at-Patient-Experiences-With-Medical-Error.aspx
Notes	The report from the Lucian Leape Institute describes a survey that interviewed 2536 American adults. Once term "medical error" was defined, **21%** report that they have **personally experienced a medical error**, and 31% say they have personally been involved with the care of someone who has experienced an error. Combined, 41% have either experienced a medical error in their own care or were personally involved in a situation where a medical error was made in the care of someone close to them. The **proportion reporting harm** when receiving medical care was much lower, about **10%** (half of those reporting an error). The most common forms of error were missed or delayed diagnosis and communication errors.

Journal articles

Delirium in Hospitalized Older Adults
Marcantonio ER
New England Journal of Medicine. 2017;377(15):1456-66.

DOI	http://dx.doi.org/10.1056/NEJMcp1605501
Notes	The *New England Journal of Medicine* has included this Clinical Practice feature looking at the issue of delirium in patients. This is a far more common problem than many are aware of and is often overlooked. This feature uses a case vignette before discussing evidence-based strategies and a review of some existing guidelines. The key clinical points include: • **Delirium** is an acute confusional state that is **extremely common** among hospitalised older patient and is strongly associated with poor short-term and long-term outcomes. • The risk of delirium can be assessed according to the presence of **predisposing (baseline) and precipitating (acute) factors**. The more predisposing factors that are present, the fewer precipitating factors that are required to cause delirium. • The first step in delirium management is **accurate diagnosis**. • After receiving a diagnosis of delirium, patients require a **thorough evaluation** for reversible causes; all correctable contributing factors should be addressed. • Behavioural disturbances should be managed with non-pharmacologic approaches first. If required for patient safety, low doses of high-potency antipsychotic agents are usually the treatment of choice. Treatment should be targeted to specific behaviours and stopped as soon as possible. • **Proactive, multifactorial interventions** and geriatrics consultation have been shown to reduce the incidence, severity, and duration of delirium.

For information on the Commission's work on cognitive impairment (dementia and delirium), including the Better Way to Care program, see https://www.safetyandquality.gov.au/our-work/cognitive-impairment/

For information on the Commission's *Delirium Clinical Care Standard*, https://www.safetyandquality.gov.au/our-work/clinical-care-standards/delirium-clinical-care-standard/

Relation between family physician retention and avoidable hospital admission in Newfoundland and Labrador: a population-based cross-sectional study
Knight JC, Mathews M, Aubrey-Bassler K
CMAJ Open. 2017 October 6, 2017;5(4):E746-E52.

DOI	http://dx.doi.org/10.9778/cmajo.20170007
Notes	Attracting and retaining healthcare professionals to and in rural and regional locations is known to be difficult. It also has implications for the health of residents of these areas. This Canadian study looked at the issue of GP retention and avoidable hospital admission for ambulatory-care-sensitive conditions in the most easterly province of Canada, Newfoundland and Labrador. Such turnover of GPs can disrupt continuity of care, leading to poorer health outcomes and greater use of health care services. Using provincial health administrative data for the 475,691 residents of Newfoundland and Labrador who held a provincial health card between 2001 and 2009the study found that there was a negative relation between physician retention and hospital admission for ambulatory-care-sensitive conditions: residents of areas with moderate or low physician retention had admission rates that were 16.5% and 19.9% higher, respectively, compared to areas with high retention. However, no relation was found when analysis was limited to those aged 65 years or more. The authors conclude that their "findings suggest that **high physician retention is associated with lower rates of hospital admission for ambulatory-care-sensitive conditions** … [and] This is consistent with our hypothesis that physician turnover acts to disrupt continuity of care, resulting in higher admission rates."

Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending
Mafi JN, Russell K, Bortz BA, Dachary M, Hazel WA, Fendrick AM
Health Affairs. 2017 October 1, 2017;36(10):1701-4.

DOI	http://dx.doi.org/10.1377/hlthaff.2017.0385
Notes	This US study used 2014 data in the Virginia All Payer Claims Database to examine the costs of 'low value' services (defined here "patient care that provides no net health benefit in specific clinical scenarios"). The results apparently showed that 40-odd low-value health services amounted to more than $USD586 million in unnecessary costs. Among these low-value services, those that were low and very low cost ($538 or less per service) were delivered far more frequently than services that were high and very high cost ($539 or more). The combined costs of the lower cost group were nearly twice those of the higher cost group (65 percent versus 35 percent). The authors conclude "**Decreasing wasteful health care spending** will **reduce patient harm and improve the efficiency** of delivery by shifting care away from low-value circumstances to clinical scenarios that improve patient-centered outcomes. Instead of pursuing a politically charged strategy to reduce the use of high-profile and higher-cost low-value services, an alternative approach that initially targets the reduction of high-volume and less costly items might be a more strategic way to catalyze the movement to tackle the problem of low-value care. These findings also suggest that in the **aggregate, minor actions** by all clinicians can have a **sizable impact on reducing unnecessary health care spending**."

Persistent Frequent Emergency Department Use: Core Group Exhibits Extreme Levels Of Use For More Than A Decade
Kanzaria HK, Niedzwiecki MJ, Montoy JC, Raven MC, Hsia RY
Health Affairs. 2017 October 1, 2017;36(10):1720-8.

Coordination Program Reduced Acute Care Use And Increased Primary Care Visits Among Frequent Emergency Care Users
Capp R, Misky GJ, Lindrooth RC, Honigman B, Logan H, Hardy R, et al.
Health Affairs. 2017 October 1, 2017;36(10):1705-11.

DOI	Kanzaria et al http://dx.doi.org/10.1377/hlthaff.2017.0658 Capp et al. http://dx.doi.org/10.1377/hlthaff.2017.0612
Notes	This pair of papers from the recent issue of *Health Affairs* look at 'frequent flyers' or patients who are frequently appearing in emergency departments (EDs). Such patients can provoke concern about the cost and sustainability of emergency departments, so understanding who they are and what brings them (back) to emergency departments. These papers discuss the situation in the USA where emergency care may have a somewhat different role to that in countries with universal primary care. Kanzaria et al sought to examine who these frequent users were. Was it the same group over time or were frequent users of ED only frequent users for a relatively short time only (possibly due to high mortality in this group). This study looked at nonelderly adult frequent ED users in California in the period 2005–15. The study found that of the frequent ED users in 2005, 30.5 percent remained frequent users in 2006. A small but nontrivial population (16.5 percent, 5.7 percent, and 1.9 percent) exhibited persistent frequent use for three, six, and eleven consecutive years, respectively. The study also found that strongest predictor of persistent frequent ED use was the intensity of ED use in the baseline study year. Further, the rate at which frequent users stopped using the ED frequently decreased over time, leaving a core group of chronic persistent users. The authors observe that "These **persistent frequent users differ from non-persistent frequent users**, who engaged in temporary intense use of the ED. Identifying and differentiating persistent frequent users is important, as they may be candidates for distinct interventions." Capp et al. examined how participation in a **care coordination program** affected subsequent ED use, hospital admissions, and primary care use. For the patients studied, in the six months after the intervention they had **significantly fewer ED visits** (a reduction of 27.9 percent) and significantly **more primary care visits** (an increase of 114.0 percent), compared to patients in the control group. For patients with mental health comorbidities, participants had significantly fewer ED visits (a reduction of 29.7 percent) and hospitalizations (30.0 percent), and significantly more primary care visits (an increase of 123.2 percent), again compared to patients in the control group.

Public Health Research & Practice
October 2017, Volume 27, Issue 4

URL	http://www.phrp.com.au/issues/october-2017-volume-27-issue-4/
Notes	A new issue of *Public Health Research & Practice* has been published. This issue reflects on some of the changes that have occurred since the 1967 referendum, when the nation voted to amend the constitution to allow the federal government to create laws for Aboriginal and Torres Strait Islander people and include them in the census, particularly with respect to progress in improving Indigenous health outcomes. This issue includes an interview with the Indigenous Health Minister, Ken Wyatt, about the policy and politics of improving Indigenous health. Articles in this issue of *Public Health Research & Practice* include:

	• Editorial: 50 years since citizenship: **successes and challenges in Indigenous health** (Sandra J Eades and Emily Banks) • Interview with the Hon. Ken Wyatt: **improving Indigenous health outcomes** from a political viewpoint (Ken Wyatt) • The Australian Burden of Disease Study: impact and causes of **illness and death in Aboriginal and Torres Strait Islander people**, 2011 (Fadwa Al-Yaman) • The **Aboriginal and Torres Strait Islander smoking epidemic**: what stage are we at, and what does it mean? (Ray Lovett, Katherine A Thurber and Raglan Maddox) • **Child injury surveillance** capabilities in NSW: informing policy and practice (Rebecca Mitchell and Luke Testa) • Identifying research priorities to improve **cancer control for Indigenous Australians** (Bronwyn A Morris, Kate Anderson, Joan Cunningham and Gail Garvey) • Trends in **fall-related ambulance use and hospitalisation** among older adults in NSW, 2006–2013: a retrospective, population-based study (Serene S Paul, Lara Harvey, Therese Carroll, Qiang Li, Soufiane Boufous, Annabel Priddis, Anne Tiedemann, Lindy Clemson, Stephen R Lord, Sandy Muecke, Jacqueline CT Close, Serigne Lo and Catherine Sherrington) • The quality of **Australian Indigenous primary health care research** focusing on social and emotional wellbeing: a systematic review (Sara Farnbach, Anne-Maree Eades, Jamie K Fernando, Josephine D Gwynn, Nick Glozier and Maree L Hackett) • Ascertainment of **self-reported prescription medication use** compared with pharmaceutical claims data (Danijela Gnjidic, Wei Du, Sallie-Anne Pearson, Sarah N Hilmer and Emily Banks, on behalf of the High Risk Prescribing Investigators) • The **Aboriginal Population Health Training Initiative**: a NSW Health program established to strengthen the Aboriginal public health workforce (Ben Li, Aaron Cashmore, Dawn Arneman, Wendy Bryan-Clothier, Lisa K McCallum and Andrew Milat)

Journal of Health Services Research & Policy
Volume: 22, Number: 4 (October 2017)

URL	http://journals.sagepub.com/toc/hsrb/22/4
Notes	A new issue of the *Journal of Health Services Research & Policy* has been published. Articles in this issue of *Journal of Health Services Research & Policy* include: • How important is information and communication technology in enabling **interprofessional collaboration**? (Nicholas Goodwin) • **Patient safety in nursing homes** in Sweden: nurses' views on safety and their role (Frieda Andersson and Katarina Hjelm) • Prevalence and costs of **defensive medicine**: a national survey of Italian physicians (Massimiliano Panella, Carmela Rinaldi, Fabrizio Leigheb, Sanita Knesse, Chiara Donnarumma, Seval Kul, Kris Vanhaecht, and Francesco Di Stanislao) • Do single-use medical devices containing biopolymers reduce the **environmental impacts of surgical procedures** compared with their plastic equivalents? (Scott R Unger, Troy A Hottle, Shakira R Hobbs, Cassandra L Thiel, Nicole Campion, Melissa M Bilec, and Amy E Landis)

	• Cost-effectiveness of Memory Assessment Services for the **diagnosis and early support of patients with dementia** in England (Manuel Gomes, Mark Pennington, Raphael Wittenberg, Martin Knapp, Nick Black, and Sarah Smith) • Impact of the level of sickness on higher **mortality in emergency medical admissions to hospital at weekends** (Mohammed Mohammed, Muhammad Faisal, Donald Richardson, Robin Howes, K Beatson, K Speed, and J Wright) • **Health services research**: building capacity to meet the needs of the health care system (Helen Barratt, Jay Shaw, Lisa Simpson, S Bhatia, and N Fulop) • Impact of information and communication technology on **interprofessional collaboration** for **chronic disease management**: a systematic review (Neil Barr, Diana Vania, Glen Randall, and Gillian Mulvale) • Children as agents of change in combatting **antibiotic resistance** (A Molnar) • **Medicaid waivers and negotiated federalism** in the US: is there relevance to other federal systems? (Carol S Weissert and William G Weissert)

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: **Postmarket medical device safety**: moving beyond voluntary reporting (Frederic S Resnic, Arjun Majithia) • Intraoperative non-technical skills: a critical target for **improving surgical outcomes** (Kara Vande Walle, Caprice Greenberg) • Providing **feedback** following **Leadership WalkRounds** is associated with **better patient safety culture, higher employee engagement** and **lower burnout** (J Bryan Sexton, Kathryn C Adair, Michael W Leonard, Terri Christensen Frankel, Joshua Proulx, Sam R Watson, Brooke Magnus, Brittany Bogan, Maleek Jamal, Rene Schwendimann, Allan S Frankel) • Impact of an **inpatient electronic prescribing system** on prescribing error causation: a qualitative evaluation in an English hospital (Seetal Jheeta Puaar, Bryony Dean Franklin)

Online resources

ISMP Medication Safety Self Assessment® for High-Alert Medications
http://www.ismp.org/selfassessments/SAHAM/
The Institute for Safe Medication Practices (ISMP) has developed the ISMP Medication Safety Self Assessment® for High-Alert Medications as a tool to aid hospitals, long-term care facilities, and certain outpatient facilities evaluate their best practices related to high-alert medications, identify opportunities for improvement, and track their experiences over time. The ISMP Medication Safety Self Assessment® for High-Alert Medications focuses on general high-alert medications and 11 specific medication categories – including opioids, insulin, neuromuscular blocking agents, chemotherapy, and moderate and minimal sedation. Participants who submit assessment findings to ISMP anonymously via a secure internet portal will be able to obtain their weighted scores so they can compare themselves to demographically similar organizations.

Medical records and data-driven healthcare
https://youtu.be/VZ1Wvb0dvGI
The Commission and the Independent Hospital Pricing Authority have developed this short animation to support improved awareness of the uses of the data coded from the patient medical record and encourage improvements in clinical documentation.

[USA] Pressure Injury Prevention in Hospitals Training Program
https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/index.html
The US Agency for Healthcare Research and Quality (AHRQ) have developed the Pressure Injury Prevention in Hospitals Training Program to support hospital quality improvement (QI) staff, patient safety officers and other staff reduce the number of patient pressure injuries in hospitals.
The content of the Training Program and supporting materials help hospitals become familiar with each of the components of the Pressure Ulcer Prevention Toolkit and learn how to overcome the challenges associated with developing, implementing, and sustaining a pressure injury prevention program.
Hospitals participating in this pilot implementation of the Training Program and Toolkit reduced their hospital acquired Stage 2+ pressure injury rates and sustained these reductions for a year (the period of time over which hospitals were followed as part of this project).
The Training Program consists of a five-module, in-person training curriculum and a series of companion Webinars on specific topics related to pressure injury prevention. An Implementation Guide provides additional suggestions for how to use the Training Program and the Toolkit.

[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 CG89 ***Child maltreatment:*** *when to suspect maltreatment in under 18s*
  https://www.nice.org.uk/guidance/cg89
- NICE Guideline NG76 ***Child abuse and neglect*** https://www.nice.org.uk/guidance/ng76
- Quality Standard QS162 ***Cerebral palsy*** *in children and young people*
  https://www.nice.org.uk/guidance/qs162