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On the Radar

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On the Radar
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Journal articles

The Hidden Cost of Regulation: The Administrative Cost of Reporting Serious Reportable Events
Blanchfield BB, Acharya B, Mort E
The Joint Commission Journal on Quality and Patient Safety. 2018.

DOI	https://dx.doi.org/10.1016/j.jcjq.2017.08.006
Notes	Paper examining the costs associated with reporting all serious reportable events (SREs) at a single US academic medical centre (teaching hospital) during one fiscal year. The administrative costs to investigate and prepare reports were shown to be approximately $8000 per event with some 17% of the costs attributed to the public reporting requirements. For the44 events that happened in the year at this hospital the administrative cost SREs was estimated at $353,291, an average cost of $8,029 per SRE, ranging $6,653 for an environmental-related SRE to $21,276 for a device-related SRE. Some readers may consider such costs as simply the cost of doing business and worth bearing in terms of preventing further errors and actually relatively trivial given the potentially devastating outcomes of errors in healthcare. How one views these may depend on one's perceptions of risk, risk appetite and role of regulation. Another view might be that is shows the value of safe, quality care as avoiding or preventing such events precludes incurring these costs. There are also arguments that such events do need to be reported (and then collated and analysed) as it is at scale that the greatest learnings can be made.

Taking Bullying Out of Health Care: A Patient Safety Imperative
Ross J
Journal of PeriAnesthesia Nursing. 2017;32(6):653-5.

Association between organisational and workplace cultures, and patient outcomes: systematic review
Braithwaite J, Herkes J, Ludlow K, Testa L, Lamprell G
BMJ Open. 2017;7(11).

DOI	Ross https://dx.doi.org/10.1016/j.jopan.2017.08.006 Braithwaite et al https://dx.doi.org/10.1136/bmjopen-2017-017708
Notes	Over the years there have been many items in *On the Radar* relating to workplace culture. Ross discusses one particularly damaging aspect, that of bullying. The author summarises the work done to highlight unprofessional and disruptive behaviours, the deleterious **impacts of bullying** on (worker and patient) **safety** and work **culture**, and the **significance of leadership** in creating a positive work environments. Braithwaite et al report on their review that sought to synthesis synthesised the evidence on the extent to which organisational and workplace cultures are associated with patient outcomes. Based on a review of 62 articles from an original 2049 that were identified, the group found 'that overall, **positive organisational and workplace cultures** were **consistently associated** with a **wide range of patient outcomes** such as reduced mortality rates, falls, hospital acquired infections and increased patient satisfaction' and thus 'supports the argument in favour of activities that **promote positive cultures in order to enhance outcomes** in healthcare organisations'

Relationship between antimicrobial-resistance programs and antibiotic dispensing for upper respiratory tract infection: An analysis of Australian data between 2004 and 2015
Wu J, Taylor D, Ovchinikova L, Heaney A, Morgan T, Dartnell J, et al
Journal of International Medical Research. 2018.

DOI	https://dx.doi.org/10.1177/0300060517740813
Notes	This paper reports on a study that looked at antimicrobial dispensing in the community and the possible association with a number of interventions, including 'a series nationwide educational and advertising interventions for general practitioners and consumers were implemented in Australia between 2009 and 2015 with the aim of reducing antibiotic prescriptions for upper respiratory tract infections (URTIs).'Using dispensing data for the period 2004–2015 the authors report that ,since the intervention, on average **126,536 fewer antibiotics were dispensed each month** representing a **14% total reduction** in dispensed scripts after the series of intervention programs began in 2009. This leads them to suggest that "Continual educational intervention programs that emphasise the judicious use of antibiotics may effectively reduce inappropriate prescribing of antibiotics for the treatment of URTIs at a national level." This may be somewhat contentious as advertising campaigns apparently lose their impact over time and thus may be to regularly reviewed and renewed.

For information about the Commission's work on antimicrobial use and resistance, see https://www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/

What hinders the uptake of computerized decision support systems in hospitals? A qualitative study and framework for implementation
Liberati EG, Ruggiero F, Galuppo L, Gorli M, González-Lorenzo M, Maraldi M, et al
Implementation Science. 2017;12(1):113.

DOI	https://dx.doi.org/10.1186/s13012-017-0644-2
Notes	Information systems and automation are frequently held out as (potential) solutions for various problems. In the health sector, solutions such as electronic health records (EHR), electronic medication management (EMM), and clinical decision support systems (CDSS) have all been touted. However, implementation is often complex and needs to be undertaken so as new risks are not created. This study sought to examine some of the factors that have hindered the uptake and can influence the implementation of CDSS. Based on interviews with 30 physicians, nurses, information technology staff, and board at a number of hospitals, including two already using a CDSS and two hospitals intending to adopt a CDSS, they found a range of positions and that these could be fluid or dynamic. Barriers found included 'clinicians' perception that the CDSSs may **reduce their professional autonomy** or may be used against them in the event of **medical-legal controversies'** as well as '**technical and usability problems** related to the technology interface'. However, when the barriers could be overcome, 'CDSSs are perceived as **a working tool at the service of its users, integrating clinicians' reasoning and fostering organizational learning**.' Interestingly, culture emerges as a factor as the authors suggest that a transparent and accountable organizational culture is needed for successful implementation.

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

The impact of non-vitamin K antagonist oral anticoagulants (NOACs) on anticoagulation therapy in rural Australia
Bellinge JW, Paul JJ, Walsh LS, Garg L, Watts GF, Schultz C.
Medical Journal of Australia 2018;208:18-23

DOI	https://dx.doi.org/10.5694/mja17.00132
Notes	Novel oral anticoagulants (NOACs) have been available in Australia for more than 5 years. This study looked at their impact on rates of anticoagulant prescribing and reported safety outcomes in rural Western Australia, for patients with atrial fibrillation or flutter (AF) or venous thromboembolism (VTE). They found that remoteness appears to influence the choice of anticoagulation therapy, with NOACs prescribed slightly more often than warfarin for patients who lived further away from medical facilities. Despite apparent improvements in overall anticoagulant prescribing to people with AF, approximately one-third of patients remained without any anticoagulant therapy, despite having AF and being at risk of stroke (CHA_2DS_2–VASc score ≥ 1). Overall rates of NOACs and warfarin were similar with 34% and 33% of patients with a valid indication prescribed these drugs respectively. In terms of safety outcomes, there were 9 hospitalisations for bleeding events (4%) in patients treated with NOACs, vs 20 events (10%) in warfarin-treated patients, while lack of efficacy (hospitalisations for a thromboembolic event) were similar in both groups. The authors suggest that there remains **room for improvement in appropriate prescribing of anticoagulants** for AF.

The role of checklists and human factors for improved patient safety in plastic surgery
Oppikofer C, Schwappach D
Plastic and Reconstructive Surgery. 2017;140(6):812e-7e.

DOI	https://dx.doi.org/10.1097/PRS.0000000000003892
Notes	There has been a number of high profile 'misadventures' and adverse events in the cosmetic health/surgery domain in Australia in recent times. This commentary piece discusses how some of the safety and quality activities used in other domains of health may be applied. The piece looks at the role of human factors and nontechnical skills for patient safety in addition to encouraging the use (and customisation) of **surgical checklists**, encouragement for **speaking up** and **patient involvement** for patient safety, encouraging **clinicians to review** their own settings and processes and procedures.

American Journal of Medical Quality
Volume: 33, Number: 1 (January/February 2018)

URL	https://journals.sagepub.com/toc/ajmb/33/1
Notes	A new issue of the *American Journal of Medical Quality* has been published. Articles in this issue of *American Journal of Medical Quality* include: • Associations Between **Community Sociodemographics** and Performance in **HEDIS Quality Measures**: A Study of 22 Medical Centers in a Primary Care Network (Jianhui Hu, M Schreiber, J Jordan, D L George, and D Nerenz) • Observations From California's **Delivery System Reform Incentive Payment** Program (Ulfat Shaikh and Kenneth W Kizer) • Gamification and Microlearning for **Engagement With Quality Improvement** (GAMEQI): A Bundled Digital Intervention for the Prevention of **Central Line–Associated Bloodstream Infection** (Benjamin Orwoll, Shelley Diane, Duncan Henry, Lisa Tsang, Kristin Chu, Carrie Meer, Kevin Hartman, and Arup Roy-Burman) • Is It Time to Abandon **Hospital Accreditation**? (John R Griffith) • Systems Opportunities to Reduce **ED Crowding** From Nonemergency Referrals (Carolyn Joy Sachs, Charles K. Yu, Peter C Nauka, and D L Schriger) • **Quality Indicators** Associated With the Level of NCQA **Accreditation** (Jason P. Richter and Brad Beauvais) • Quick Sequential [Sepsis-Related] Organ Failure Assessment (qSOFA) and St. John Sepsis Surveillance Agent to Detect **Patients at Risk of Sepsis**: An Observational Cohort Study (Robert C Amland and Bharat B Sutariya) • Inappropriate Utilization in **Fee-for-Service Medicare** and Medicare Advantage Plans (Shriram Parashuram, Seung Kim, and Bryan Dowd) • CALM Interventions: **Behavioral Health** Crisis Assessment, Linkage, and Management Improve **Patient Care** (Natalie A Lester, Laura R Thompson, Kendal Herget, Julie A Stephens, John V Campo, Eric J Adkins, Thomas E Terndrup, and Susan Moffatt-Bruce) • The Impact of **Electronic Medical Records** on **Hospital-Acquired Adverse Safety Events**: Differential Effects Between Single-Source and Multiple-Source Systems (Jaeyong Bae, Kimberly J Rask, and E R Becker) • **Reducing Unnecessary Blood Chemistry Testing** in the Emergency Department: Implementation of Choosing Wisely (Arjun K Venkatesh, David Hajdasz, Craig Rothenberg, Meir Dashevsky, Vivek Parwani, Mark Sevilla, Marc Shapiro, and Ian Schwartz)

	• **Quality of Care** and Its **Impact on One-Year Mortality**: The Georgia Coverdell **Acute Stroke Registry** (Moges S Ido, Michael R Frankel, Ike S Okosun, and Richard B Rothenberg) • **Anesthesia Quality and Patient Safety** in China: A Survey (Bin Zhu, Huan Gao, Xiangyong Zhou, and Jeffrey Huang) • **Physician Engagement**: The "Secret Sauce" to Success in Bundled Health Care (Daniel Engelman and Evan M Benjamin) • **Improving Wisely** Using **Physician Metrics** (Martin A Makary, Ambar Mehta, and Tim Xu) • Improved **Newborn Care**: Evidence-Based Protocol for the Evaluation and Management of Early-Onset **Sepsis** (Christine Klingaman, Luke King, and Michele Neff-Bulger)

Journal of Health Services Research & Policy
Volume: 23, Number: 1 (January 2018)

URL	http://journals.sagepub.com/toc/hsrb/23/1
Notes	A new issue of the *Journal of Health Services Research & Policy* has been published. Articles in this issue of the *Journal of Health Services Research & Policy* include: • Editorial: **Integration** – reflections from Northern Ireland (Michael Donnelly and Ciaran O'Neill) • The elusive search for the **public voice in health** policy: the case for 'systems thinking' (John Boswell • Characteristics of **school-based health services** associated with students' mental health (Simon Denny, Hamish Howie, Sue Grant, Ross Galbreath, Jennifer Utter, Theresa Fleming, and Terryann Clark) • Factors determining perceptions of **fairness in access to hospital outpatient departments** in Taiwan (Ta-Ping Lu, Pei-Luen Patrick Rau, Zhi Guo, and Cui-Ling Chen) • **Hospital readmissions** and the **day of the week** (Aman Verma, Christian Rochefort, Guido Powell, and David Buckeridge) • Major **health service transformation and the public voice**: conflict, challenge or complicity? (Graham P Martin, Pam Carter, and Mike Dent) • **Patient-reported safety incidents** as a new source of patient safety data: an exploratory comparative study in an acute hospital in England (Gerry Armitage, Sally Moore, Caroline Reynolds, Pierre-Antoine Laloë, Claire Coulson, Rosie McEachan, Rebecca Lawton, I Watt, J Wright, and J O'Hara) • Differences in **salaries of physician assistants** in the USA by race, ethnicity and sex (Darron Smith and Cardell Jacobson) • Enacting **localist health policy** in the English NHS: the 'governing assemblage' of Clinical Commissioning Groups (Jonathan Hammond, Anna Coleman, and Kath Checkland) • How do **aggregated patient-reported outcome measures** data stimulate health care improvement? A realist synthesis (Joanne Greenhalgh, Sonia Dalkin, Elizabeth Gibbons, Judy Wright, Jose Maria Valderas, David Meads, and Nick Black) • Strengthening **stakeholder involvement in health workforce governance**: why we need to talk about power (Ellen Kuhlmann and Viola Burau)

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: **Low-value care**: an intractable global problem with no quick fix (John N Mafi, Michael Parchman) • Dynamics of **dignity and safety**: a discussion (Dawn Goodwin, Jessica Mesman, Marian Verkerk, Suzanne Grant)

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: • Implementation status of **morbidity and mortality conferences** in Swiss hospitals: a national cross-sectional survey study (Isabelle Praplan-Rudaz; Yvonne Pfeiffer; David L B Schwappach) • Are people getting **quality thalassemia care** in twin cities of Pakistan? A comparison with international standards (Tehreem Tanveer; Haleema Masud; Zahid Ahmed Butt) • Standardized languages and notations for **graphical modelling of patient care processes**: a systematic review (Pierpaolo Mincarone; Carlo Giacomo Leo; Maria del Mar Trujillo-Martín; Jan Manson; Roberto Guarino; Giuseppe Ponzini; Saverio Sabina) • Review of **chronic non-cancer pain research** among Aboriginal people in Canada (Nancy Julien; Anaïs Lacasse; Oscar Labra; Hugo Asselin) • Are **root cause analyses recommendations** effective and sustainable? An observational study (Peter D Hibbert; Matthew J W Thomas; Anita Deakin; William B Runciman; Jeffrey Braithwaite; Stephanie Lomax; Jonathan Prescott; Glenda Gorrie; Amy Szczygielski; Tanja Surwald; Catherine Fraser) • It's not just 'What' you do, it's also the 'Way' that you do it: **Patient and Public Involvement** in the Development of **Health Research** (Tracey J Devonport; Wendy Nicholls; Lynne H Johnston; Robin Gutteridge; A Watt) • Evaluation of **system mapping** approaches in **identifying patient safety risks** (Mecie Can Emre Simsekler; James R Ward; P John Clarkson)

Online resources

Medical Devices Safety Update
https://www.tga.gov.au/publication-issue/medical-devices-safety-update-volume-6-number-1-january-2018
Volume 6, Number 1, January 2018
The Therapeutic Goods Administration (TGA) has released the latest edition of its medical device safety bulletin. Topics covered in this issue include:

- Inappropriate use of **scalpel blade removers** potentially transmits infection – A recent device incident report highlights the issue of inappropriate use of scalpel blade removers during surgical procedures potentially transmitting infection between patients.
- ECRI lists ransomware as 2018 top hazard – As noted in *On the Radar* Issue 352, ransomware and other cybersecurity threats have been named as the top **health technology hazard** worldwide, followed by endoscope reprocessing failures and contamination of mattresses and bedding.

- Registry adds surgeon and hospital variation to joint replacement report –the Australian Orthopaedic Association **National Joint Replacement Registry** has addressed the issue of individual surgeon and hospital variation in outcomes and examined the role that prosthesis choice has in that variation.
- **Recent safety alerts** – TGA safety alerts relating to medical devices published since the last edition of *Medical Devices Safety Update*.
