# AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

# On the Radar

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**On the Radar**
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## Books

*Healthy settings for older people are healthy settings for all: the experience of Friuli-Venezia Giulia, Italy*
Burgher MS, editor
Copenhagen: WHO Regional Office for Europe; 2018.

| URL | http://www.euro.who.int/en/countries/italy/publications/healthy-settings-for-older-people-are-healthy-settings-for-all-the-experience-of-friuli-venezia-giulia,-italy-2018 |
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| Notes | A report from the WHO that shows how age-friendly environments have been created at the subnational level, using examples primarily from the Autonomous Region of Friuli-Venezia Giulia, Italy but also from other regions belonging to the WHO Regions for Health Network. Over the past 20 years, Friuli-Venezia Giulia has utilized WHO frameworks on healthy ageing and scaled up the pioneering experience of the city of Udine to develop a whole-of-the-region policy response to an ageing population, involving many sectors and all levels of governance. With the older segment of its population reaching 25% and still increasing, Friuli-Venezia Giulia put in place an integrated system to promote healthy ageing. The system incorporates new models of social protection and fosters new social relations and networks in local areas in order to promote sustainability; solidarity in relationships, behaviours and actions; and social responsibility. As many communities will see substantial increases in the proportion of their population who are older, this report can suggest possible directions for improved ageing. The report indicates that healthy settings for older people are healthy settings for all. |

## Reports

*Safer care saves money: How to improve patient care and save public money at the same time*
Duckett S, Jorm C, Moran G, Parsonage H
Melbourne: Grattan Institute; 2018. p. 55.

| URL | https://grattan.edu.au/report/safer-care-saves-money/ |
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| Notes | One of the challenges put to those advocating better safety is that of cost. This short report from the Grattan Institute adds to the literature that shows that better, safer care is cost-effective. The authors argue that if all hospitals reduced their complication rates to those of the better performing hospitals, as much as $1.5 billion could be saved, the number of complications would be reduced by 250,000 and more than 300,000 additional patients treated. The authors argue that better and more timely reporting (particularly to health facilities, unit and clinicians) and accreditation that drives improvement (and the information sharing) could be important levers for improving care and saving money and/or increasing the throughput of hospitals. That a quality health service is a learning, reflexive service is no revelation. Indeed, in work on clinical quality registries published in 2008, the Australian Commission on Safety and Quality in Health Care was arguing that timely information from registries could be used to inform and improve practice at the unit and individual level. The provision of accurate, valid and timely information can be of utility to all those involved in the health sector, from clinicians, units, services, funders, regulator and patients, as it can contribute to greater visibility and appreciation of the safety and quality of care. The role and efficacy of accreditation in quality improvement has been long debated, however, the value and application of standards, such as the National Safety and Quality Health Service (NSQHS) Standards, is also recognised. |

For information about the National Safety and Quality Health Service (NSQHS) Standards, see
https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/

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

*Leadership in Clinical Informatics*
A HISA White Paper
Health Informatics Society of Australia
Melbourne: HISA; 2018. p. 22.

| URL | https://www.hisa.org.au/wp-content/uploads/2018/08/HISA-_Leadership-Clinical-Informatics_FINAL.pdf |
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| Notes | The Health Informatics Society of Australia (HISA) has released this short 'white paper' that recognises the role of clinicians in leading digital transformation in health. HISA's Clinical Informatics Community of Practice believes leadership in clinical informatics is essential to delivering a truly digital health system. They consider that leadership skills in clinical informatics need to be developed so as to ensure technology brings value to healthcare delivery and patient experience. This leadership capability needs to be acknowledged by organisations embarking on their digital transformation and, by professional colleges who hold their registered health care professionals accountable for their conduct and practice. |

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

## Journal articles

*Social disparities in patient safety in primary care: a systematic review*
Piccardi C, Detollenaere J, Vanden Bussche P, Willems S
International Journal for Equity in Health. 2018;17(1):114.

| DOI | http://doi.org/10.1186/s12939-018-0828-7 |
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| Notes | It is widely recognised that health has many social determinants. This includes how safety risks can merge and be addressed (or not). The review paper summarises the literature on the social dimension of patient safety in the primary care setting. Examining literature published in 2006–2017, was found to "suggest that **vulnerable social groups are likely to experience adverse patient safety events in primary care**", with the literature focused more on gender and ethnic disparities rather than income and educational level. |

*The dilemma of patient safety work: perceptions of hospital middle managers*
Sanner M, Halford C, Vengberg S, Röing M
Journal of Healthcare Risk Management. 2018 [epub].

| DOI | http://doi.org/10.1002/jhrm.21325 |
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| Notes | Safety and quality is rightly seen as everyone's business. However, day-to-day responsibility for these issues can fall on the shoulders of particular people, often in ways that are out of proportion with their authority and resources to address them. This paper recounts the views of 27 middle managers at a Swedish teaching hospital. The interviews revealed that they **perceived patient safety to be a low priority** and that **senior management interest** in patient safety was **lacking**. They also reveal that they had concerns about the **underreporting** of patient safety incidents and **insufficient resources** for safety–related work. |

*Defining patient safety events in inpatient psychiatry*
Marcus SC, Hermann RC, Cullen SW
Journal of Patient Safety. 2018 [epub].

| DOI | http://doi.org/10.1097/PTS.0000000000000520 |
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| Notes | While many safety and quality issues are pertinent to all domains of care, many domains pose specific challenges and risks. This paper looks at the patient safety events that may arise in the inpatient psychiatric setting. The authors suggest "a framework for characterizing patient safety in hospital-based mental health care", along with definitional issues and attempt to delineate a "a comprehensive set of definitions of the types of safety events that occur in this setting".<br>They argue that events in this setting can be "broadly categorized as adverse events and medical errors".<br>The list of **adverse events** includes **adverse drug events** and **non-drug adverse events**, including **self-harm** or **injury** to self, **assault**, **sexual contact**, patient **falls**, and other **injuries**.<br>The **medical errors** category includes **medication errors** and **non-medication errors**, such as **elopement** and **contraband**. |

*Antimicrobial resistance: a threat to global health*
Jee Y, Carlson J, Rafai E, Musonda K, Huong TTG, Daza P, et al
The Lancet Infectious Diseases. 2018;18(9):939-40.

*Ethnic disparities in community antibacterial dispensing in New Zealand, 2015*
Whyler N, Tomlin A, Tilyard M, Thomas M
The New Zealand Medical Journal. 2018;131(1480):50-60.

*US Emergency Department Visits for Adverse Drug Events From Antibiotics in Children, 2011–2015*
Lovegrove MC, Geller AI, Fleming-Dutra KE, Shehab N, Sapiano MRP, Budnitz DS
Journal of the Pediatric Infectious Diseases Society. 2018 [epub].

*Antibiotics for prolonged wet cough in children*
Marchant J, Petsky HL, Morris PS, Chang AB
Cochrane Database of Systematic Reviews. 2018.

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| DOI | Jee et al https://doi.org/10.1016/S1473-3099(18)30471-7 <br> Whyler et al https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1480-17-august-2018/7664 <br> Lovegrove et al https://doi.org/10.1093/jpids/piy066 <br> Marchant et al https://doi.org/10.1002/14651858.CD004822.pub3 |
| Notes | A number of articles all linked by the common feature of antimicrobials/antibacterials/antibiotics. <br> Jee et al remind us of the vast current and potential impact of resistance to these vital medicines. They report that "an **estimated 700 000 deaths** are attributed to AMR [**antimicrobial resistance**] **annually**, with a projected **economic impact of US$100 trillion by 2050**." The article also provides a summary of the Addressing Antimicrobial Resistance: A Threat to Global Health and the Achievement of Universal Health Coverage event held in conjunction with the 71st World Health Assembly to strengthen global responses to AMR that are informed by country-specific experiences of the implementation of national AMR surveillance systems. <br> Whyler et al report on their finding of substantial variation in dispensing of antibacterials by ethnicity in New Zealand. The found that "Pacific and Maori people, who have very much higher rates of many infectious diseases, have only moderately higher rates of dispensing of antibiotics, when compared with people of European, Middle Eastern, Latin American or African, or Asian ethnicity." They argue that clinicians "**need to reduce antibiotic prescribing for all population groups**, but particularly for those groups with lower rates of serious infectious diseases", but perhaps the call might focus more on ensuring that prescribing is appropriate. <br> Lovegrove et al report on the rate of adverse drug events related to antibiotics found in the USA. Noting that antibiotics are among the most commonly prescribed medications for children they also observe that "at least **one-third of pediatric antibiotic prescriptions are unnecessary**". Using US national surveillance data and dispensing data, the authors estimate that 69464 emergency department (ED) visits were made annually in the USA for antibiotic ADEs among children aged ≤19 years from 2011 to 2015. These are nearly half of the ED visits for ADEs that came from systemic medication. Further, **40.7% of ED visits for antibiotic ADEs involved a child aged ≤2 years**, and **86.1%** involved an **allergic reaction**. **Amoxicillin** had the highest rate of ED visits for antibiotic ADEs among children aged ≤2 years, whereas **sulfamethoxazole-trimethoprim** resulted in the highest rate among children aged 10 to 19 years (29.9 and 24.2 ED visits per 10000 dispensed prescriptions, respectively). However, Marchant et al remind us that while there may be inappropriate use, there are many instances where they are entirely appropriate. In their Cochrane Review they find that for chronic wet cough in children "Evidence suggests antibiotics are efficacious for the treatment of children with chronic wet cough (greater than four weeks) with an NNTB [number needed to treat for an additional beneficial outcome] of three" |

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

For information about the Commission's work on variation and to access the *Australian Atlas of Healthcare Variation* series, see https://www.safetyandquality.gov.au/atlas/

*Developing a hospital-wide quality and safety dashboard: a qualitative research study*
Weggelaar-Jansen AMJWM, Broekharst DSE, de Bruijne M
BMJ Quality & Safety. 2018 [epub].

| DOI | http://doi.org/10.1136/bmjqs-2018-007784 |
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| Notes | Dashboards often appeal as they offer a single, easy-to-use and easy to comprehend overview of the health of a system. A good dashboard needs to be founded on meaningful metrics and timely, accurate data. This paper the development and implementation hospital-wide quality and safety dashboards in Dutch hospitals. |

*International Journal for Quality in Health Care*
Volume 30 Issue 7 August 2018

| URL | https://academic.oup.com/intqhc/issue/30/7 |
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| Notes | A new issue of *International Journal for Quality in Health Care* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue include:<br><br>• Editorial: **Continuous quality and patient safety improvement** from developing countries to developed countries (Che-Ming Yang)<br>• Quality of **cross-infection control in dental laboratories**. A critical systematic review (I Vázquez-Rodríguez; A Estany-Gestal; J Seoane-Romero; M J Mora; P Varela-Centelles; U Santana-Mora)<br>• Criteria for **evaluating programme theory diagrams** in quality improvement initiatives: a structured method for appraisal (Laurel Issen; Thomas Woodcock; Christopher McNicholas; Laura Lennox; Julie E Reed)<br>• Is **health literacy** associated with greater medical care trust? (Tzu-I Tsai; Wen-Ry Yu; Shoou-Yih D Lee)<br>• Factors associated with ever use of **mammography** in a limited resource setting. A mixed methods study (L Cruz-Jiménez; G Torres-Mejía; A Mohar-Betancourt; L Campero; A Ángeles-Llerenas; C Ortega-Olvera; L Martínez-Matsushita; N Reynoso-Noverón; C Duggan; B O Anderson)<br>• **Pharmacist interventions** in **high-risk obstetric inpatient unit**: a medication safety issue (Nice M O Silva; Mariana R Gnatta; Marília B Visacri; Amanda C Ferracini; Priscila G Mazzola; Mary Â Parpinelli; F G Surita)<br>• Improving **immediate newborn care** practices in Philippine hospitals: impact of a national quality of care initiative 2008–2015 (Maria Asuncion A Silvestre; Priya Mannava; Marie Ann Corsino; Donna S Capili; Anthony P Calibo; Cynthia Fernandez Tan; John C S Murray; Jacqueline Kitong; H L Sobel)<br>• A systematic approach to develop a core set of parameters for boards of directors to govern **quality of care in the ICU** (Anke J M Oerlemans; Evert de Jonge; Johannes G van der Hoeven; Marieke Zegers)<br>• Management of patients with **coronary heart disease in family medicine**: correlates of quality of care (Ksenija Tušek-Bunc; Davorina Petek)<br>• **Incidence and mortality from adverse effects of medical treatment** in the UK, 1990–2013: levels, trends, patterns and comparisons (Raimundas Lunevicius; Juanita A Haagsma)<br>• Appropriateness of **magnetic resonance imaging** requested by primary care physicians for patients with **knee pain** (J M Gómez-García; F J Gómez-Romero; M Arencibia-Jiménez; J F Navarro-Gracia; M Sánchez-Mollá) |

| | • Time needed to resolve **patient complaints** and factors influencing it: a cohort study (Jonathan Lee; Tze Ping Loh; David Eng Hui Ong; Michael George Caleb; Aymeric Yu Tang Lim; Peter George Manning) |
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*Pediatric Quality & Safety*
Vol. 3, No. 4, July/August 2018

| URL | https://journals.lww.com/pqs/toc/2018/07000 |
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| Notes | A new issue of *Pediatric Quality & Safety* has been published. Articles in this issue of *Pediatric Quality & Safety* include: <br>• A Saturated Approach to the Four-Phase, Brain-Based **Simulation Framework for TeamSTEPPS®** in a Pediatric Medicine Unit (Clapper, Timothy C.; Ching, Kevin; Mauer, Elizabeth; Gerber, Linda M.; Lee, Joanna G.; Sobin, Brittany; Ciraolo, KerriAnn; Osorio, Snezana Nena; DiPace, J. I.) <br>• A Retrospective Review of a Bed-mounted Projection System for Managing **Pediatric Preoperative Anxiety** (Caruso, Thomas J.; Tsui, Jeremy H.; Wang, Ellen; Scheinker, David; Sharek, Paul J.; Cunningham, C.; Rodriguez, S. T.) <br>• Decreasing **Radiograph Errors** in Pediatric Sports Medicine Clinic (Valasek, Amy E.; Gallup, James; Wheeler, T. Arthur; Valleru, Jahnavi) <br>• A Quality Improvement Initiative to **Decrease Time to Antibiotics** for Children with Intestinal Failure, Fever, and a Central Line (Hariharan, Selena; Mezoff, Ethan A.; Dandoy, Christopher E.; Zhang, Yue; Chiarenzelli, Janis; Troutt, M. L.; Simpkins, J.; Dewald, M.; Klotz, K.; Mezoff, A. G.; Cole, C. R.) <br>• Implementing a Standardized **Clinical Pathway** Leads to Reduced **Asthma** Admissions and Health Care Costs (McCoy, Elisha M.; Kink, Rudy J.; Harrold, La Precious L.; Longjohn, Mindy K.; Meredith, Mark L.; Pishko, Stephen D.) <br>• **Total Parenteral Nutrition** Standardization and Electronic Ordering to Reduce Errors: a Quality Improvement Initiative (Crews, Jacquelyn; Rueda-de-Leon, Elena; Remus, Denise; Sayles, Russell; Mateus, Jazmine; Shakeel, Fauzia) <br>• Improving Follow-up Skeletal Survey Compliance in Suspected **Nonaccidental Trauma** Patients: What's the FUSS About? (Gan, Tong; Draus, John M. Jr) <br>• Quality Initiative to Improve **time to Antibiotics for Febrile Pediatric Patients** with Potential Neutropenia (Monroe, Kathy; Cohen, Clay T.; Whelan, Kimberly; King, Amber; Maloney, Lisa; Deason, Janet; Nichols, John Charles; Friedman, Gregory K.; Kutny, Matthew; Hayes, Leslie) <br>• **I-PASS Handoff** Program: Use of a Campaign to Effect Transformational Change (Rosenbluth, Glenn; Destino, Lauren A.; Starmer, Amy J.; Landrigan, Christopher P.; Spector, N. D.; Sectish, T. C.; I-PASS Campaign Committee) |

*Journal of Patient Safety and Risk Management*
Volume: 23, Number: 4 (August 2018)

| URL | http://journals.sagepub.com/toc/cric/23/4 |
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| Notes | A new issue of *Journal of Patient Safety and Risk Management* has been published. Articles in this issue of *Journal of Patient Safety and Risk Management* include: <br>• The easy part is over: Creating **safe systems of care** (Albert W Wu) <br>• The role of **the patient in patient safety**: What can we learn from healthcare's history? (Ian Leistikow and Frank Huisman) <br>• **Value-based purchasing** may unfairly penalize specialty centers performing combined liver–colon multivisceral resections (Ira L Leeds, Peter J Pronovost, J Matthew Austin, and Elliott R Haut) |

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| | <ul><li>A British **doctor's duty** to offer help in emergencies outside of a clinical setting (Charlotte Cliffe)</li><li>Operating management system for h**igh reliability: Leadership, accountability, learning and innovation in healthcare** (Richard M Day, Renee J Demski, Peter J Pronovost, Kathleen M Sutcliffe, Eileen M Kasda, Lisa L Maragakis, Lori Paine, Melinda D Sawyer, and Laura Winner)</li><li>Creating a comprehensive, unit-based approach to **detecting and preventing harm in the neonatal intensive care unit** (Emily W Sedlock, Madelene Ottosen, Klaus Nether, Dean F. Sittig, Jason M Etchegaray, Andrada Tomoaia-Cotisel, Nicole Francis, Lauren Yager, Leslie Schafer, Rebekah Wilkinson, Amir Khan, Cody Arnold, Allison Davidson, and Eric J Thomas)</li></ul> |

*Healthcare Policy*
Vol. 14 No. 1, 2018

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| URL | https://www.longwoods.com/publications/healthcare-policy/25546/1/vol.-14-no.-1-2018 |
| Notes | A new issue of *Healthcare Policy* has been published with the theme 'Measuring Progress in Access to Health Services'. Articles in this issue of *Healthcare Policy* include:<ul><li>Editorial: Measuring Progress in **Access to Health Services** (Jennifer Zelmer)</li><li>Improving Healthcare Providers' Interactions with Trans Patients: Recommendations to Promote **Cultural Competence** (Ella Vermeir, Lois A Jackson and Emily Gard Marshall)</li><li>Using an Integrated Knowledge Translation (IKT) Approach to Enable Policy Change for **Electronic Consultations** in Canada (Clare Liddy, Isabella Moroz, Justin Joschko, Tanya Horsley, Craig Kuziemsky, Katharina Kovacs, Sandi Kossey, Gunita Mitera and Erin Keely)</li><li>Community-Based Reform Efforts: The Case of the **Aging at Home** Strategy (Allie Peckham, David Rudoler, Joyce M. Li and Sandra D'Souza)</li><li>The Changing Landscape of **Continuing Care** in Alberta: Staff and Resident Characteristics in Supportive Living and Long-Term Care (Susan E Slaughter, C Allyson Jones, Misha Eliasziw, Carla Ickert, C A Estabrooks and A S Wagg)</li><li>State of the Evidence for **Emergency Medical Services (EMS) Care**: The Evolution and Current Methodology of the Prehospital Evidence-Based Practice (PEP) Program (Alix J E Carter, Jan L Jensen, David A Petrie, Jennifer Greene, Andrew Travers, Judah P Goldstein, Jolene Cook, Dana Fidgen, Janel Swain, Luke Richardson and Ed Cain)</li><li>Stakeholder Views on **Solutions to Improve Health System Performance** (Astrid Brousselle, Damien Contandriopoulos, Jeannie Haggerty, Mylaine Breton, Michèle Rivard, M-D Beaulieu, G Champagne and M Perroux)</li></ul> |

*International Journal for Quality in Health Care* online first articles

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| URL | https://academic.oup.com/intqhc/advance-access |
| Notes | *International Journal for Quality in Health Care* has published a number of 'online first' articles, including:<ul><li>Process evaluation of the effects of **patient safety auditing** in hospital care (part 2) (Mirelle Hanskamp-Sebregts; Marieke Zegers; Wilma Boeijen; Hub Wollersheim; Petra J van Gurp; Gert P Westert)</li><li>Risk of **health morbidity** for the **uninsured**: 10-year evidence from a large hospital center in Boston, Massachusetts (Zhaoyi Chen; Jae Min; Jiang Bian; Mo Wang; Le Zhou; Mattia Prosperi)</li></ul> |

*BMJ Quality and Safety* online first articles

| URL | https://qualitysafety.bmj.com/content/early/recent |
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| Notes | *BMJ Quality and Safety* has published a number of 'online first' articles, including:<br><br>• Effects of a multifaceted **medication reconciliation** quality improvement intervention on patient safety: final results of the MARQUIS study (Jeffrey L Schnipper, Amanda Mixon, Jason Stein, Tosha B Wetterneck, Peter J Kaboli, Stephanie Mueller, Stephanie Labonville, Jacquelyn A Minahan, Elisabeth Burdick, Endel John Orav, Jenna Goldstein, Nyryan V Nolido, S Kripalani)<br>• Recognising the importance of informal communication events in improving **collaborative care** (Sarah Burm, Kaitlyn Boese, Lisa Faden, Sandy DeLuca, Noureen Huda, Kathy Hibbert, Mark Goldszmidt) |

## 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:

• NICE Guideline NG103 **Flu vaccination**: *increasing uptake*
https://www.nice.org.uk/guidance/ng103

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