AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Reports

Funds pooling in Australia: Could alliance contracting hold the key?
Deeble Institute Perspectives Brief No. 3
Jackson C
Canberra: Australian Healthcare and Hospitals Association; 2018. p. 9.

URL	https://deebleinstitute.org.au/publication/deeble-institute-perspective-briefs/deeble-institute-perspectives-no3-funds-pooling
Notes	This brief from the Australian Healthcare and Hospitals Association's Deeble Institute looks at the potential 'pooled funding' across state and territory jurisdictions to enhance universal health coverage and minimise fragmentation in risk-sharing mechanisms. The author suggests that this "pooled population-based health funding at scale would be new, challenging and potentially confronting to Australian health and hospital providers" who have previously been funded individually for deliverables based on activity. Some of the key questions posed in this brief include: • What international evidence or experience in successfully pooling funds between primary healthcare and acute care sectors could guide jurisdictions? • Which international models best align with Australia's health system, service delivery arrangements, deliverables and culture? • What governance mechanism could bring diverse organisational and jurisdictional groups together in successful partnerships?

Snakes & Ladders: The Journey to Primary Care Integration. A health policy report – September 2018
Consumers Health Forum, The George Institute for Global Health, and the University of Queensland MRI Centre for Health System Reform and Integration
2018. p. 20.

URL	https://chf.org.au/media-releases/health-system-strains-make-it-time-act http://www.georgeinstitute.org.au/media-releases/health-system-strains-make-it-time-to-act-0
Notes	This report stems from an expert roundtable of consumers, clinicians, academics, government and private providers that was convened by the Consumers Health Forum, The George Institute for Global Health and the University of Queensland MRI Centre for Health System Reform and Integration. The roundtable considered that Australia's health system is under strain and in urgent need of transformation to strengthen consumer-centred and community-based primary health services. The report identifies 5 themes and 10 priorities for action, as well as suggesting a 5 year plan for implementation and transformation of primary care. The themes and priorities include: Clear the way by removing funding barriers 1. Fund equitable access to a revised model of Health Care Homes across Australia, 2. Strengthen Medicare through the development of regional budgets combining Commonwealth and State/Territory funding. Create regional solutions 3. Establish formal agreements between the Commonwealth, the states and territories, Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) (or their equivalent) to improve local and regional system performance and deliver integrated, consumer centred services. 4. Empower PHNs to take greater responsibility and accountability for creating primary health care systems in their local areas. 5. Require PHNs and LHNs to work together as co-commissioners of services Test and showcase innovation 6. Implement a major demonstration project to empower consumers with complex chronic diseases to plan and manage their health 7. Fund a Consumer Enablement Portal Link up the system 8. Recognising the importance of professional collaboration and team-based care within care settings as well as across primary, secondary and tertiary health care, introduce funding models which promote joined up models of health service delivery 9. Recognise the important role of primary health care information – including patient experience measures – as fundamental to better patient management, service development and quality improvement, integration, and accountability. Lead into the future 10. Invest in the establishment of a government-led National Centre for Health Care Innovation and Improvement.

Journal articles

Patient-Centered Insights: Using Health Care Complaints to Reveal Hot Spots and Blind Spots in Quality and Safety
Gillespie A, Reader TW
The Milbank Quarterly. 2018;96(3):530-67.

DOI	https://doi.org/10.1111/1468-0009.12338
Notes	Paper describing the use of the **Healthcare Complaints Analysis Tool (HCAT)** (that the same authors had developed – see https://doi.org10.1136/bmjqs-2015-004596) to assess a sample of 1100 'real world' complaints' taken from the English National Health Service. Complaints information can reveal "valuable and uniquely patient-centered insights on quality and safety", particularly around continuity and co-ordination of care. The paper describes how the HCAT was used to identify hot spots (where harm and near misses occur) and blind spots (before admissions, after discharge, systemic and low level problems, and errors of omission). The authors suggest "a 2-step mixed-methods approach to move from individual complaints to actionable insights for organizational learning." In this approach, the first step is "quantitative monitoring of complaint frequency, hot spots (harm and near misses), and blind spots (entry-exit, systemic, and omissions)." Then, comparisons with benchmark data (historical or comparable institutions) identify trends that trigger the second step of analysis which "entails triangulation with other data sources (eg, incident reports, surveys, soft data), both to ensure representativeness and to identify discordant and potentially revealing discrepancies."

An integrative review exploring the perceptions of patients and healthcare professionals towards patient involvement in promoting hand hygiene compliance in the hospital setting
Alzyood M, Jackson D, Brooke J, Aveyard H
Journal of Clinical Nursing. 2018;27(7-8):1329-45.

DOI	http://doi.org/10.1111/jocn.14305
Notes	Involving patients and consumers in many aspects of health care, particularly safety and quality, has been a strong theme in the last decade or so. This review looked at involving patients in hand hygiene programs and found a fair amount of variation in how patients could be involved and whether they would want to be. The review focused on 19 papers and found that while patients were willing to remind healthcare professionals (especially nurses), healthcare professionals perception towards patients' involvement varied. Placing patients in the position of enforcing or supervising compliance of those treating them poses challenges for many. Indeed, is this something that patients and consumers should be asked or expected to do as it changes the patient-clinician dynamic? As the authors observe "Simple messages promoting patient involvement may lead to complex reactions in both patients and healthcare professionals."

For information about the Commission's work on healthcare associated infection, including the National Hand Hygiene Initiative, see https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

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

Using Co-Design to Develop a Collective Leadership Intervention for Healthcare Teams to Improve Safety Culture
Ward M, De Brún A, Beirne D, Conway C, Cunningham U, English A, et al
International Journal of Environmental Research and Public Health. 2018;15(6):1182.

DOI	https://doi.org/10.3390/ijerph15061182
Notes	This paper paints a more positive picture of how to engage patients (and consumers). It describes how they were participants in the co-design of a collective leadership intervention to improve healthcare team performance and patient safety culture. This example saw healthcare staff, patient representatives and advocates (as they are not the same), and health systems researchers work. The authors found that the "co-design method, while challenging at times, had many benefits including grounding the intervention in the real-world experiences of healthcare teams."

What 'just culture' doesn't understand about just punishment
Reis-Dennis S
Journal of Medical Ethics. 2018 [epub].

DOI	http://doi.org/10.1136/medethics-2018-104911
Notes	The importance of culture in health care improvement has been often stated. One element of this has been the assertion of the need for a supportive and just culture, rather than a blaming and shaming culture. This has been said to encourage greater transparency and openness about errors, adverse events, near misses and so on. By allowing people to air these things in a 'safe' setting is thought to allow for better responses. This piece problematizes this by suggesting that it may lead to a diminution of responsibility and accountability. It is not the first to make these claims, but perhaps places a greater emphasis on punishment and moralising than others have.

Patient and consumer safety risks when using conversational assistants for medical information: an observational study of Siri, Alexa, and Google Assistant
Bickmore TW, Trinh H, Olafsson S, O'Leary TK, Asadi R, Rickles NM, et al
Journal of Medical Internet Research. 2018;20(9):e11510.

DOI	http://doi.org/10.2196/11510
Notes	In the past few years there have been various warnings of the dangers of 'Dr Google', with a more recent waning of the these and some acceptance that internet resources could help some patients be more informed of their conditions. This study looked at how the newer technology of 'conversational assistants', specifically Apple's Siri, Amazon's Alexa, and Google Assistant, responded to medical question. The short answer is Don't! The answers these devise provided ranged from negligible value to potentially harmful. Another case of technology that is not (yet) ready for 'primetime' in this particular use.

BMJ Quality & Safety
October 2018 - Volume 27 - 10

URL	https://qualitysafety.bmj.com/content/27/10
Notes	A new issue of *BMJ Quality and Safety* 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 of *BMJ Quality and Safety* include: • Editorial: Beyond barriers and facilitators: the central role of practical knowledge and informal networks in implementing **infection prevention interventions** (Julia E Szymczak) • Editorial: Understanding **ethical climate, moral distress, and burnout**: a novel tool and a conceptual framework (Elizabeth Dzeng, J Randall Curtis) • Implementing **infection prevention practices** across European hospitals: an

	in-depth qualitative assessment (Lauren Clack, Walter Zingg, Sanjay Saint, Alejandra Casillas, Sylvie Touveneau, F da Liberdade Jantarada, U Willi, T van der Kooi, L J Damschroder, J H Forman, M Harrod, S Krein, D Pittet, H Sax) • **Ethical decision-making** climate in the **ICU**: theoretical framework and validation of a self-assessment tool (Bo Van den Bulcke, Ruth Piers, Hanne Irene Jensen, Johan Malmgren, Victoria Metaxa, Anna K Reyners, Michael Darmon, Katerina Rusinova, Daniel Talmor, Anne-Pascale Meert, Laura Cancelliere, Làszló Zubek, Paolo Maia, Andrej Michalsen, Johan Decruyenaere, Erwin J O Kompanje, Elie Azoulay, Reitske Meganck, Ariëlla Van de Sompel, Stijn Vansteelandt, Peter Vlerick, Stijn Vanheule, D D Benoit) • **Paediatric hospital admission processes** and outcomes: a qualitative study of parents' experiences and priorities (JoAnna K Leyenaar, Paul A Rizzo, Emily R O'Brien, Peter K Lindenauer) • Pilot randomised controlled trial to improve **hand hygiene** through mindful moments (Heather Gilmartin, Sanjay Saint, Mary Rogers, Suzanne Winter, Ashley Snyder, Martha Quinn, Vineet Chopra) • The **ConCom Safety Management Scale**: developing and testing a measurement instrument for control-based and commitment-based safety management approaches in hospitals (Carien W Alingh, Mathilde M H Strating, Jeroen D H van Wijngaarden, Jaap Paauwe, Robbert Huijsman) • **Measurement and monitoring of safety**: impact and challenges of putting a conceptual framework into practice (Eleanor Chatburn, Carl Macrae, Jane Carthey, Charles Vincent) • Speak up-related climate and its association with **healthcare workers' speaking up and withholding voice behaviours**: a cross-sectional survey in Switzerland (David Schwappach, Aline Richard) • Perceptions of **rounding checklists** in the **intensive care unit**: a qualitative study (Bethany Danae Hallam, Courtney C Kuza, Kimberly Rak, Jessica C Fleck, Melanie M Heuston, Debjit Saha, Jeremy M Kahn) • **Hospital-level care coordination** strategies associated with better **patient experience** (Jose F Figueroa, Yevgeniy Feyman, Xiner Zhou, K J Maddox) • Implementing **electronic patient-reported outcomes measurements**: challenges and success factors (Lisa Nordan, Lorrie Blanchfield, Shehzad Niazi, J Sattar, C E Coakes, R Uitti, M Vizzini, J M Naessens, A Spaulding) • Role of **patient and public involvement in implementation research**: a consensus study (Kara A Gray-Burrows, Thomas A Willis, Robbie Foy, Martin Rathfelder, Pauline Bland, Allison Chin, Susan Hodgson, Gus Ibegbuna, Graham Prestwich, Kirsty Samuel, L Wood, F Yaqoob, R R C McEachan)

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: **Composite measures of healthcare quality**: sensible in theory, problematic in practice (Rocco Friebel, Adam Steventon) • Implementing **bedside rounds to improve patient-centred outcomes**: a systematic review (John T Ratelle, Adam P Sawatsky, Deanne T Kashiwagi, Will M Schouten, Patricia J Erwin, Jed D Gonzalo, T J Beckman, C P West) • **Patient safety and the ageing physician**: a qualitative study of key stakeholder attitudes and experiences (Andrew A White, William M Sage, Paulina H Osinska, Monica J Salgaonkar, Thomas H Gallagher)

Pennsylvania Patient Safety Advisory
September 2018, Vol. 15, No. 3

URL	http://patientsafety.pa.gov/ADVISORIES/Pages/201809_home.aspx
Notes	The Pennsylvania Patient Safety Authority has published their latest *Pennsylvania Patient Safety Advisory*. Topics in this issue include: • Adapting Verification Processes for Preventing **Wrong Radiology Events** – developing and implementing verification processes specific to the medical-imaging care continuum is essential to reduce the risk of harm from wrong radiology events • The Breakup: Errors when **Altering Oral Solid Dosage Forms** – these errors may disproportionately impact vulnerable patient populations with dysphagia in acute care, rehabilitation, and long-term care facilities • **Speaking Up for Safety**—It's Not Simple • A Second Breadth: **Hospital-Acquired Pneumonia** in Pennsylvania, Nonventilated versus Ventilated Patients – Non-ventilator hospital-acquired pneumonia continues to be as lethal as ventilator-associated pneumonia, but that it demonstrates higher incidence and is more costly as a whole • Safety Stories: **A Weighty Problem** –brief highlight of a patient weight event reported through the Pennsylvania Patient Safety Reporting System • Safety Stories: **Site Marks** –brief highlight of surgical site marking events reported through the Pennsylvania Patient Safety Reporting System • Principles for Reliable Performance of **Correct-Site Nerve Blocks** –An initiative that assesses the frequency of wrong-site nerve blocks and presents anaesthesia providers and healthcare facilities with practices to prevent them • A New Pairing: **Root Cause and Success Analysis** – Root cause analysis is commonly used in attempts to improve the safety of healthcare delivery, but a variation—success analysis—may also be useful.

Online resources

[USA] Community-Acquired Pneumonia Clinical Decision Support Implementation Toolkit
https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/ambulatory-care/cap-toolkit.html
The (US) Agency for Healthcare Research and Quality (AHRQ) has produced this Community-Acquired Pneumonia (CAP) Patient Safety Clinical Decision Support Implementation Toolkit aimed at helping clinicians in emergency departments, primary care and other ambulatory settings use clinical decision support (CDS) to identify and manage patients with community-acquired pneumonia.
The toolkit consists of:

- Community-Acquired Pneumonia Clinical Decision Support Implementation Toolkit Handbook on how to use the toolkit
- Prototype of the CDS alert for electronic health records (vendor-agnostic) for the ED and a short pamphlet on use of the alert in the ED
- Prototype of the CDS alert for electronic health records (vendor-agnostic) for primary care and a short pamphlet on use of the alert in primary care
- Workflow diagrams of how the CAP alert can be integrated into the ED or primary care workflows
- Training slide decks for the ED and primary care setting on how and when to use the CAP alert in the electronic health record and how to incorporate it into the workflow for both the Emergency Department Setting and the Primary Care Setting.

[Scotland] Scottish Atlas of Variation
http://www.isdscotland.org/products-and-services/scottish-atlas-of-variation/
NHS Scotland has developed this online interactive atlas of (healthcare) variation. This version is a Beta release and will be updated following consultation. As well as providing maps and visualisations it also contains an Introduction (covering why healthcare variation matters and what the Atlas shows), FAQs and Supporting Documentation.
This structure is rather similar to the *Australian Atlas of Healthcare Variation* series (each edition of which is produced as both a hardcopy document and an interactive atlas). For information about and to access the *Australian Atlas of Healthcare Variation* series, see https://www.safetyandquality.gov.au/atlas/

[USA] Health Care Quality-Spending Interactive
https://www.commonwealthfund.org/health-care-quality-spending-interactive
The Commonwealth Fund has also produced a data visualisation tool. This site allows users to see how health care spending relates to quality of care in all US states, as well as in the USA's more than 300 local health care markets. The Quality-Spending Interactive includes data for working-age adults with employer-sponsored health insurance, as well as Medicare patients.
The tool allows users to integrate their findings into their work, by:

- Choosing quality measures and filtering the results by state or local health care market, and then seeing how a state fares compared to others
- Taking a screenshot of a customized graph to use
- Offering resources to help users consider action based on what has been learnt from the too.

[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 QS25 ***Asthma*** https://www.nice.org.uk/guidance/qs25
- Quality Standard QS175 ***Eating disorders*** https://www.nice.org.uk/guidance/qs175
