



On the Radar

Issue 394

5 November 2018

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On the Radar

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Communicating for Safety resource portal

<https://www.c4sportal.safetyandquality.gov.au>

Communication is integral to all aspects of patient care, and is a core clinical skill that can be developed and improved with practice, experience, continuous learning, mentorship and support. Effective communication has a significant positive influence on patient experience and satisfaction; and poor communication is known to contribute to teamwork failures, errors, misdiagnosis and inappropriate treatment. Clinical communication is therefore an important safety and quality issue.

To support clinical communication improvement, the Australian Commission on Safety and Quality in Health Care has released a new Communicating for Safety resource portal

<https://www.c4sportal.safetyandquality.gov.au>

The online portal provides clinicians and health service managers with an easily navigable repository of tools and guides to support improvement in clinical communications, and implementation of the National Safety and Quality Health Service (NSQHS) Standards (second edition).



Communicating for Safety
resource portal

Journal articles

The price of fear: estimating the financial cost of bullying and harassment to the NHS in England

Kline R, Lewis D

Public Money & Management. 2018 [epub]

Gosport must be a tipping point for professional hierarchies in healthcare—an essay by Philip Darbyshire and David Thompson

Darbyshire P, Thompson D

BMJ. 2018;363:k4270.

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| DOI | Kline and Lewis https://doi.org/10.1080/09540962.2018.1535044 Darbyshire and Thompson https://doi.org/10.1136/bmj.k4270 |
| Notes | <p>Culture is a recurring issue when it comes to lapses in quality in safety. This last week or so has seen a number of items in which the unifying feature is that of the deleterious, if not dangerous, impacts of poor culture. These have included the reports of a Sydney hospital's Intensive Care Unit (ICU) losing its training accreditation due to unacceptable behaviours (https://www.smh.com.au/national/nsw/westmead-hospital-icu-stripped-of-training-accreditation-over-alleged-bullying-20181026-p50c8j.html), another Sydney hospital's cardiothoracic surgery department also losing training accreditation, further reports of poor behaviours in other facilities, a paper on the costs of bullying (and the real costs are not just financial, however broadly those are measured) (Kline and Lewis) and an essay in response to the opioid misuse at an English hospital that is thought to have contributed to some 600 deaths (Darbyshire and Thompson).</p> <p>Kline and Lewis sought to estimate some of the financial costs of bullying and harassment to the NHS in England. Looking at sickness absence costs to the employer, employee turnover, diminished productivity, sickness presenteeism (productivity lost when staff continue to come to work while being bullied and are more prone to making mistakes), compensation, litigation and industrial relations costs, they 'conservatively estimate bullying and harassment to cost the taxpayer £2.281 billion per annum.'</p> <p>Interprofessional communication and relations were among the cultural issues present at Gosport War Memorial Hospital in the 1990s. The clinical editor of the <i>BMJ</i> observed in a piece titled 'End the culture of fear in healthcare' (https://doi.org/10.1136/bmj.k4467) that: 'A key finding of the independent report into deaths at Gosport War Memorial Hospital, where around 600 people received fatal and medically unjustified doses of opioids, was a hospital culture of uncritical deference to doctors and a fear of raising concerns. ... Philip Darbyshire and David Thompson issue an urgent call for the report to serve as a tipping point in ending professional hierarchies in clinical practice. ... Subservience and deference, endemic in health systems, are harming patients, they say, with professionals fearing retribution, disapproval, career limiting consequences, and worse if they dare to question or challenge colleagues.</p> <p>How do we begin to dismantle the deeply embedded hierarchies of status and profession? Darbyshire and Thompson find answers in the existing evidence base for strong leadership to create safe, open, questioning healthcare organisations, where patients and families are included in decisions, and bad behaviour is not tolerated, no matter the rank. "We do not need more research," they argue, "we need more leaders with the courage and creativity to implement what we already know."</p> <p>In a social media exchange I pondered whether the cultural issues at the particular Sydney hospital would be limited to the ICU. An extremely experienced clinician and health administrator responded that in his view it was widespread and asserted that</p> |

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| | ‘Every part of healthcare "system" has an obligation to be much better than this. Very hard to explain to our community how this sort of stuff is acceptable’. My response was that this ubiquity ‘is why it is everyone's problem and everyone's responsibility. Culture is often seen as too hard to fix. It takes top down, bottom up and sideways action, i.e. everyone has a role to speak up, act out and be humane and respectful.’ |
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Emergency department checklist: an innovation to improve safety in emergency care

Redfern E, Hoskins R, Gray J, Lugg J, Hastie A, Clark C, et al

BMJ Open Quality. 2018;7(3):e000325.

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| DOI | http://doi.org/10.1136/bmjoc-2018-000325 |
| Notes | <p>Checklists and toolkits have been rather popular. The WHO Surgical Safety Checklist is in widespread use and checklists have been developed for a range of settings. This piece describes the experience of developing, implementing and evaluating a checklist in an inner-city hospital emergency department (ED) in England. The authors report “The implementation of our ED safety checklist was associated with improvements in key ED clinical performance indicators. There was improved management of time-critical conditions which included a mean increase of over 5% in CT scanning within an hour for patients with a suspected stroke. Additionally, there was a mean increase of 25% in hourly observations and Early Warning Score calculation with no clinical incidents relating to failure or delay in recognising a deteriorating patient.”</p> <p>Furthermore, they assert, “a simple checklist aimed at identifying the deteriorating patient in a busy ED can be successfully implemented and used effectively by staff unfamiliar with the intense and demanding work of the ED. The use of this checklist is supported and endorsed nationally by National Health Service (NHS) Improvement, NHS England, the Royal College of Emergency Medicine, the Royal College of Nursing and the Care Quality Commission.”</p> <p>A toolkit to support implementation of the checklist is available at https://www.weahsn.net/what-we-do/enhancing-patient-safety/the-deteriorating-patient/emergency-department-ed-safety-checklist/</p> |

Ten tips for advancing a culture of improvement in primary care

Kiran T, Ramji N, Derocher MB, Rajesh G, Davie S, Lam-Antoniades M

BMJ Quality & Safety. 2018 [epub].

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| DOI | https://doi.org/10.1136/bmjqs-2018-008451 |
| Notes | <p>Piece reflecting on the quality improvement ‘journey’ and experiences of a Canadian primary care practice. The authors note that while they can distil their seven years of practice transformation into ten tips, “Success has required deep engagement with both patients and clinicians, a long-term vision, and requisite patience.”</p> <p>Notwithstanding this, their ten tips (that are expanded upon in the piece) are:</p> <ol style="list-style-type: none"> 1. Commit the time and resources 2. Appeal to intrinsic motivation 3. Measure and improve patient experience 4. Try and pick an early win 5. Learn and adjust course when things don’t go as planned 6. Try, try and try again 7. Involve patients in the improvement work 8. Welcome criticism and accept imperfection 9. Think in terms of ongoing improvement, not time-limited projects 10. Integrate quality improvement with management and operations. |

For information about the Commission’s work on primary health care, see <https://www.safetyandquality.gov.au/our-work/primary-health-care/>

Estimating the hospital costs of inpatient harms

Anand P, Kranker K, Chen AY

Health Services Research. 2018.

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| DOI | http://doi.org/10.1111/1475-6773.13066 |
| Notes | This study sought to estimate the additional hospital costs associated with inpatient medical harms, including the costs from subsequent readmissions within 90 days. The study used data for 2009–2011 across 12 US states and compared hospital costs incurred by patients experiencing a specific harm during their hospital stay to the costs incurred by similar patients who did not experience that harm. The authors report finding that different forms of harm could lead to highly variable additional costs, with “the costliest inpatient harms, such as surgical site infections and severe pressure ulcers, are associated with approximately \$[USD]30 000 in additional index stay costs per harm.” |

For information about the Commission’s work on hospital acquired complications, see <https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications/>

Association between patient outcomes and accreditation in US hospitals: observational study

Lam MB, Figueroa JF, Feyman Y, Reimold KE, Orav EJ, Jha AK

BMJ. 2018;363:k4011.

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| DOI | http://doi.org/10.1136/bmj.k4011 |
| Notes | The role of accreditation in quality and safety has been debated for some time. This study sought to examine whether patients admitted to accredited US hospitals had better outcomes than those admitted to hospitals reviewed through state surveys, and whether accreditation by The Joint Commission conferred any additional benefits. This observational study covered more than 4 million patients aged 65 years and older admitted for 15 common medical and six common surgical conditions during 2014–2017 to 4400 American hospitals (3337 accredited (2847 by The Joint Commission) and 1063 underwent state based review). The study used risk adjusted mortality and readmission rates at 30 days and patient experience scores as their main outcome measures. The findings were that “US hospital accreditation by independent organizations is not associated with lower mortality , and is only slightly associated with reduced readmission rates for the 15 common medical conditions selected in this study. There was no evidence in this study to indicate that patients choosing a hospital accredited by The Joint Commission confer any healthcare benefits over choosing a hospital accredited by another independent accrediting organization.” |

For information about the Commission’s work on national standards and accreditation, see <https://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/>

Revised Australian national guidelines for colorectal cancer screening: family history

Jenkins MA, Ouakrim DA, Boussioutas A, Hopper JL, Ee HC, Emery JD, et al

Medical Journal of Australia. 2018 [epub].

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| DOI | https://doi.org/10.5694/mja18.00142 |
| Notes | The Australian national guidelines for colorectal cancer screening have been revised and this item describes the rationale, evidence and recommendations for colorectal cancer screening by family history for people without a genetic syndrome that are reflected in the revised guidelines. The main recommendations are that, based on 10- |

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| | <p>year risks of colorectal cancer</p> <ol style="list-style-type: none"> 1. People at near average risk due to no or weak family history (category 1) are recommended screening by immunochemical faecal occult blood test (iFOBT) every 2 years from age 50 to 74 years. 2. Individuals with moderate risk due to their family history (category 2) are recommended biennial iFOBT from age 40 to 49 years, then colonoscopy every 5 years from age 50 to 74 years. 3. People with a high risk due to their family history (category 3) are recommended biennial iFOBT from age 35 to 44 years, then colonoscopy every 5 years from age 45 to 74 years. |
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Australian Journal of Primary Health

Virtual Issue: Aboriginal and Torres Strait Islander Health

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| URL | http://www.publish.csiro.au/py/virtualissue/2422 |
| Notes | <p>The <i>Australian Journal of Primary Health</i> has released a 'Virtual Issue' that focuses on Aboriginal and Torres Strait Islander Health. The virtual issue is a compilation of papers involving Aboriginal and Torres Strait Islander health which have been published in <i>Australian Journal of Primary Health</i>. Papers in this virtual issue include:</p> <ul style="list-style-type: none"> • Aboriginal and Torres Strait Islander health (Geoffrey Spurling, Catrina Felton-Busch and Sarah Larkins) • Evaluating Aboriginal and Torres Strait Islander health promotion activities using audit and feedback (Lynette O'Donoghue, Nikki Percival, Alison Laycock, Janya McCalman, Komla Tsey, Christine Armit and R Bailie) • 'I'm not sure it paints an honest picture of where my health's at' – identifying community health and research priorities based on health assessments within an Aboriginal and Torres Strait Islander community: a qualitative study (Geoffrey K Spurling, Chelsea J Bond, P J Schluter, C I Kirk and D A Askew) • Community participation in health service reform: the development of an innovative remote Aboriginal primary health-care service (Carole Reeve, John Humphreys, John Wakerman, Vicki Carroll, Maureen Carter, Tim O'Brien, Carol Erlank, Rafik Mansour and Bec Smith) • Reducing recurrence of bacterial skin infections in Aboriginal children in rural communities: new ways of thinking, new ways of working (Susan Thomas, Kristy Crooks, Kylie Taylor, P D Massey, R Williams and G Pearce) • Sharing the tracks to good tucker: identifying the benefits and challenges of implementing community food programs for Aboriginal communities in Victoria (Margaret Murray, Emily Bonnell, Sharon Thorpe, Jennifer Browne, Liza Barbour, Catherine MacDonald and Claire Palermo) • The community network: an Aboriginal community football club bringing people together (Alister Thorpe, Wendy Anders and Kevin Rowley) • Research Implementing the Flinders Model of Self-management Support with Aboriginal People who have Diabetes: Findings from a Pilot Study (Malcolm W Battersby, Jackie Ah Kit, Colleen Prideaux, Peter W Harvey, James P Collins and Peter D Mills) • Indigenous men's support groups and social and emotional wellbeing: a meta-synthesis of the evidence (Janya McCalman, Komla Tsey, Mark Wenitong, Andrew Wilson, Alexandra McEwan, Y C James and M Whiteside) • Using participatory action research to prevent suicide in Aboriginal and Torres Strait Islander communities (Adele Cox, Pat Dudgeon, Christopher Holland, Kerrie Kelly, Clair Scrine and Roz Walker) |

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| | <ul style="list-style-type: none"> • ‘Yarn with me’: applying clinical yarning to improve clinician–patient communication in Aboriginal health care (Ivan Lin, Charmaine Green and Dawn Bessarab) • Understanding patient access patterns for primary health-care services for Aboriginal and Islander people in Queensland: a geospatial mapping approach (K S Panaretto, A Dellit, A Hollins, G Wason, C Sidhom, K Chilcott, D Malthouse, S Andrews, J Mein, B Ahkee and R McDermott) • The power of talk and power in talk: a systematic review of Indigenous narratives of culturally safe healthcare communication (Warren Jennings, Chelsea Bond and Peter S Hill) • Health and wellbeing outcomes of programs for Indigenous Australians that include strategies to enable the expression of cultural identities: a systematic review (Sarah MacLean, Rebecca Ritte, AThorpe, S Ewen and K Arabena) |
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BMJ Quality and Safety online first articles

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| URL | https://qualitysafety.bmj.com/content/early/recent |
| Notes | <p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Editorial: Virtual postoperative clinic: can we push virtual postoperative care further upstream? (Daniel Cornejo-Palma, David R Urbach) • Explaining organisational responses to a board-level quality improvement intervention: findings from an evaluation in six providers in the English National Health Service (Lorelei Jones, Linda Pomeroy, Glenn Robert, Susan Burnett, Janet E Anderson, Stephen Morris, Estela C Barbosa, N J Fulop) • External validation of the Hospital Frailty Risk Score and comparison with the Hospital-patient One-year Mortality Risk Score to predict outcomes in elderly hospitalised patients: a retrospective cohort study (Finlay McAlister, Carl van Walraven) • Systems consultation for opioid prescribing in primary care: a qualitative study of adaptation (Nora Jacobson, Roberta Johnson, Bri Deyo, Esra Alagoz, Andrew Quanbeck) • Ten tips for advancing a culture of improvement in primary care (Tara Kiran, Noor Ramji, M B Derocher, G Rajesh, S Davie, M Lam-Antoniades) • Effect of data validation audit on hospital mortality ranking and pay for performance (Skerdi Haviari, François Chollet, Stéphanie Polazzi, Cecile Payet, Adrien Beauveil, Cyrille Colin, Antoine Duclos) |

International Journal for Quality in Health Care online first articles

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| URL | https://academic.oup.com/intqhc/advance-access |
| Notes | <p><i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Association of patient-reported experiences with health resource utilization and cost among US adult population, medical expenditure panel survey (MEPS), 2010–13 (Khurram Nasir; Victor Okunrintemi) • Measures of hospital competition and their impact on early mortality for congestive heart failure, acute myocardial infarction and cardiac surgery (Pietro Guida; Massimo Iacoviello; Andrea Passantino; Domenico Scrutinio) |

Online resources

Future Leaders Communiqué

<http://vifmcommuniques.org/future-leaders-communiqué-volume-3-issue-4-october-2018/>

Victorian Institute of Forensic Medicine

Volume 3 Issue 4 October 2018

This issue of the *Future Leaders Communiqué* focuses on how difficulties in **recognising and communicating abnormal results** from laboratory and imaging investigations can lead to significant patient harm. The case study examines the experiences a 65-year-old man who was admitted to a regional hospital after a quad bike crash who subsequently died of **sepsis**. One of the aspects of this is that it can be challenging to know how to interpret an abnormal result and to determine what action is required. The importance of **seeking help** from colleagues and working in, and contributing to, an environment that fosters a **supportive culture** is discussed. The expert commentaries look at sepsis and the importance of communication in medical teams.

[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 NG109 **Urinary tract infection (lower): antimicrobial prescribing**
<https://www.nice.org.uk/guidance/ng109>
- NICE Guideline NG110 **Prostatitis (acute): antimicrobial prescribing**
<https://www.nice.org.uk/guidance/ng110>
- NICE Guideline NG111 **Pyelonephritis (acute): antimicrobial prescribing**
<https://www.nice.org.uk/guidance/ng111>

[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:

- Self-monitoring of blood glucose provides little benefit for most people with **type 2 diabetes**
- Albumin administrations can prolong survival for some people with **liver disease**
- Closing five **emergency departments** not linked with increased hospital admissions, though ambulance call-outs increased
- A football programme for **overweight men** achieves sustained weight loss
- The blood-thinner **apixaban** is less likely to cause major bleeding than **warfarin**
- MRI scan does not help to find the cause of **pelvic pain in women**
- Negative pressure dressings are no better than standard dressings for **open fractures**
- Financial incentives may help workers **quit smoking**
- No benefit from monitoring **antiepileptic drug levels in pregnancy**
- **Non-urgent attendances to emergency departments** are more common among younger adults.

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