On the Radar

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On the Radar
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Reports

Improving the quality of health services: tools and resources. Turning recommendations into practice
World Health Organization
Geneva: World Health Organization; 2018.

URL	https://apps.who.int/iris/handle/10665/310944
Notes	The World Health Organization (WHO) has released this document that compiles together a range of WHO resources with the aim of supporting the implementation of quality improvement approaches to make health services more effective, safe and people-centred. The compilation lists the main quality improvement tools and resources currently used within WHO's Department of Service Delivery and Safety. However, as is noted, this compendium is not an exhaustive list of quality improvement interventions.

Journal articles

The Overlap Between Falls and Delirium in Hospitalized Older Adults: A Systematic Review
Sillner AY, Holle CL, Rudolph JL
Clinics in Geriatric Medicine. 2019 [epub].

DOI	https://doi.org/10.1016/j.cger.2019.01.004
Notes	Falls and delirium are rather common – and can have serious consequences. This study reports on a systematic review on association between falls and delirium in older adults (aged 65 years or older) The results of the review 'suggest that **falls and delirium are inextricably linked'**. The authors suggest that this indicated 'a need to further refine fall risk assessment tools and protocols to specifically include delirium for consideration as a risk factor'.

For information on the Commission's work on cognitive impairment, including dementia and delirium, see https://www.safetyandquality.gov.au/our-work/cognitive-impairment/

For information on the Commission's work on falls prevention, see https://www.safetyandquality.gov.au/our-work/falls-prevention/

An environmental cleaning bundle and health-care-associated infections in hospitals (REACH): a multicentre, randomised trial
Mitchell BG, Hall L, White N, Barnett AG, Halton K, Paterson DL, et al
The Lancet Infectious Diseases. 2019 [epub].

DOI	https://doi.org/10.1016/S1473-3099(18)30714-X
Notes	The reduction of healthcare associated infections has seen an array of different strategies, including the promotion of hand hygiene and the provision of alcohol-based hand gels. This paper reports on another form of intervention – that of ensuring that the hospital environment itself is clean. The study sought to evaluate the effectiveness of an environmental cleaning bundle (the REACH bundle) to reduce health care-associated infections in hospitals. The study was undertaken in 11 acute care hospitals in Australia that each had an intensive care unit, were classified by the as a major hospital (public hospitals) or having more than 200 inpatient beds (private hospitals), and had a health-care-associated infection surveillance programme. The REACH cleaning bundle was a multimodal intervention that focused on optimising product use, technique, staff training, auditing with feedback, and communication, for routine cleaning. The primary outcomes were incidences of health-care-associated *Staphylococcus aureus* bacteraemia, *Clostridium difficile* infection, and vancomycin-resistant enterococci infection. While after the intervention, **vancomycin-resistant enterococci infections reduced** from 0·35 to 0·22 per 10 000 occupied bed-days, the **incidences of *S aureus* bacteraemia and *C difficile* infections did not change significantly**. The authors assert that 'The REACH cleaning bundle was successful at improving cleaning thoroughness and showed great promise in reducing vancomycin-resistant enterococci infections. Our work will inform hospital cleaning policy and practice, highlighting the value of investment in both routine and discharge cleaning practice.'

For information on the Commission's work on healthcare associated infection prevention, see https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Criminalisation of unintentional error in healthcare in the UK: a perspective from New Zealand
Ameratunga R, Klonin H, Vaughan J, Merry A, Cusack J
BMJ. 2019;364:l706.

DOI	https://doi.org/10.1136/bmj.l706
Notes	Piece reflecting on the case of the paediatric trainee doctor Hadiza Gawa-Garba in the UK. The authors discuss the case, open disclosure, the more general issues of unintentional error and how New Zealand law, as an example, would have seen the case handled differently. The authors make the distinction between an error "when one tries to do the right thing but actually does the wrong thing" and a violation "when one deliberately does the wrong thing—but without malevolent intent". The article's key messages include: • Healthcare systems should provide an adequate and effective response to patients who have been unintentionally harmed while receiving care • To improve patient safety we need a greater focus on learning and resolution rather than retribution and blame, recognising the importance of protecting confidential personal reflective practice while encouraging open disclosure and system transparency • We urgently need to improve the clinical working environment and resourcing for safe functioning of hospitals. The authors also provide their view of the **desirable elements of a response to inadvertently caused harm in healthcare**: • Patients or their families should receive open disclosure and an apology. Where possible, the healthcare related injury should be treated rapidly and without charge • When relevant, there should be compensation for the consequences of the injury • Appropriate mechanisms should be in place to hold to account those responsible for the delivery of care, including healthcare professionals, management, and those responsible for the governance of hospitals • Punishment may be appropriate, but should be proportionate to the moral culpability of the behaviour in question rather than to the outcomes of complex clinical problems. Furthermore, punishment should itself serve to advance rather than inhibit the cause of improving patient safety • Responses to problems (including patient harm) should be timely—complex adaptive systems need repeated and rapid adjustment to function effectively and patient safety is not well served by responses that take years to be determined and implemented • Motivated staff who try hard to care for sick people, often under difficult circumstances, should be afforded the safety net of a "just culture" rather than either a "no blame" or an undue focus on finding the individual who is to blame.

For information on the Commission's work on open disclosure, including the *Australian Open Disclosure Framework*, https://www.safetyandquality.gov.au/our-work/open-disclosure/

Lifetime risk of prostate cancer overdiagnosis in Australia: quantifying the risk of overdiagnosis associated with prostate cancer screening in Australia using a novel lifetime risk approach
Pathirana T, Hayen A, Doust J, Glasziou P, Bell K
BMJ Open. 2019;9(3):e022457.

DOI	http://dx.doi.org/10.1136/bmjopen-2018-022457
Notes	Issues around diagnosis, including diagnostic error, under- and over-diagnosis, etc., have garnered a deal of attention in recent years. This paper is among the latest addition to the literature on over diagnosis. That literature already includes material on possible overdiagnosis of a number of cancers, including prostate, thyroid and breast cancer with the suggestion that screening can lead to a proportion of people being diagnosed when such diagnoses are not clinically significant and can (needlessly) expose people to be harm, cost and distress. Among the difficulties with this issue has been that of quantification, being able to determine the level of overdiagnosis. This is not dissimilar to the measurement issues when discussing variation and appropriateness. What are the "right" rates for a given intervention? This study sought to quantify the risk of overdiagnosis associated with prostate cancer screening in Australia. The authors argue that for Australian men, 'The lifetime risk of being diagnosed with prostate cancer increased from 6.1% in 1982 (1 in 17) to 19.6% in 2012 (1 in 5). Using 2012 competing mortality rates, the lifetime risk in 1982 was 11.5% (95% CI 11.0% to 12.0%). The excess lifetime risk of prostate cancer in 2012 (adjusted for changing competing mortality) was 8.2% (95% CI 7.6% to 8.7%) (1 in 13). This corresponds to **41% of prostate cancers being overdiagnosed**.'

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

Essential activities for electronic health record safety: A qualitative study
Ash JS, Singh H, Wright A, Chase D, Sittig DF
Health Informatics Journal. 2019 [epub].

DOI	https://doi.org/10.1177/1460458219833109
Notes	That changes, such as the introduction of technology, can help address existing issues but can cause new ones is well understood. The introduction on electronic health records (EHR) has had such impacts and there is a literature documenting this. This paper reports on a study that saw a multidisciplinary team apply a multi-method qualitative approach (termed a Rapid Assessment Process) in five healthcare sites in the USA to examine best practices around the implementation and usage of electronic health records. The study identified 3 clusters of activities/tasks that they argue are essential to ensure for electronic health records to be used safely. The authors assert that not only do these activities and tasks need to be identified, but 'the **responsibility** for accomplishing these essential activities must be shared by **explicitly identified individuals and teams**.' **Decision-making activities**, included overseeing HER safety, planning for HER safety, and reviewing EHR safety **Organisational learning activities**, involved monitoring EHR safety, testing, analysing, and reporting **User-related activities**, included training, communication, and building and managing safe clinical decision support.

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

Medical device-related pressure ulcers: A systematic review and meta-analysis
Jackson D, Sarki AM, Betteridge R, Brooke J
International Journal of Nursing Studies. 2019;92:109-20.

DOI	https://doi.org/10.1016/j.ijnurstu.2019.02.006
Notes	This study reviewed the literature that reported pressure injuries due to or related to medical devices so as to identify those commonly associated with pressure injuries. Based on 29 studies comprising data on 126,150 patients the study found that 'estimated pooled incidence and prevalence of medical device-related pressure injuries were 12% (95% CI 8–18) and 10% (95% CI 6–16) respectively'. The commonly identified medical devices associated with the risk of developing medical device-related pressure injuries include **respiratory devices**, **cervical collars**, **tubing devices**, **splints**, and **intravenous catheters**.

Diagnostic error as a result of drug-laboratory test interactions
van Balveren Jasmijn A, Verboeket-van de Venne Wilhelmine PHG, Erdem-Eraslan L, de Graaf Albert J, Loot Annemarieke E, Musson Ruben EA, et al
Diagnosis. 2019;6(1):69-71.

DOI	https://doi.org/10.1515/dx-2018-0098
Notes	Issues with diagnosis, including diagnostic error, have been attracting increased interest. This paper raises an aspect of this that may be largely unappreciated as it affects the results of the diagnostics that are relied upon. The authors note that many drug-laboratory test interactions (DLTIs) are known and that they are potentially important in interpreting laboratory test results and 'Failure to recognize these interactions may lead to misinterpretation of test results, a delayed or erroneous diagnosis or unnecessary extra tests or therapy, which may harm patients'. The authors suggest that a DLTI decision support application could help in reducing such errors.

Helping the vision impaired
Paola S
Australian Journal of Pharmacy. 2018 (07/12/2018).

DOI	https://ajp.com.au/news/helping-the-vision-impaired/
Notes	News item on the Our Pills Talk Medication Safety App (https://ourpillstalk.com.au/) and its potential to aid people who are blind or have limited vision in managing their medication use safely. The smartphone app can read medication labels out loud (and in a number of languages), The app needs the pharmacist to create and apply a personalised QR barcode to the medication.

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: • Reinvigorating stagnant science: implementation laboratories and a meta-laboratory to efficiently advance the **science of audit and feedback** (JM Grimshaw, Noah Ivers, Stefanie Linklater, Robbie Foy, Jill J Francis, Wouter T Gude, Sylvia J Hysong The Audit and Feedback MetaLab) • **Electronic health record-based clinical decision support alert** for **severe sepsis:** a randomised evaluation (Norman Lance Downing, Joshua Rolnick, Sarah F Poole, Evan Hall, Alexander J Wessels, Paul Heidenreich, Lisa Shieh) • Relationship between **nursing home quality indicators** and **potentially preventable hospitalisation** (Dongjuan Xu, Robert Kane, Greg Arling)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-articles
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Perceived quality of **palliative care in intensive care units** among doctors and nurses in Taiwan (Ying-Xuan Ke; Sophia H Hu; Naomi Takemura; Chia-Chin Lin)

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:
- Clinical Guideline CG103 **Delirium**: *prevention, diagnosis and management*
  https://www.nice.org.uk/guidance/cg103

[USA] Question Builder App
https://www.ahrq.gov/patient-safety/question-builder.html
The US Agency for Healthcare Research and Quality (AHRQ) has developed this app to help patients be more engaged in their own healthcare and to help make clinical appointments more efficient. The app helps patients prepare and organize questions and other helpful information ahead of time and puts that information at their fingertips. The Question Builder app is available at no charge on iTunes and Google Play.

[USA] 5 Ways to Advance Transparency in Health Care
http://www.ihi.org/communities/blogs/5-ways-to-advance-transparency-in-health-care
Blog post by leading writer on transparency and open disclosure Thomas Gallagher. Starting with an incident that occurred when he was a third-year medical student and how it led him to focus his career on transparency after care problems, Gallagher looks to how we might yet improve transparency. He makes five recommendations:
1. Implement a "transparency bundle"
2. Recognize that openness alone is insufficient
3. Prioritize empathy and compassion when sharing information.
4. Invest time, resources, and attention
5. Apply improvement principles to transparency practices.

For information on the Commission's work on open disclosure, including the *Australian Open Disclosure Framework*, https://www.safetyandquality.gov.au/our-work/open-disclosure/

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