AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

Books

The Intersection of Behavioral Health, Mental Health, and Health Literacy: Proceedings of a Workshop
National Academies of Sciences, Engineering, Medicine
Alper J, Wojtowicz A, editors
Washington, DC: The National Academies Press; 2019.

DOI	https://doi.org/10.17226/25278
Notes	This book is the outcome (and summary of) a workshop held in Washington D.C. in July 2018. The workshop was held to explore issues associated with effective communication with individuals with mental or behavioural health issues and to identify ways in which health literacy approaches can facilitate communication. In particular, the workshop aimed to gain a better understanding of how behavioural health and mental health concerns can adversely affect communications between providers and patients and their families. This publication summarises the discussions that took place throughout the workshop, highlighting key lessons, practical strategies, and the needs and opportunities for using the principles of health literacy to improve communication among health care providers, individuals with behavioural health and mental health challenges, and family members.

Reports

An Action Plan for Medical Devices: Improving Australia's medical device regulatory framework
Therapeutic Goods Administration
Canberra: TGA; 2019. p. 11.

URL	https://www.tga.gov.au/publication/action-plan-medical-devices
Notes	The Therapeutic Goods Administration (TGA) has released this Action Plan outlining how the TGA will improve the regulatory environment for medical devices by further attention to patient safety. The Action Plan outlines a 'three part strategy to strengthen Australia's regulatory system whilst continuing to be patient focused and have greater transparency. It outlines actions that continue to improve the safety, performance and quality of medical devices in Australia and improve health outcomes for patients who require medical devices.' The three strategies are: 1. Improve how new devices get on the market (More rigour in assessment processes, More reviews of low and medium risk devices, Higher level scrutiny of clinical evidence and Ensure new and emerging technologies are safe) 2. Strengthen monitoring and follow-up of devices already in use (Scope the introduction of unique device identifiers, Enhance inspections and reviews to confirm ongoing quality and safety, Explore removing reporting barriers including potential of mandatory reporting of adverse events by healthcare facilities, and Greater data analysis, information sharing and joined up systems with hospitals) 3. Provide more information to patients about the devices they use (Publish more information about decisions made and the medical device products regulated by the TGA, Strengthen consumer awareness of how safety and performance of medical devices are assessed, Find and implement ways to help consumers report adverse events more easily and Establish expert groups with consumer representation). The Action Plan also describes reform activities currently underway that the TGA will implement along with ways to improve transparency and to increase public confidence in Australia's medical device regulatory system. The TGA will be seeking feedback on these activities.

Staffing on Wards
Making decisions about healthcare staffing, improving effectiveness and supporting staff to care well.
Themed review
National Institute for Health Research
London: NHS NIHR; 2019. p. 38.

URL / DOI	https://www.dc.nihr.ac.uk/themed-reviews/research-on-ward-staffing.htm https://doi.org/10.3310/themedreview-03553
Notes	The UK's National Institute for Health Research (NIHR) has produced this themed review of the evidence from the NIHR and others on the (somewhat vexed) issue of staffing on hospital wards. The review examines at the evidence around how many staff are needed on wards and how managing them is key to the safety and efficiency of hospitals. The review features more than 20 published studies and examines issues to consider when deciding the shape of the ward team. Among the conclusions were: • Determining the right number of staff and mix of education and skills is not a precise science and requires a risk assessment based on the best available evidence. • The way staff are managed and the work processes contribute to the staff's capacity to provide safe and effective care.

	• Getting the most out of staff requires good leadership to create positive ward environments and to support individual members of staff. Ward leadership shapes how staff are deployed, sets standards for staff to follow, and is key to creating a safe and healthy climate for both staff and patients. Investment in developing the skills of ward leaders to do this and ensuring they have protected time to deliver has been shown to be key in providing high quality care as well as attracting and retaining staff.

Journal articles

Quality improvement in ambulatory surgery centers: a major national effort aimed at reducing infections and other surgical complications
Davis KK, Mahishi V, Singal R, Urman RD, Miller MA, Cooke M, et al
Journal of Clinical Medicine Research. 2018;11(1):7-14.

DOI	http://doi.org/10.14740/jocmr3603w
Notes	The safety and quality risks of a health setting can vary. This study describes the impact of a quality improvement program focussing on ambulatory surgery centres (ASCs). The project recruited 665 ASCs in 47 states of the USA to participate in an intervention to improve safe practice through implementation of a surgical safety checklist and infection control practices. The authors report that (unsurprisingly) barriers to implementation and data collection were encountered. They also noted that the tailoring of interventions in necessary – as has been noted previously, context matters and understanding context is vital to implementing almost any change or intervention.

Evaluation of medication errors at the transition of care from an ICU to non-ICU location
Tully AP, Hammond DA, Li C, Jarrell AS, Kruer RM
Critical Care Medicine. 2019;47(4):543-9.

DOI	http://doi.org/10.1097/CCM.0000000000003633
Notes	Transitions of care are a known locus of risk. These are points where there can be a failure to communicate important information, failure to adequately transfer or hand over care of a patient between individuals, teams, units or services. This study looked at the specific issue of medication errors for patients transferred from intensive care units (ICUs). The study was a 7-day point prevalence study that encompassed 958 patients who were transferred from an ICU to a non-ICU location in a group of hospitals (34 in the USA and 2 in the Netherlands). The authors report that 450 patients (45.7%) had a medication error occur during transition of care. Further, among those patients who experienced a medication error, an average of 1.88 errors per patient occurred. The most common types of errors were continuation of medication with ICU-only indication (28.4%), untreated condition (19.4%), and pharmacotherapy without indication (11.9%). Seventy-five percent of errors reached the patient but did not cause harm. Renal replacement therapy during ICU stay and number of medications ordered following transfer were identified as factors associated with occurrence of error. Orders for anti-infective, hematologic agents, and IV fluids, electrolytes, or diuretics at transition of care were associated with an increased odds of error. Factors associated with decreased odds of error included daily patient care rounds in the ICU and orders discontinued and rewritten at the time of transfer from the ICU.

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

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

The association between complications, incidents, and patient experience: retrospective linkage of routine patient experience surveys and safety data
de Vos MS, Hamming JF, Boosman H, Marang-van de Mheen PJ
Journal of Patient Safety. 2019 [epub].

DOI	http://doi.org/10.1097/PTS.0000000000000581
Notes	Multiple sources of information can contribute to understanding the larger safety and quality picture in a health service or system. This paper reports on a retrospective study that sought to examine the relationship between patient experience data and complaints and data on complications and safety incidents. Using data for 4,236 surgical inpatients from a teaching hospital. The results showed that patient-reported problems were associated with occurrence of complications/incidents among patients with negative experiences, but not among patients with positive experiences. The authors suggest that 'Linking safety data to patient experience data can reveal ways to optimize care.' They also suggest that 'Increased attention should be paid to respecting patient preferences, continuity, and transition, particularly when complications or incidents occur.'

For information on the Commission's work on patient reported outcome measures, see
https://www.safetyandquality.gov.au/our-work/indicators/patient-reported-outcome-measures/

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

Australian Health Review
Volume 43(2) 2019

URL	http://www.publish.csiro.au/ah/issue/9363
Notes	A new issue of *Australian Health Review* has been published. Articles in this issue of *Australian Health Review* include: • Towards **value-based healthcare** – modelling an answer for **cancer care** delivery (Christobel Saunders) • Turning attention to **clinician engagement** in Victoria (Christine Jorm, Robyn Hudson and Euan Wallace) • Bridging existing **governance** gaps: five evidence-based **actions that boards can take** to pursue high quality care (Sandra G Leggat and Cathy Balding) • Associations between **clinical indicators of quality and aged-care residents' needs and consumer and staff satisfaction**: the first Australian study (Yun-Hee Jeon, Anne-Nicole Casey, Kha Vo, Kris Rogers, Belinda Poole and Judith Fethney) • **Revenue of consultant physicians for private out-patient consultations** (Gary L Freed and Amy R Allen) • Relative contribution of **overweight and obesity to rising public hospital in-patient expenditure** in South Australia (Allison Larg, John R Moss and Nicola Spurrier) • Role of **strategic human resource management in crisis management** in Australian greenfield hospital sites: a crisis management theory perspective

	(Madeleine Iris Kendrick, Timothy Bartram, Jillian Cavanagh and J Burgess)
	• A wake-up call for **physical activity promotion** in Australia: results from a survey of Australian nursing and allied health professionals (Nicole Freene, Sophie Cools, Danny Hills, Bernie Bissett, Kate Pumpa and Gabrielle Cooper)
	• Identification of **vulnerability within a child and family health service** (Katarina Kimla, Dania Nathanson, Susan Woolfenden and Karen Zwi)
	• Outcomes following changing from a two-tiered to a three-tiered **hospital rapid response system** (The Concord Medical Emergency Team (MET) 2 Study Investigators)
	• A feasible model for early intervention for **high-risk substance use in the emergency department** setting (Rebecca Howard, Stephanie Fry, Andrew Chan, Brigid Ryan and Yvonne Bonomo)
	• Comparative **emergency department resource utilisation across age groups** (Ellen Burkett, Melinda G Martin-Khan and Leonard C Gray)
	• **Outpatient consultant physician service usage** in Australia by specialty and state and territory (Gary L Freed and Amy R Allen)
	• **HealthPathways improving access to care** (Stephen D Gill, Sarah Mansfield, Margie McLeod, Kathryn von Treuer, Matthew Dunn and F Quirk)
	• Exploring the **experiences of Aboriginal and Torres Strait Islander patients** admitted to a metropolitan health service (Craig Wotherspoon and Cylie M Williams)
	• Repositioning **interprofessional education** from the margins to the centre of Australian health professional education – what is required? (Roger Dunston, Dawn Forman, Jill Thistlethwaite, Carole Steketee, G D Rogers and M Moran)
	• Factors that affect **general practice as a choice of medical speciality:** implications for policy development (Amit Vohra, Richard Ladyshewsky and Stephen Trumble)
	• Perspectives from practice: **complexities of personal care workers** (Julie-Anne Martyn, Sally Zanella and Adele Wilkinson)

Medical Journal of Australia
Volume 210, Issue 6 Supplement

URL	https://www.mja.com.au/journal/2019/210/6/supplement
Notes	The most recent edition of the *Medical Journal of Australia* was accompanied by a Supplement that had been coordinated and sponsored by the Australian Digital Health Agency. The Supplement has the title *Expanding the evidence base in digital health*. Articles in this supplement issue of the *Medical Journal of Australia* include: • **Sharing information safely and securely**: the foundation of a modern health care system (Meredith AB Makeham, Angela Ryan) • **Australia's digital health journey** (Steven J Hambleton, John Aloizos) • Towards routine use of **national electronic health records** in Australian **emergency departments** (Paul Miles, Andrew Hugman, Angela Ryan, Fiona Landgren, Grace Liong) • **Digital health benefits evaluation frameworks**: building the evidence to support Australia's National Digital Health Strategy (Janice S Biggs, Andrea Willcocks, Mitchell Burger, Meredith AB Makeham) • Gathering data for decisions: best practice use of **primary care electronic records for research** (Rachel Canaway, Douglas IR Boyle, Jo-Anne E Manski-Nankervis, Jessica Bell, Jane S Hocking, Ken Clarke, Malcolm Clark, Jane M Gunn, Jon D Emery)

	- Attitudes of health professionals to using routinely collected **clinical data for performance feedback and personalised professional development** (Tim Shaw, Anna Janssen, Roslyn Crampton, Fenton O'Leary, Philip Hoyle, Aaron Jones, Amith Shetty, Naren Gunja, Angus G Ritchie, Heiko Spallek, Annette Solman, Judy Kay, Meredith AB Makeham, Paul Harnett) - Nudging hospitals towards **evidence-based decision support for medication management** (Johanna I Westbrook, Melissa T Baysari) - Consumer-directed technologies to improve **medication management and safety** (Andre Q Andrade, Elizabeth E Roughead) **App utility and adoption in a tertiary children's hospital** (Cheryl McCullagh, Melanie Keep, Anna Janssen, Hiran Selvadurai, Tim Shaw) - Preparing Australia for **genomic medicine: data, computing and digital health** (David P Hansen, Marcel E Dinger, Oliver Hofmann, Natalie Thorne, Tiffany F Boughtwood) **My Health Record implementation in private specialist practice** (Jillian Tomlinson) - Using **My Health Record in a private obstetrics and gynaecology clinic** (Elizabeth Jackson) **Telehealth** a game changer: closing the gap in **remote Aboriginal communities** (Marianne St Clair, David P Murtagh, John Kelly, Jeff Cook) **Artificial intelligence and the clinical world**: a view from the front line (Christopher Pearce, Adam McLeod, Natalie Rinehart, Robin Whyte, Elizabeth Deveny, Marianne Shearer)

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: Emerging principles for **health system value improvement** programmes (Christopher Moriates, Victoria Valencia) - Assessing the **quality of health care in the management of bronchiolitis** in Australian children: a population-based sample survey (Nusrat Homaira, Louise K Wiles, Claire Gardner, Charlotte J Molloy, Gaston Arnolda, Hsuen P Ting, Peter Damian Hibbert, Jeffrey Braithwaite, Adam Jaffe)

Online resources

Clinical Communiqué
Volume 6. Issue 1. March 2019
http://vifmcommuniques.org/clinical-communique-volume-6-issue-1-march-2019/
This Clinical Communiqué examines **fixation error**. Fixation error is defined here as 'the phenomenon whereby a person or group falls into a pattern of thinking that there is only one possible explanation. This can take on several forms, including task fixation on a procedure, or diagnostic fixation to the exclusion of other possibilities, as unfortunately demonstrated in the two cases presented. The first case sees hospital staff fixate on machine malfunction as the cause of abnormal physiological readings; while in the second, a number of visual and verbal cues lead staff to erroneously fixate on one diagnosis, rather than explore other viable differentials.'

[UK] NICE Guidelines and Quality Standards
https://www.nice.org.uk/guidance
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 NG123 **Urinary incontinence and pelvic organ prolapse in women:** *management* https://www.nice.org.uk/guidance/ng123
- NICE Guideline NG124 **Specialist neonatal respiratory care** *for babies born preterm* https://www.nice.org.uk/guidance/ng124

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