AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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The next issue of *On the Radar* is scheduled for distribution on Monday 6 May 2019.

On the Radar is a summary of some of the recent publications in the areas of safety and quality in health care. Inclusion in this document is not an endorsement or recommendation of any publication or provider. Access to particular documents may depend on whether they are Open Access or not, and/or your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

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On the Radar
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National Safety and Quality Health Service Standards user guide for governing bodies
Australian Commission on Safety and Quality in Health Care
Sydney: ACSHQC; 2019. p. 67.
https://nationalstandards.safetyandquality.gov.au/resources

The Australian Commission on Safety and Quality in Health Care has developed the *National Safety and Quality Health Service Standards user guide for governing bodies* to advise members of governing bodies exercising their governance responsibilities in the implementation of the NSQHS Standards. This document outlines the actions in the NSQHS Standards that require health service organisation leaders, especially members of the governing body, to act.

The User Guide is available on the National Safety and Quality Health Service Standards microsite
https://nationalstandards.safetyandquality.gov.au/resources

Osteoarthritis of the knee: A decision support tool for patients considering treatment options
https://www.safetyandquality.gov.au/wp-content/uploads/2019/04/OAK-DST-FINAL-APRIL-8.pdf

The Australian Commission on Safety and Quality in Health Care has developed a decision support tool for patients on osteoarthritis (OA) of the knee. The tool provides evidence-based information about the main treatment options for OA of the knee, including the risks, benefits and costs. The tool aims to support patients to make more informed decisions and includes questions that patients may wish to discuss with their doctor or health professional.

The decision support tool is available from
https://www.safetyandquality.gov.au/wp-content/uploads/2019/04/OAK-DST-FINAL-APRIL-8.pdf
A promotional poster to support the release of the tool is also available from
https://www.safetyandquality.gov.au/wp-content/uploads/2019/04/OAK-DST-FINAL-APRIL-8.pdf

This decision support tool is based on the treatment options in the Commission's *Osteoarthritis of the Knee Clinical Care Standard*. Further information about the Commission's work on Patient and Consumer Centred Care and Clinical Care Standards can be found at https://www.safetyandquality.gov.au

Reports

How to Talk About Patient Safety
Hendricks R, O'Neil M, Volmert A
Boston: Betsy Lehman Center for Patient Safety; 2019. p. 24.

URL	https://www.betsylehmancenterma.gov/assets/uploads/Patient-Safety-MessageMemo-2019.pdf https://www.betsylehmancenterma.gov/research/reframing-patient-safety-issues
Notes	US report (from the Betsy Lehman Center and FrameWorks Institute) that argues that the way patient safety is framed, including the language of patient safety, does not engage or resonate with the public. While much of this may seem self-evident there are elements that may not be universally welcomed. For example, the use of the aviation metaphor has already seen quite extensive pushback with those arguing that it is an imperfect metaphor. The strategies suggested include: • Explicitly define the terms patient safety and medical error to increase understanding • Talk about medical care rather than health care to help people focus on safety • Connect the dots between causes and solutions • Use the Aviation metaphor to help people make sense of how errors arise and how they can be reduced • Use the Fail-Safe metaphor to help people grasp what solutions look like • Adopt an efficacious rather than a crisis tone • Explain rather than assert the prevalence of medical errors • Pan back to include the whole picture, rather than zooming in on one cause or solution • Explain the importance of patient involvement without talking about "empowerment."

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/

Journal articles

Bringing perioperative emergency manuals to your institution: a "How To" from concept to implementation in 10 steps
Agarwala AV, McRichards LK, Rao V, Kurzweil V, Goldhaber-Fiebert SN
The Joint Commission Journal on Quality and Patient Safety. 2019;45(3):170-9.

DOI	https://doi.org/10.1016/j.jcjq.2018.08.012
Notes	Paper describing the implementation of emergency manuals (EMs) in the perioperative setting. Emergency manuals are defined as 'context-relevant sets of crisis checklists or cognitive aids designed to enable professional teams to deliver optimal care during critical events'. The authors describe their implementation that had 10 steps in four distinct phases. The implantation plans major goals were: 1. place EMs in every anaesthetising location 2. create inter-professional engagement 3. demonstrate that a majority of anaesthesia clinicians would use the new tool in some way within the first year. The authors report that in the six months following implementation, 67.0% of clinicians had used the EM, with 24.1% using it for clinical care and 9.2% using it during a critical event.

Must we bust the trust?: Understanding how the clinician–patient relationship influences patient engagement in safety
Mishra SR, Haldar S, Khelifi M, Pollack AH, Wanda P
AMIA Annu Symp Proc. 2018:1425-34.

The impact of patient–physician alliance on trust following an adverse event
Shoemaker K, Smith CP
Patient Education and Counseling. 2019 [epub].

Incivility and patient safety: a longitudinal study of rudeness, protocol compliance, and adverse events
Riskin A, Bamberger P, Erez A, Foulk T, Cooper B, Peterfreund I, et al
Joint Commission Journal on Quality and Patient Safety. 2019 [epub].

Is physician mentorship associated with the occurrence of adverse patient safety events?
Harrison R, Sharma A, Lawton R, Stewart K
Journal of Patient Safety. 2019 [epub].

URL / DOI	Mishra et al https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6371248/ Shoemaker et al https://doi.org/10.1016/j.pec.2019.02.015 Riskin et al https://doi.org/10.1016/j.jcjq.2019.02.002 Harrison et al https://doi.org/10.1097/PTS.0000000000000592
Notes	A number of items that reflect on the importance of interpersonal relationships in health care, including what can happen when there are ruptures or disharmony. These reiterate the vital role that culture – individually and collectively – plays. Health care is a human activity built upon information and communication and thus relationships matter, between clinicians and between clinicians and patients, their families and carers. Mishra et al report on a study that used semi-structured interviews with hospitalised patients to explore their views on information systems that could help patients be more involved in the prevention of medical errors. They report that the **clinician-patient relationship was important in encouraging or discouraging patients and caregivers from engaging**. Creating patient engagement systems alone may not be enough if the relationships are not supporting their engagement. Shoemaker et al looked at clinician-patient relationships in the maternity setting by surveying women across the US about their experience in giving birth, include unexpected procedures, adverse events, support from healthcare institutions, and perceived betrayals by healthcare institutions. Unsurprisingly, adverse events and institutional betrayal correlated with lower patient trust, but they also found that **patients who were more involved in decision-making with their physician were found to have more trust in them following adverse events** than those who did not. The authors suggest that 'physicians can work proactively to lessen the detrimental effects of adverse events on patient trust, but the patient-physician relationship is still impacted by healthcare institutions.' Riskin et al provide an update on the area of clinician behaviour, particularly uncivil or non-collegiate behaviour. Such (poor) behaviours to colleagues and/or patients have previously been found to be potentially deleterious to safety and quality. This study compared nurses' reports of rudeness with hand hygiene and medication protocol compliance data and adverse events in an Israeli hospital setting. The authors report that '231 rudeness incidents were reported in 98 shifts, most stemming from a patient or family**. Compliance with hand hygiene was significantly lower up to 24 hours after rudeness exposure** ($p = 0.03$). **Rudeness** significantly **increased team members' state depletion** ($p = 0.002$) and was **associated with decreased information sharing** ($p = 0.046$) but was **not directly associated with adverse events or level of compliance with medication and hand hygiene protocols.**'

	Harrison et al report on another potentially influential relationship, that of the clinician and mentor. The paper reports on a study that examined how having a mentor can have an impact on a physicians' involvement in an adverse event or near miss. A survey of 1755 fellows and members of the Royal College of Physicians London found that about 85% reported involvement in either an adverse event or near miss, and nearly half described having a mentor. **Physicians with mentors had a reduced probability of getting involved in an adverse event or near miss** of 12.69% (95% confidence interval = -17.41 to -7.98) and 11.12% (95% confidence interval = -15.84 to -6.41).

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

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/

Abandon the term "second victim"
Clarkson MD, Haskell H, Hemmelgarn C, Skolnik PJ
BMJ. 2019;364:l1233.

DOI	https://doi.org/10.1136/bmj.l1233
Notes	Editorial in the *BMJ* calling for the term 'second victim' to not be used. The authors seem to suggest that it reduces the centrality of the 'first' victim, the harmed patient. They seem to find referring to the clinician involved as the 'second victim' (and the health facility as the 'third victim' in a 'triangle of victimhood') as reducing the significance of the event. It is imaginable that while there may be sympathy for the argument of remembering the primacy of the patient (and for the facility as victim to be downplayed), the obscuring of the potential impact of an error on the clinician will not be appreciated. Errors, particularly catastrophic ones, can have a life-changing (and career-threatening) impact on clinicians and they too should be supported, just as patients and their families and carers should. Showing compassion is not a zero sum game – showing compassion for one party does not mean we cannot also show compassion for others.

Reclaiming the systems approach to paediatric safety
Cheung R, Roland D, Lachman P
Archives of Disease in Childhood. 2019 [epub].

DOI	http://doi.org/10.1136/archdischild-2018-316401
Notes	Commentary arguing for a systems approach, encompassing huddles and early warning systems as means of addressing communication issues that can contribute to safety and quality issues. This is predicated on the view that care is a team activity and safety and quality is not solely determined by the performance of individual clinicians.

Journal of Patient Experience
Volume: 6, Number: 1 (March 2019)

URL	https://journals.sagepub.com/toc/jpxa/6/1
Notes	A new issue of the *Journal of Patient Experience* has been published. Articles in this issue of the *Journal of Patient Experience* include: • Changing Roles, Changing Perspectives—**Vulnerability as a Patient** (Monika Schuler) • **Healing in the Absence of a Cure** (Libby Byrne) • Developing a Strategy for the Improvement in **Patient Experience** in a Canadian Academic **Department of Surgery** (Lindy Luo, Alan J Forster, Kathleen Gartke, John Trickett, and Fraser D Rubens) • Why **Mindfulness/Meditation Is a "No-Brainer" for Health-Care Professionals** (Leonard H Calabrese) • Impact of **Language Barriers on Quality of Care and Patient Safety** for Official Language Minority Francophones in Canada (Danielle de Moissac and Sarah Bowen) • Facilitators and Barriers Affecting **Adherence Among People Living With HIV/AIDS**: A Qualitative Perspective (Syed Imran Ahmed, Maryam Farooqui, Syed Azhar Syed Sulaiman, Mohamed A Hassali, and C K C Lee) • Preference for **Subcutaneous Injection or Intravenous Infusion** of Biological Therapy Among Italian **Patients With SLE** (Marina Falanga, Augusta Canzona, and Davide Mazzoni) • Geographically Localized Medicine **House-Staff Teams and Patient Satisfaction** (Zishan Siddiqui, Amanda Bertram, Stephen Berry, Timothy Niessen, Lisa Allen, Nowella Durkin, Leonard Feldman, Carrie Herzke, Rehan Qayyum, Peter Pronovost, and Daniel J Brotman) • Understanding **Parents' Experiences** and Information Needs on **Pediatric Acute Otitis Media**: A Qualitative Study (Salima Meherali, Alyson Campbell, Lisa Hartling, and Shannon Scott) • Accuracy of **Inpatient Recall of Interaction With a Pharmacist**: A Validation Study From 2 Acute Care Teaching Hospitals (Vaninder K Sidhu, Lauren Bresee, Kyle Kemp, Sheri Koshman, Taciana Pereira, and Sheena Neilson) • Perspective on **Living With a Skin Condition** and its Psychological Impact: A Survey (A Kanji) • **Primary Care Practice Workplace Social Capital**: A Potential Secret Sauce for Improved Staff Well-Being and Patient Experience (Adam T Perzynski, Aleece Caron, David Margolius, and Joseph J Sudano, Jr) • Comparative Usability Study of a Newly Created Patient-Centered Tool and Medicare.gov Plan Finder to Help **Medicare Beneficiaries Choose Prescription Drug Plans** (Cheryl D Stults, Sayeh Fattahi, Amy Meehan, M Kate Bundorf, Albert S Chan, Ting Pun, and Ming Tai-Seale)

Health Affairs
Vol. 38, No. 4

URL	https://www.healthaffairs.org/toc/hlthaff/38/4
Notes	A new issue of *Health Affairs* has been published, with the theme 'Physicians, Medicare & More. Articles in this issue of *Health Affairs* include: • An Education In **Meeting Patients Where They Live** (T R Goldman) • Assessing **First Visits By Physicians** To Medicare **Patients Discharged To Skilled Nursing Facilities** (Kira L Ryskina, Y Yuan, S Teng, and R Burke) • **Primary Care Physician Networks** In Medicare Advantage (Yevgeniy Feyman, José F Figueroa, Daniel E Polsky, Michael Adelberg, and A Frakt) • Knowledge Of Practicing **Physicians** About Their **Legal Obligations** When Caring For Patients With **Disability** (Nicole D Agaronnik, Elizabeth Pendo, Eric G Campbell, Julie Ressalam, and Lisa I Iezzoni) • Medicare's **Bundled Payments For Care Improvement Initiative** Maintained Quality Of Care For Vulnerable Patients (Brandon C Maughan, Daver C Kahvecioglu, Grecia Marrufo, Gina M Gerding, Syvart Dennen, Jaclyn K Marshall, Daniel M Cooper, Colleen M Kummet, and L A Dummit) • The Role Of **Social, Cognitive, And Functional Risk Factors In Medicare Spending** For Dual And Nondual Enrollees (Kenton J Johnston, and Karen E Joynt Maddox) • Patient Readmission Rates For All Insurance Types After Implementation Of The **Hospital Readmissions Reduction Program** (Enrico G Ferro, Eric A Secemsky, Rishi K Wadhera, Eunhee Choi, Jordan B Strom, Jason H Wasfy, Yun Wang, Changyu Shen, and Robert W Yeh) • Maryland's Experiment With **Capitated Payments** For Rural Hospitals: Large Reductions In Hospital-Based Care (Jesse M Pines, Sonal Vats, Mark S Zocchi, and Bernard Black) • **When Is The Price Of A Drug Unjust?** The Average Lifetime Earnings Standard (Ezekiel J Emanuel) • **Multimorbidity And Health Outcomes** In Older Adults In Ten European Health Systems, 2006–15 (Raffaele Palladino, Francesca Pennino, Martin Finbarr, Christopher Millett, and Maria Triassi) • **Do Incentive Payments Reward The Wrong Providers?** A Study Of Primary Care Reform In Ontario, Canada (Richard H Glazier, Michael E Green, Eliot Frymire, Alex Kopp, William Hogg, Kamila Premji, and T Kiran) • The Affordable Care Act In The Heart Of The **Opioid Crisis**: Evidence From West Virginia (Brendan Saloner, R Landis, B D Stein, and C L Barry) • News **Media Reporting On Medication Treatment For Opioid Use Disorder** Amid The Opioid Epidemic (Alene Kennedy-Hendricks, Jonathan Levin, Elizabeth Stone, Emma E. McGinty, Sarah E Gollust, and C L Barry) • Measuring The **Lifetime Costs Of Serious Mental Illness** And The Mitigating Effects Of Educational Attainment (Seth A Seabury, Sarah Axeen, Gwyn Pauley, Bryan Tysinger, Danielle Schlosser, John B Hernandez, Hanke Heun-Johnson, Henu Zhao, and Dana P Goldman) • My Struggle To Access **Lifesaving Mental Health Care** (Ashley R Clayton)

Journal of Health Services Research & Policy
Volume: 24, Number: 2 (April 2019)

URL	https://journals.sagepub.com/toc/hsrb/24/2
Notes	A new issue of the *Journal of Health Services Research & Policy* has been published. Articles in this issue of the *Journal of Health Services Research & Policy* include: • Editorial: Increasing **middle managers' commitment to innovation** implementation: An agenda for research (Sarah A Birken) • Does rural health system reform aimed at **improving access to primary health care affect hospitalization rates**? An interrupted time series analysis of national policy reforms in Iran (Arash Rashidian, Sedigheh Salavati, Hanan Hajimahmoodi, and Mehrnaz Kheirandish) • Australian pharmacy perspectives on **increasing access to medicines through reclassification** (Amary Mey, Michelle King, Fiona Kelly, Gary Grant, James Townshend, L Baumann-Birkbeck, P Woods, and D Hope) • Factors influencing **middle managers' commitment to the implementation of innovations in cancer care** (Robin Urquhart, Cynthia Kendell, Amy Folkes, Tony Reiman, Eva Grunfeld, and Geoff Porter) • Patterns of **geriatric health assessment** use among community dwelling older Australian women over a 14-year period (Tazeen Majeed, Meredith Tavener, Xenia Dolja-Gore, Balakrishnan Nair, C Chojenta, and J Byles) • **Awareness as a dimension of health care access**: exploring the case of rural palliative care provision in Canada (Arlanna Pugh, Heather Castleden, Melissa Giesbrecht, Colleen Davison, and Valorie Crooks) • Improving **community support for older people's needs** through commissioning third sector services: a qualitative study (Neil Chadborn, Chris Craig, Gina Sands, Justine Schneider, and John Gladman) • Interviewing **older people** about their **experiences of emergency hospital admission**: methodology in health services research (Rachel Thwaites, Jon Glasby, Nick Le Mesurier, and Rosemary Littlechild) • **Patient and public involvement in the design, administration and evaluation of patient feedback tools**, an example in psychiatry: a systematic review and critical interpretative synthesis (Rebecca Baines, John Donovan, Sam Regan de Bere, Julian Archer, and Ray Jones)

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: • Effect on **secondary care** of providing enhanced support to **residential and nursing home residents**: a subgroup analysis of a retrospective matched cohort study (Therese Lloyd, Stefano Conti, Filipe Santos, Adam Steventon) • **Patient activation** intervention to facilitate participation in recovery after **total knee replacement** (MIME): a cluster randomised cross-over trial (Jo McDonall, Richard de Steiger, John Reynolds, Bernice Redley, Patricia M Livingston, Anastasia F Hutchinson, Mari Botti) • Improving rates of ferrous sulfate prescription for suspected **iron deficiency anaemia in infants** (Corinna J Rea, Clement Bottino, Jenny Chan Yuen, Kathleen Conroy, Joanne Cox, Alexandra Epee-Bounya, Radhika Kamalia, Patricia Meleedy-Rey, Kalpana Pethe, R Samuels, P Schubert, A J Starmer)

Online resources

[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 NG125 ***Surgical site infections****: prevention and treatment*
  https://www.nice.org.uk/guidance/ng125
- Clinical Guideline CG132 ***Caesarean section*** https://www.nice.org.uk/guidance/cg132
