AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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Welcome to the first issue of *On the Radar* for 2012.

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.

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This week's content

Reports

Implementation guide SAB Consultation Edition November 2011
Implementation guide CDI Consultation Edition November 2011
Implementation guide CLABSI Consultation Edition November 2011
ACSQHC, Sydney. 2011

Notes	Three implementation guides have been developed for use by Australian hospitals and organisations to support the implementation of surveillance for *Staphylococcus aureus* bacteraemia (SAB), *Clostridium difficile* infection (CDI) and Central Line Associated Bloodstream Infections (CLABSI). The guides have been developed by the Commission's Healthcare Associated Infection Technical Advisory Group in collaboration with the clinical experts and the surveillance units from jurisdictions and are designed to support and standardise existing surveillance activities in line with the national definitions for SAB, CDI and CLABSI. Each of the guides contains interpretation of the definitions, flowcharts, inclusions and exclusion for each of the surveillance topics, as well a list of examples to assist with decisions on those more difficult cases. The guides are not intended to replace or inform clinical management of infections or patient management but to standardise how key infection data is collected and reported. All comments and feedback will be reviewed and responded to as part of the consultation process.
URL	http://www.health.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-03

Research in Ambulatory Patient Safety 2000–2010: A 10-Year Review
Lorincz CY, Drazen E, Sokol PE, Neerukonda KV, Metzger J, Toepp MS, et al.
Chicago IL 2011: American Medical Association, 2011.

Notes	Complementing the Commission's discussion paper and consultation report on Patient Safety in Primary Care is this report from the American Medical Association summarising the past decade's research in this area. While some areas have seen some activity there remains much that is little-known or unknown. Indeed, the scale of safety and quality issues and their impact is rather unclear. As this report notes 'Though some very high-quality work on ambulatory safety took place between 2000 and 2010, research and initiatives in ambulatory safety were remarkably limited, both in quantity and in the ability to generalize from the studies that were reported.'
URL	www.ama-assn.org/go/patientsafety http://www.ama-assn.org/resources/doc/ethics/research-ambulatory-patient-safety.pdf
TRIM	57480

For information on the Commission's work on patient safety in primary health care, including the discussion paper and consultation report, see
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PatientSafety-PHC

Journal articles

The Savings Illusion — Why Clinical Quality Improvement Fails to Deliver Bottom-Line Results
Rauh SS, Wadsworth EB, Weeks WB, Weinstein JN.
New England Journal of Medicine 2011;365(26):e48.

Notes	Does improving quality save money? This paper suggests perhaps not. However it also makes the important observation that quality improvements can lift the capacity of a service. Interestingly it does not refer to the work by John Øvretveit (such as *Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers*. London. Health Foundation, 2009) or discussed these issues in some detail. The paper is also is somewhat at odds with the Institute for Healthcare Improvement's Impacting Cost + Quality initiative. However, it could be said that that initiative focuses on costs and waste with quality as a secondary topic. These raise the question of where does the focus best lie – on safety and quality with cost reductions as a fortuitous windfall gain where they occur, on cost and expenditure with quality improvement regarded as a desired consequence, or on attempting to find a happy medium where safer, higher quality care delivers cost-effective care that is appropriate, reduces follow-up or re-admission due to errors, etc? There is also the question of where saving is measured. Improved safety and quality may reduce costs for a patient or by patient – for example through reduced medications, reduced rates of 'never' events, reduced length of stay, reduced return to theatre, reduced readmissions, etc. – but these do not necessarily translate to reduced facility of systems costs as they are likely to allow for additional throughput or capacity (however, this could drive greater revenue).
DOI/	NEJM paper: http://dx.doi.org/10.1056/NEJMp1111662

URL	IHI initiative: http://www.ihi.org/offerings/Initiatives/IMPACTingCostQuality/Pages/default.aspx Øvretveit paper: http://www.health.org.uk/publications/does-improving-quality-save-money/

Using Patient-Reported Outcomes to Improve Health Care Quality
Martha Hostetter and Sarah Klein
Quality Matters, December 2011/January 2012.

Notes	In the latest issue of the Commonwealth Fund's *Quality Matters* newsletter is this item on patient-reported outcome measures 'PROMS'. According to the Commonwealth Fund, these 'are a critical way to assess whether clinicians are improving the health of patients. Unlike process measures, which capture provider productivity and adherence to the standards of recommended care, or patient experience measures, which focus on aspects of care delivery such as communication, PROMs attempt to capture whether the services provided actually improved patients' health and sense of well-being.' Such measures could be part of a suite of measures that clinicians, service providers, facilities, funders and consumers could use to assess the quality of care. A number of clinical quality registries collect such measures — at intervals as long as 12 months after discharge as they consider these important measures in determining the efficacy and quality of treatments.
URL	http://www.commonwealthfund.org/Newsletters/Quality-Matters/2011/December-January-2012/In-Focus.aspx

For information about the Commission's work on patient and consumer centred care, see
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PCCC

What do patients and relatives know about problems and failures in care?
Iedema R, Allen S, Britton K, Gallagher TH.
BMJ Quality & Safety 2011 [epub].

Notes	Article reporting on how patients (and family members) perceive and understand problems and failures in care. Based on 100 interviews of patients and/or family members who have experienced severe adverse events in care, including deaths. The work revealed that patients and family members do have considerable knowledge about health risks, problems and incidents; that this knowledge and insight can be particularly valuable, and that frequently there are significant hurdles put in the way of acknowledging and utilising this knowledge. The understanding, experience and perspectives of patients are all of great importance in improving care. This ranges from patients being at the centre of their care, of understanding and being engaged in their care through to involvement and engagement of patients in activities that drive improvements to care. The paper suggests processes and avenues for genuine dialogue need to be devised to unlock the knowledge and enhance care around the individual patients and at the larger scale.
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000100
TRIM	57453

For information on the Commission's work on clinical communications, see
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-05

For information on the Commission's work on open disclosure, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-02

BMJ Quality and Safety online first articles

Notes	In recent weeks the *BMJ Quality and Safety* has published a number of 'online first' articles. These include: • Association between implementation of an intensivist-led medical emergency team and mortality (Constantine J Karvellas, Ivens A O de Souza, R T Noel Gibney, Sean M Bagshaw) • The association of workflow interruptions and hospital doctors' workload: a prospective observational study (M Weigl, A Müller, C Vincent, P Angerer, N Sevdalis) • Quality of in-hospital cardiac arrest calls: a prospective observational study (Naheed Akhtar, Richard A Field, Liz Greenwood, Robin P Davies, Sarah Woolley, Matthew W Cooke, Gavin D Perkins) • 'Wading through treacle': quality improvement lessons from the frontline (Alice Roueche, Jocelyn Hewitt) • Knowledge implementation in healthcare practice: a view from The Netherlands (Michel Wensing, Roland Bal, Roland Friele) • Improving hand hygiene in a paediatric hospital: a multimodal quality improvement approach (Ahmed Jamal, G O'Grady, E Harnett, D Dalton, D Andresen) • Promoting patient-centred care through trainee feedback: Assessing Residents' C-I-CARE (ARC) Program (Timothy Wen, Brian Huang, Virgie Mosley, Nasim Afsar-manesh) • Medical errors reported by French general practitioners in training: results of a survey and individual interviews (Emily Venus, Eric Galam, Jean-Pierre Aubert, Michel Nougairede) • Medical error, incident investigation and the second victim: doing better but feeling worse? (Albert W Wu, Rachel C Steckelberg) • Reducing post-caesarean surgical wound infection rate: an improvement project in a Norwegian maternity clinic (Ole A Dyrkorn, Marit Kristoffersen, Mette Walberg)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

Notes	In recent weeks the *International Journal for Quality in Health Care* has published a number of 'online first' articles. These include: • Talking openly: using '6D cards' to facilitate holistic, patient-led communication (Julia Neufeind and Margaret Hannah) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr075v1?papetoc • What do we know about patients' perceptions of continuity of care? A meta-synthesis of qualitative studies (Sina Waibel, Diana Henao, Marta-Beatriz Aller, Ingrid Vargas, and Maria-Luisa Vazquez) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr068v1?papetoc • Assessing adherence to guidelines for common mental disorders in routine clinical practice (Esther van Fenema, Nic J.A. van der Wee, Mark Bauer, Cornelis J. Witte, and Frans G. Zitman) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr076v1?papetoc

	• Evaluation of the Pharmacy Safety Climate Questionnaire in European community pharmacies (Denham L. Phipps, Jolanda De Bie, Hanne Herborg, Mara Guerreiro, Christiane Eickhoff, Fernando Fernandez-Llimos, Marcel L. Bouvy, Charlotte Rossing, Uta Mueller, and Darren M. Ashcroft) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr070v1?papetoc • How hospital leaders implemented a safe surgery protocol in Australian hospitals (Judith Mary Healy) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr078v1?papetoc • Impact of format and content of visual display of data on comprehension, choice and preference: a systematic review (Zoe Hildon, Dominique Allwood, and Nick Black) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr072v1?papetoc • Assessing the effect of estimation error on risk-adjusted CUSUM chart Performance (Mark A. Jones and Stefan H. Steiner) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr082v1?papetoc • Adverse events in Spanish intensive care units: the SYREC study (Paz Merino, Joaquin Alvarez, Mari Cruz Martin, Angela Alonso, and Isabel Gutierrez SYREC Study Investigators) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr083v1?papetoc • Improving doctor-patient communication in the outpatient setting using a facilitation tool: a preliminary study (Naama Neeman, Thomas Isaac, Suzanne Leveille, Clementina Dimonda, Jacob Y. Shin, Mark D. Aronson, and Steven D. Freedman) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr081v1?papetoc • Putting theory into practice: the introduction of obstetric near-miss case reviews in the Republic of Moldova (V Baltag, VFilippi, and Alberta Bacci) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr079v1?papetoc • Changes in clients' care ratings after HIV prevention training of hospital workers in Malawi (A F. Chimwaza, J L. Chimango, C P N Kaponda, K F. Norr, J L. Norr, D L. Jere, and Sitingawawo I. Kachingwe) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr080v1?papetoc • Health system responsiveness for delivery care in Southern Thailand (Tippawan Liabsuetrakul, Porntip Petmanee, Sunittha Sanguanchua, and Nurleesa Oumudee) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr085v1?papetoc • Look back and talk openly: responding to and communicating about the risk of large-scale error in pathology diagnoses (Rosemary Aldrich, Peter Finlayson, Kim Hill, and Margaret Sullivan) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr084v1?papetoc

BMJ Quality and Safety
January 2012, Vol 21, Issue 1

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: • The operating room dance [Editorial] (Julie Ann Freischlag) • Factors that influence the expected length of operation: results of a prospective study (B M Gillespie, Wendy Chaboyer, Nicole Fairweather) • The Model for Understanding Success in Quality (MUSIQ): building a

	theory of context in healthcare quality improvement (Heather C Kaplan, Lloyd P Provost, Craig M Froehle, Peter A Margolis) • Understanding ethnic and other socio-demographic differences in patient experience of primary care: evidence from the English General Practice Patient Survey (G Lyratzopoulos, M Elliott, J M Barbiere, A Henderson, L Staetsky, C Paddison, J Campbell, M Roland) • Exploring situational awareness in diagnostic errors in primary care (Hardeep Singh, T D Giardina, Laura A Petersen, Michael W Smith, Lindsey Wilson Paul, Key Dismukes, Gayathri Bhagwath, Eric J Thomas) • Overall patient satisfaction with hospitals: effects of patient-reported experiences and fulfilment of expectations (Oyvind A Bjertnaes, Ingeborg Strømseng Sjetne, Hilde Hestad Iversen) • Development of a primary care physician task list to evaluate clinic visit workflow (Tosha B Wetterneck, Jamie A Lapin, Daniel J Krueger, G Talley Holman, John W Beasley, Ben-Tzion Karsh) • How do centres begin the process to prevent contrast-induced acute kidney injury: a report from a new regional collaborative (Jeremiah R Brown, Peter A McCullough, Mark E Splaine, Louise Davies, Cathy S Ross, Harold L Dauerman, John F Robb, Richard Boss, David J Goldberg, Frank A Fedele, Mirle A Kellett, William J Phillips, Peter N Ver Lee, Eugene C Nelson, Todd A MacKenzie, Gerald T O'Connor, Mark J Sarnak, David J Malenka, for the Northern New England Cardiovascular Disease Study Group) • Lean thinking transformation of the unsedated upper gastrointestinal endoscopy pathway improves efficiency and is associated with high levels of patient satisfaction (Theresa Hydes, Navjyot Hansi, Timothy M Trebble) • How event reporting by US hospitals has changed from 2005 to 2009 (D O Farley, A Haviland, A Haas, Chau Pham, W B Munier, James B Battles) • Determination of the psychometric properties of a behavioural marking system for obstetrical team training using high-fidelity simulation (Pamela J Morgan, Deborah Tregunno, Richard Pittini, Jordan Tarshis, Glenn Regehr, Susan Desousa, Matt Kurrek, Ken Milne) • A 'Communication and Patient Safety' training programme for all healthcare staff: can it make a difference? (Peter Lee, Kellie Allen, M Daly)
URL	http://qualitysafety.bmj.com/content/vol21/issue1/

American Journal of Medical Quality
January 2012, Vol 27, Issue 1

Notes	A new issue of the *American Journal of Medical Quality* has been published.. Articles in this issue include: • Cardiac Surgical Outcomes Improvement Led by a Physician Champion Working With a Nurse Clinical Coordinator (John R. Stanford, Laurie Swaney-Berghoff, and Kimberly Recht) • Do Timely Outpatient Follow-up Visits Decrease Hospital Readmission Rates? (Deanne T. Kashiwagi, M. Caroline Burton, Lisa L. Kirkland, Steven Cha, and Prathibha Varkey) • Process Factors Affecting Door to Percutaneous Coronary Intervention for Acute Myocardial Infarction Patients (Michael A. Horst, Jennifer J. Stuart, Nichole McKinsey, and Angela S. Gambler) • Preventing Wrong Site, Procedure, and Patient Events Using a Common

	Cause Analysis (R Mallett, M Conroy, L Z Saslaw, and S Moffatt-Bruce) • Using a Framework for Spread of Best Practices to Implement Successful Venous Thromboembolism Prophylaxis Throughout a Large Hospital System (Timothy I. Morgenthaler, Jenna K. Lovely, Robert R. Cima, Carl F. Berardinelli, Leslie A. Fedraw, Timothy J. Wallerich, Deborah J. Hinrichs, and Prathibha Varkey) • An Assessment of Patient Sign-Outs Conducted by University at Buffalo Internal Medicine Residents (D Wheat, C Co, R Manochakian, and E Rich) • Effect of Illness Severity and Comorbidity on Patient Safety and Adverse Events (James M. Naessens, Claudia R. Campbell, Nilay Shah, Bjorn Berg, John J. Lefante, Arthur R. Williams, and Richard Culbertson) • The Mayo Clinic Value Creation System (Stephen J. Swensen, James A. Dilling, C. Michel Harper, Jr, and John H. Noseworthy) • A Successful, Voluntary, Multicomponent Statewide Effort to Reduce Health Care-Associated Infections (Marcia M. Ward, Gerd Clabaugh, Thomas C. Evans, and Loreen Herwaldt) • Inappropriate Use of D-Dimer Assay and Pulmonary CT Angiography in the Evaluation of Suspected Acute Pulmonary Embolism (Fang Yin, Thomas Wilson, Albert Della Fave, Moira Larsen, Jenni Yoon, Binyam Nugusie, Howard Freeland, and Robert Dobbin Chow) • Promoting Equity: Developing Quality Measures for Sickle Cell Disease (Paula Tanabe and Romana Hasnain-Wynia)
URL	http://ajm.sagepub.com/content/vol27/issue1/?etoc

Online resources

[US] Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals
http://www.ahrq.gov/qual/ptflow/
From the US Agency for Healthcare Research and Quality (AHRQ), this guide provides step-by-step instructions for planning and implementing strategies that improve patient flow through emergency departments (EDs). It also examines the value of forming a patient flow team, describes how to measure ED performance and provides a framework for selecting improvement strategies.

[US] Consumer Assessment of Healthcare Providers and Systems (CAHPS) podcasts
http://cahps.ahrq.gov/News-and-Events/Podcasts.aspx.
The third podcast in a series focused on quality improvement features Gregg Meyer, Senior Vice President of the Massachusetts General Hospital and Physicians Organization and Director of the Edward P. Lawrence Center for Quality and Safety. Mr. Meyer discusses the importance of leadership to support quality improvement efforts.

On the Radar reader survey

Thank you very much to those of you who completed the survey — 159 responses were received. The responses have been overwhelmingly positive. Accepting that responding to the survey inevitably means a self-selecting population that is largely to be well-disposed to the topic (even though a couple of respondents did say that they never read *On the Radar*), it has still been an extremely heartening response.

More than 90% of respondents read most or every issue; rated it as one of their top 3 sources; and consider *On the Radar* to be the right length with the appropriate level of detail and with the appropriate structure and mix of content. It also is apparent that availability, format and the like are well-accepted.

It is generally considered easy to use, with the most concerns stemming from the ability to access documents via the provided links. This is usually determined by the access rights your organisations have established. It has been decided to include material that may require subscription or purchase as to exclude all such material may mean useful or important material being missed.

It has been gratifying to see that many of you do take a bit of time with *On the Radar* (more than 25% taking more than 10 minutes) and that many of you keep copies of it.
But perhaps the more important figure has been the high proportion of you who say that *On the Radar* has direct application to your work (nearly 80% saying always or often) or that you follow-up on an item (more than 95% saying always or often).

Clearly how items apply varies greatly as you have told us you work in a wide range of settings and roles (and geographies). Hospital and governmental agencies are the most common settings, with clinical roles and roles with direct responsibility for safety and quality the most popular.

The number of people that *On the Radar* is being forwarded on to was something we've been interested in knowing. While many people forward an item or an issue on to 1 or 2 or even 10 people, some have been forwarding on to more, including an 'entire hospital', '200+ people', or 'more than 1,000 people'.

The qualitative aspect — your comments — have added a richness to the quantitative. These have also been extremely positive and encouraging. The few critical comments are also very helpful in identifying things for us to consider. Your comments on possible sources have been useful in indicating that we have included all the major sources identified and also a number of things to investigate.

Again, thank you very much for taking the time to complete the survey and to provide your feedback. It is much appreciated.