



On the Radar

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2 years of On the Radar

5 July 2010 saw the first issue of *On the Radar* appear. The aim, as stated in that first issue was to *give Commission personnel a quick update on what is being published in Australia and overseas. It is meant to help you stay informed about current and emerging issues in the safety and quality field.* In many ways that aim remains. However, due to demand and requests it was then made available to anyone wanting such information.

The Commission takes a transparent approach based on collaboration and facilitation with many other individuals and organisations living with issues of safety and quality in health care. One of the roles for the Commission is the sharing of knowledge with and between others so we can collectively address these important issues, and *On the Radar* is one part of how the Commission does this.

On the Radar has proven very popular, as shown through the number of people subscribing to it, from how it is being widely distributed, and from the results of the survey we conducted. We hope you continue to find it useful.

Dr Niall Johnson
Editor

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

Patient Safety: From Learning to Action 2012: Fifth Queensland Health report on clinical incidents and sentinel events in the Queensland public health system 2009–10 and 2010–11
 Patient Safety and Quality Improvement Service, Queensland Health
 Brisbane: Queensland Health. ISBN 978-1-921707-61-2

Notes	<p>Queensland Health has just published the fifth edition of their <i>From learning to action</i> report.</p> <p>From the Executive Summary: ‘This report is for all Queenslanders, but in particular for Queensland Health staff and community members interested in knowing what is being done to improve patient safety. It is also for anyone who wants to share in, and benefit from, what has been learnt since a comprehensive patient safety system was introduced into Queensland Health.’</p>
URL	http://www.health.qld.gov.au/psq/reports/docs/lta5.pdf

National Voluntary Consensus Standards for Patient Safety Measures: A Consensus Report
 National Quality Forum
 Washington D.C. National Quality Forum, 2012.

Notes	<p>The US National Quality Forum has published this report suggesting six evidence-based measures that are suitable for public reporting and quality improvement efforts. The recommended patient safety measures focus on healthcare associated infections, urinary tract infections, surgical site infections, bloodstream infections, and radiation dosing.</p>
URL	http://www.qualityforum.org/Publications/2012/06/National_Voluntary_Consensus_Standards_for_Patient_Safety_Measures_A_Consensus_Report.aspx

Journal articles

Defining Patient Safety in Hospice: Principles to Guide Measurement and Public Reporting
 Casarett D, Spence C, Clark MA, Shield R, Teno JM
 Journal of Palliative Medicine 2012 (epub}.

Notes	<p>A domain of medicine that perhaps has not had the same concentration of safety and quality is that of hospice or palliative care. Given that mortality is the expected outcome could possibly explain this, but should not mean any lapse in quality or safety of care is appropriate.</p> <p>The authors describe three ‘serious conflicts’ that they see arising when safety measures from other settings are applied to hospice care.</p> <ol style="list-style-type: none"> 1. Safety measures that are imposed in order to reduce morbidity and mortality may be irrelevant for a hospice patient whose goals focus on comfort. 2. Safety measures that are defined in patients with a life expectancy of years can be inappropriate for hospice patients whose typical survival is measured in days 3. Difficulties in assigning responsibility for the safety of hospice patients, whose care is provided mostly by family and friends. <p>These, they claims, suggest that generally accepted safety measures ‘are often inappropriate for hospice care, and can lead to unintended consequences if they are applied without critical evaluation or modification’.</p>
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	The authors suggest ‘three principles that can guide the development of hospice-appropriate safety measures by considering a patient's goals and life expectancy, and the degree to which responsibility for a patient's care is shared’. Again, the core message may be that context matters.
DOI	http://dx.doi.org/10.1089/jpm.2011.0530

Preventing overdiagnosis: how to stop harming the healthy
Moynihan R, Doust J, Henry D
BMJ 2012;344.

Notes	<p>Some of the recent literature around diagnosis errors has been focussed on the misdiagnosis. This paper looks at another aspect, over-diagnosis. This relates to issues of appropriateness of care, particularly whether care is actually necessary and the possibility of harm from over-diagnosing, diagnosing and treating conditions that perhaps require little more than ‘watchful waiting’. There are arguments that suggest ‘defensive medicine’ and a fear of litigation are drivers for some of this. Similarly patient and clinician views that anything ‘abnormal’ must be treated immediately can be at play.</p> <p>As the authors state ‘A burgeoning scientific literature is fuelling public concerns that too many people are being overdosed, overtreated, and overdiagnosed. Screening programmes are detecting early cancers that will never cause symptoms or death, sensitive diagnostic technologies identify “abnormalities” so tiny they will remain benign, while widening disease definitions mean people at ever lower risks receive permanent medical labels and lifelong treatments that will fail to benefit many of them.⁶ With estimates that more than \$200bn (£128bn; €160bn) may be wasted on unnecessary treatment every year in the United States, the cumulative burden from overdiagnosis poses a significant threat to human health.</p> <p>Narrowly defined, overdiagnosis occurs when people without symptoms are diagnosed with a disease that ultimately will not cause them to experience symptoms or early death. More broadly defined, overdiagnosis refers to the related problems of overmedicalisation and subsequent overtreatment, diagnosis creep, shifting thresholds, and disease mongering, all processes helping to reclassify healthy people with mild problems or at low risk as sick.</p> <p>The downsides of overdiagnosis include the negative effects of unnecessary labelling, the harms of unneeded tests and therapies, and the opportunity cost of wasted resources that could be better used to treat or prevent genuine illness.’</p>
DOI	http://dx.doi.org/10.1136/bmj.e3502

Science-Based Training in Patient Safety and Quality
Pronovost PJ, Weisfeldt ML
Annals of Internal Medicine 2012 (epub).

Notes	Opinion piece by Peter Pronovost and Myron Weisfeldt calling for a more ‘scientific’, systematic approach to safety and quality education.
DOI	http://annals.org/article.aspx?articleid=1181874

Health and Illness in a Connected World: How Might Sharing Experiences on the Internet Affect People's Health?

Ziebland SUE, Wyke S

Milbank Quarterly 2012;90(2):219-249.

Notes	<p>Technology changes all our lives and almost every aspect of our lives. Health and healthcare and the use of technology is an area of much development and many contradictions. It is also an area where consumers are increasingly using technologies, particularly information technology and especially the Internet, to find and share information about health, healthcare, providers and other issues. This piece in <i>Milbank Quarterly</i> examines some of the aspects of how the sharing of information, including experiences, may affect our health.</p> <p>The authors' review and research led them to identify seven 'domains' through which online patients' experiences could affect health with each domain having potential positive and negative impacts. Five of the identified domains (finding information, feeling supported, maintaining relationships with others, affecting behaviour, and experiencing health services) are 'relatively well rehearsed', while two (learning to tell the story and visualizing disease) are 'less acknowledged but important features of online resources'.</p> <p>The conclusion the authors offer is that the 'value of first-person accounts, the appeal and memorability of stories, and the need to make contact with peers all strongly suggest that reading and hearing others' accounts of their own experiences of health and illness will remain a key feature of e-health. The act of participating in the creation of health information (e.g., through blogging and contributing to social networking on health topics) also influences patients' experiences and has implications for our understanding of their role in their own health care management and information.'</p>
DOI	<p>http://dx.doi.org/10.1111/j.1468-0009.2012.00662.x</p>

American Journal of Medical Quality

1 July 2012; Vol. 27, No. 4

Notes	<p>The latest issue of the <i>American Journal of Medical Quality</i> has been published. This issue includes the following:</p> <ul style="list-style-type: none"> • Editorial: Reducing Health Care Disparities: Next Steps Require Better Evidence (Donald E. Casey, Jr.) • Addressing Health Care Disparities Using Public Reporting (Anne McGeary Snowden, Vicki Kunerth, A M Carlson, J A McRae, and E Vetta) • Use of Electronic Documentation for Quality Improvement in Hospice (J G Cagle, F S Rokoske, D Durham, A P Schenck, C Spence, and L C Hanson) • Improving Transitions: Efficacy of a Transfer Form to Communicate Patients' Wishes (William J Zafirau, Sara S Snyder, Susan E Hazelett, Ankit Bansal, and S McMahan) • Improving Awareness of Best Practices to Reduce Surgical Site Infection: A Multistakeholder Approach (Alexandria Skoufalos, J L Clarke, M Napp, K J Abrams, B Berman, D Armellino, M E Schilling, and V Pracilio) • A Hospital's Adoption of Information Technology Is Associated With Altered Risks of Hospital-Acquired Venous Thromboembolism (Hsou Mei Hu and Huey-Ming Tzeng) • Differential Impact of a Crew Resource Management Program According to Professional Specialty (D Suva, G Haller, A Lübbecke, and P Hoffmeyer)
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	<ul style="list-style-type: none"> • HIV Quality of Care Assessment at an Academic Hospital: Outcomes and Lessons Learned (Christine A Kerr, Naama Neeman, Roger B Davis, Joanne Schulze, Howard Libman, L Markson, M Aronson, and S K Bell) • Evaluating Transitions of Care of Hospitalized Medical Patients to Long-Term Care Facilities: A Retrospective Review of Venous Thromboembolism Prophylaxis (Bradley L Burton, Ada Ibe Offurum, Brian Grover, Badia Faddoul, Mangla Gulati, and Kristin L Seidl) • Provider Attitudes Toward Clinical Protocols in Obstetrics (Sayeedha G Uddin, Jill A Marsteller, J Bryan Sexton, Susan E Will, and Harold E Fox) • Inappropriate Use of Payment Weights to Risk Adjust Readmission Rates (Richard L Fuller, Norbert I Goldfield, Richard F Averill, and J S Hughes) • Perspective: Engaging Trainees in Performance Improvement Projects: The Quality and Safety Innovation Challenge (Naama Neeman, Sumant R Ranji, and Niraj L Sehgal) • Commentary: Establishing Safety and Quality as Core Values: A Hospital Road Map (Simon C Mathews and Peter J Pronovost)
DOI	http://ajm.sagepub.com/content/vol27/issue4/?etoc

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