AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

Issue 92
13 August 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.

Access to particular documents may depend on whether they are Open Access or not, and/or whether your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

On the Radar is available via email or as a PDF document from http://www.safetyandquality.gov.au/publications-resources/on-the-radar/

If you would like to receive *On the Radar* via email, please email us at mail@safetyandquality.gov.au

For information about the Commission and its programs and publications, please visit http://www.safetyandquality.gov.au/ You can also follow us on Twitter @ACSQHC.

This week's content

Reports

Do changes to patient-provider relationships improve quality and save money? A review of the evidence about value improvements made by changing communication, collaboration and support for self-care
Øvretveit J
London. The Health Foundation, 2012.

Evidence: Helping people share decision making. A review of evidence considering whether shared decision making is worthwhile
The Health Foundation
London: The Health Foundation, 2012.

When doctors and patients talk: making sense of the consultation
Fischer M, Ereaut G
London. The Health Foundation, 2012.

Notes	A series of reports from the (UK) Health Foundation all examining aspects of patient-clinician communication and decision-making. John Øvretveit's latest report "presents evidence of the suffering and costs associated with sub-optimal communication and collaboration between health professionals and patients, and sub-optimal support for self-care. The review found there was evidence of negative health consequences for patients when health professionals failed sufficiently to consider patients' preferences and lifestyle and also when they did not agree assessment and treatment plans in a collaborative

	way. Additionally, there is research that shows that many patients and their carers feel unsupported in their efforts to take care of their health conditions, and that there is a high cost to the health system of failure to provide adequate support for self-care. Research also shows factors outside the health system that affect people's ability to care for their health conditions." Øvretveit also reports finding that there "are interventions and changes to promote patient–professional communication and collaboration to bring about a more active role for patients and to support self-care." He concludes that "[w]hether **interventions are effective and save money depends on:** **— targeting the patients most likely to be helped,** **— implementing the intervention effectively,** **— factoring in the provider and patient environments that help and hinder the intervention".** The *Helping people share decision making* report brings together evidence and provides a summary of the current state of knowledge about shared decision making. This evidence shows that **shared decision making improves patient's satisfaction, involvement in their care and knowledge of their condition**. Fischer and Ereaut explore the main form of interaction between a patient and a clinician – the consultation. Their report reveals the anxieties that both parties may feel, with doctors and patients each having their own concerns. They offer an analysis of the current relationship, identifying the mutual fears that drive doctors and patients and the invisible structures that are natural to the doctor but hidden from the patient. It also describes the potential for a **more nuanced model for the consultation**. They suggest that for patients to be better involved in making decisions about their own care, the consultation needs to change. The report looks at five main themes, or ways of thinking differently about the current patient–clinician relationship, which might lead to different thinking about how to act. These themes are: • **making sense of 'the consultation'** • **fear as a driver of the dynamic** • **invisible structures** • **fragmented conversations** • **system dynamics.**
URL	Øvretveit: http://www.health.org.uk/publications/do-changes-to-patient-provider-relationships-improve-quality-and-save-money *Evidence* report: http://www.health.org.uk/publications/helping-people-share-decision-making Fischer and Ereaut http://www.health.org.uk/publications/when-doctors-and-patients-talk-making-sense-of-the-consultation
TRIM	Øvretveit: 66943 *Evidence* report: 66944 Fischer and Ereaut: 66941

Journal articles

Evaluation of current Australian health service accreditation processes (ACCREDIT-CAP): protocol for a mixed-method research project
Hinchcliff R, Greenfield D, Moldovan M, Pawsey M, Mumford V, Westbrook JI, Braithwaite J
BMJ Open 2012;2:e001726

Notes	This paper by the ACCREDIT collaboration outlines their first research project to evaluate the current accreditation processes in Australia. The evaluation will involve three mixed-method studies looking at accreditation models, critical elements of accreditation, and standards and their impact. The studies will utilise documentary analyses, surveys, focus groups and individual interviews, and include stakeholders from across the Australian healthcare system: accreditation agencies; federal and state government departments; consumer advocates; professional colleges and associations; and staff of acute, primary and aged care services. The results of the project will help to build the evidence base regarding current accreditation processes and their capacity to promote high-quality and safe organisational and clinical performance.
DOI	http://dx.doi.org/10.1136/bmjopen-2012-001726

For information on the Commission's work on accreditation, see
http://www.safetyandquality.gov.au/our-work/accreditation/

What is preventable harm in healthcare? A systematic review of definitions
Nabhan M, Elraiyah T, Brown DR, Dilling J, Leblanc A, Montori VM, et al.
BMC Health Services Research 2012;12(1):128.

Notes	Report on a systematic review of what the literature suggests is preventable harm. The review used 127 studies (published in English in the period January 2001–June 2011 including a definition of preventable harm). The three most prevalent preventable harms in the included studies were: **medication adverse events** (33/127 studies, 26%), **central line infections** (7/127, 6%) and **venous thromboembolism** (5/127, 4%). The top three themes or definitions for preventable harm were: **presence of an identifiable modifiable cause** (58/132 definitions, 44%), **reasonable adaptation to a process will prevent future recurrence** (30/132, 23%), **adherence to guidelines** (22/132, 16%). The authors conclude that there is "limited empirical evidence of the validity and reliability of the available definitions of preventable harm" and that the most common definition is 'presence of an identifiable, modifiable cause of harm'.
DOI	http://www.biomedcentral.com/1472-6963/12/128

Safety management in different high-risk domains – All the same?
Grote G
Safety Science 2012;50(10):1983-1992.

Notes	A non-medical view on what constitutes management of safety in various 'high-risk domains'. The author's intent was examine what different high-risk industries can learn from each other and what limits for generalising safety management methods exist. The author considers that there are three attributes crucial to any organisation's functioning that affect the way safety management systems should be designed, run, and assessed. These being

	(1) the kinds of safety to be managed (2) the general approach to managing uncertainty as a hallmark of organizations that manage safety, and (3) the regulatory regime within which safety is managed.
DOI	http://dx.doi.org/10.1016/j.ssci.2011.07.017

Integration of balance and strength training into daily life activity to reduce rate of falls in older people (the LiFE study): randomised parallel trial
Clemson L, Singh MAF, Bundy A, Cumming RG, Manollaras K, O'Loughlin P, Black D
BMJ 2012;345:e4547

Notes	An Australian study looking at the effectiveness of a lifestyle integrated approach to balance and strength training intervention in the prevention of falls among people aged 70 years or more who were living at home and assessed to be at high risk of falling. In the three arm, randomised parallel trial, 107 participants were allocated to receive a Lifestyle integrated Functional Exercise (LiFE) approach (taught principles of balance and strength training and integrated selected activities into everyday routines). Compared with a sham control program of gentle exercise, the LiFE approach to balance and strength training demonstrated a **significant 31% reduction the rate of falls**.
DOI	http://dx.doi.org/10.1136/bmj.e4547

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

Achieving the 'perfect handoff' in patient transfers: building teamwork and trust
Clarke D, Werestiuk KIM, Schoffner A, Gerard J, Swan K, Jackson B, et al.
Journal of Nursing Management 2012;20(5):592-598.

Notes	The latest addition to the handover/handoff literature is this commentary on one hospital's use of 'appreciative inquiry' to identify components of handoffs that can help improve unit-to-unit transfers. The appreciative inquiry approach sought to build on successful handoffs by understanding what was working well and focused on "the situational variables necessary for the perfect transfer, the mode and content of transfer-related communication, and important factors in communication with the patient and family." The authors report positively on this approach, particularly in that "[g]iving staff members the opportunity to contribute positively to process improvements and share their ideas for innovation has the potential to highlight expertise and everyday accomplishments enhancing morale and reducing conflict."
DOI	http://dx.doi.org/10.1111/j.1365-2834.2012.01400.x

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

Exploring Relationships Between Patient Safety Culture and Patients' Assessments of Hospital Care
Sorra J, Khanna K, Dyer N, Mardon R, Famolaro T
Journal of Patient Safety 2012.

Notes	The paper reports on an examination of the relationship between safety culture (as measured by the Hospital Survey on Patient Safety Culture) and patient satisfaction (as measured by the Consumer Assessment of Healthcare Providers and Systems Hospital Survey) across 73 US hospitals.

	The authors report evidence that a strong safety culture is associated with improved patient satisfaction scores, noting that "that hospitals where staff have more positive perceptions of patient safety culture tend to have more positive assessments of care from patients."
DOI	http://dx.doi.org/10.1097/PTS.0b013e318258ca46

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Using Six Sigma to improve once daily gentamicin dosing and therapeutic drug monitoring performance (Sean Egan, Philip G Murphy, Jerome P Fennell, Sinead Kelly, Mary Hickey, Carolyn McLean, Muriel Pate, Ciara Kirke, Annette Whiriskey, Niall Wall, E McCullagh, J Murphy, T Delaney) • Reciprocal **peer review for quality improvement**: an ethnographic case study of the Improving Lung Cancer Outcomes Project (Emma-Louise Aveling, Graham Martin, Senai Jiménez García, Lisa Martin, Georgia Herbert, Natalie Armstrong, Mary Dixon-Woods, Ian Woolhouse) • **Determinants of success of quality improvement collaboratives**: what does the literature show? (Marlies E J L Hulscher, Loes M T Schouten, Richard P T M Grol, Heather Buchan) • Junior doctors and patient safety: evaluating knowledge, attitudes and perception of safety climate (Piyush Durani, Joseph Dias, Harvinder P Singh, Nicholas Taub)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

High Impact Innovations
http://www.innovation.nhs.uk/pg/dashboard
The (UK) Department of Health, with the National Health Service (NHS) Institute for Innovation and Improvement and NHS Improvement, has launched an implementation support web site for the NHS. The web site allows users to learn about the innovations, read case studies, access support to help with implementation – including procurement, help with business cases development and service re-design, benchmark performance, share their experiences, score others' case studies and develop ideas and online communities. The web sites discussion forums enable innovators from the NHS, public, private, academic, scientific and business communities to get in touch, share ideas, and post details of their own innovations.