On the Radar

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On the Radar
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Reports

International Profiles of Health Care Systems
Thomson S, Osborn R, Squires D, Jun M
New York. The Commonwealth Fund, 2012.

Notes	The (US) Commonwealth Fund has released its latest update on the health care systems of selected nations, including Australia. This report contains overviews of the health care systems of Australia, Canada, Denmark, England, France, Germany, Japan, Iceland, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States. Each overview covers health insurance, public and private financing, health system organization, quality of care, health disparities, efficiency and integration, care coordination, use of health information technology, use of evidence-based practice, cost containment, and recent reforms and innovations.
URL	http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Nov/International-Profiles-of-Health-Care-Systems-2012.aspx
TRIM	72144

Journal articles

Developing mental health-care quality indicators: toward a common framework
Fisher CE, Spaeth-Rublee B, Pincus HA, for the IIMHL Clinical Leaders Group
International Journal for Quality in Health Care 2012 [epub].

Notes	Something of a progress report on the international effort to develop a common framework of indicators for mental health system performance. Examining quality measurement initiatives for mental health involved 29 programs from 11 countries and 2 cross-national programs meant 656 total measures across 17 domains and 80 sub-domains! The paper describes the next steps and notes the ultimate aim: "quality measurement initiatives that will help to transform mental health services worldwide." The project can not be faulted for lack of ambition.
DOI	http://dx.doi.org/10.1093/intqhc/mzs074

Integration of patient safety systems in a suburban hospital
Stride P, Seleem M, Nath N, Horne A, Kapitsalas C
Australian Health Review 2012;36(4):359-362.

Notes	This paper describes how one hospital has sought to bring their patient safety activities together into a mutually reinforcing integrated safety system. Activities that have been brought together include the Medical Emergency Team, mortality review, clinical handover, hand hygiene, medication safety, and falls prevention. The authors "believe our concept of interlinked safety groups informed by chart audits and other forms of surveillance has improved patient safety, and has created a culture where more staff are informed of safety teams and strive to reduce error."
DOI	http://dx.doi.org/10.1071/AH11099

Implementation of a quality care management system for patients with arthritis of the hip and knee
Doerr CR, Graves SE, Mercer GE, Osborne RH
Australian Health Review 2012 [epub]

Notes	Another example of how local activities that aim to understand what is happening in a given setting and seeking to enhance the safety and quality of care there can produced improved outcomes. Such projects may not be transferable or generalisable. However, they can offer useful templates – ranging from the approach of understanding the local context through to replicability elsewhere. This is also an example of how understanding the entire patient journey, rather than just particular steps or a series of discreet events, can lead to improvements. In this instance the authors describe how a quality care management system for patients with arthritis of the hip and knee was developed and implemented. According to the authors, system "not only optimises conservative management but ensures that joint replacement surgery is undertaken in an appropriate and timely manner. This new service model addresses identified barriers to service access and provides a **comprehensive, coordinated strategy for patient management**. Over 4 years the model has **reduced waiting times** for initial outpatient assessment from 8 to 3 months and surgery from 18 to 8 months, while **decreasing length of stay** from 6.3 to 5.3 days for hips and 5.8 to 5.3 days for knees. The service reforms have been accompanied by positive feedback from patients and referring general practitioners in relation to the improved coordination of care and enhanced efficiency in service delivery."
DOI	http://dx.doi.org/10.1071/AH11107

Constructing a framework for quality activity in primary care
Perera GAR, Dowell AC, Morris CJ.
Australian Health Review 2012 [epub].

Notes	Paper describing the development and details of the New Zealand "framework to facilitate quality-improvement activity in primary care settings." The framework "identifies the components of primary care practice and locates this model within the concepts and activities necessary for quality improvement. It may be used by primary care organisations and practices to facilitate focussed quality-improvement activity and self-directed process review. The framework was developed for, and within a New Zealand primary care setting, and is applicable internationally and within other healthcare settings."
DOI	http://dx.doi.org/10.1071/AH11097

Encouraging participation in health system reform: is clinical engagement a useful concept for policy and management?
Bonias D, Leggat SG, Bartram T
Australian Health Review 2012;36(4):378-383.

Notes	The potential value and importance of clinical leadership and engagement for the improvement of health care and health care systems has been taken largely as read in recent years and if often cited as a key requirement for improvement. This paper discusses the significance of clinical engagement in Australian health, particularly given how many clinicians are independent. The authors note that "Clinical engagement is defined as the cognitive, emotional and physical contribution of health professionals to their jobs, and to improving their organisation and their health system within their working roles in their employing health service. While this construct applies to employees, engagement of independent practitioners is a different construct that needs to recognise out-of-role requirements for clinicians to become engaged in organisational and system reform." The motivations and levers that may be applicable to employee clinicians may differ from those applicable to independent clinicians.

Are patients discharged with care? A qualitative study of perceptions and experiences of patients, family members and care providers
Hesselink G, Flink M, Olsson M, Barach P, Dudzik-Urbaniak E, Orrego C, et al.
BMJ Quality & Safety 2012;21(Suppl 1):i39-i49.

"It's like two worlds apart": an analysis of vulnerable patient handover practices at discharge from hospital
Groene RO, Orrego C, Suñol R, Barach P, Groene O
BMJ Quality & Safety 2012;21(Suppl 1):i67-i75.

Notes	The *BMJ Safety and Quality* published a supplement given over to the Proceedings from the European Handover Research Collaborative. These two papers looked at discharge and both reveal how the patient is perhaps more the object of discharge than a participant and that engaging the patient, making discharge much more patient-centred may be a way of enhancing discharge. Hesselink et al sought to examine "the barriers and facilitators to patient-centred care in the hospital discharge process" using a qualitative study using purposive sampling of 192 individual interviews and 26 focus group interviews five European Union countries with patients and/or family members, hospital physicians and nurses, and community general practitioners and nurses. They report that four themes emerged: !1) healthcare providers do not sufficiently prioritise discharge consultations with patients and family members; (2) discharge communication ranged from instructing patients and family members to shared decision-making; (3) patients often feel unprepared for discharge, and post-discharge care is not tailored to individual patient needs and preferences; and (4) pressure on available hospital beds and community resources affect the discharge process. They also assert that there needs to be "a focus on **improving communication** among care providers, patients and families, and between hospital and community care providers" as a key driver to improving discharge. Groene et al conducted interviews with patients, hospital professionals and primary care professionals in two hospitals and their associated primary care centres in Catalonia, Spain to examine the patients' role in handovers, with particular interest in vulnerable patients. Similar to other work, they report that discharge handovers are often haphazard, that healthcare professionals do not consider current handover practices safe and that these issues can lead to misinformation, omission or duplication of tests or interventions and, potentially, patient harm. They also note that "**Vulnerable patients may be at greater risk given their limited language, cognitive and social resources. Patient safety at discharge could benefit from strategies to enhance patient education and promote empowerment.**"
DOI	Hesselink et al http://dx.doi.org/10.1136/bmjqs-2012-001165 Groene et al http://dx.doi.org/10.1136/bmjqs-2012-001174

For information about the Commission's work on safety in e-health, including electronic discharge summary systems, see http://www.safetyandquality.gov.au/our-work/safety-in-e-health/

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

Handover training: does one size fit all? The merits of mass customisation
Kicken W, Van der Klink M, Barach P, Boshuizen H
BMJ Quality & Safety 2012;21(Suppl 1):i84-i88.

The Handover Toolbox: a knowledge exchange and training platform for improving patient care
Drachsler H, Kicken W, van der Klink M, Stoyanov S, Boshuizen HPA, Barach P
BMJ Quality & Safety 2012;21(Suppl 1):i114-i120.

Notes	Another pair of papers from the *BMJ Safety and Quality* supplement given over to the Proceedings from the European Handover Research Collaborative. These two papers looked at the balance between standardisation and customisation – what is sometimes known as **mass customisation** or **flexible standardisation** – in both training and implementation. These are approaches that offer a standardised framework that can be customised or is flexible enough to take into consideration the context, the setting and the (local) needs. Kicken et al conclude that "The idea of completely standardised handover training is not in line with the identified differences in preferences and recommendations between different handover stakeholders. Mass customisation of training, in which **generic training is adapted to local or individual needs**, presents a promising solution to address general and specific needs, while containing the financial and time costs of designing and delivering handover training." Drachsler et al present their Handover Toolbox which has developed following these ideas. They state that "the Toolbox aims to support physicians, nurses, individuals in health professions training, medical educators and handover experts by providing customised handover training tools for different clinical needs and contexts."
DOI	Kicken et al http://dx.doi.org/10.1136/bmjqs-2012-001164 Drachsler et al http://dx.doi.org/10.1136/bmjqs-2012-001176

Impact of a Chronic Disease Management Program on Hospital Admissions and Readmissions in an Australian Population with Heart Disease or Diabetes
Hamar GB, Rula EY, Wells A, Coberley C, Pope JE, Larkin S
Population Health Management 2012 [epub].

Notes	A number of private health insurance companies have established chronic disease management programs (CDMPs) for their customers, often with the aim of reducing "unnecessary health care utilization" and thus costs. This paper reports on the early impact of one such programme by comparing 5,053 members who participated in the CDMP with 23,077 other members on the rate of hospital admissions, readmissions, and average length of hospital stay (ALOS) for individuals with heart disease or diabetes. The study showed that "After both 12 and 18 months, treatment members displayed decreases in admissions … and readmissions … and ALOS after 18 months …versus the comparison group". Longer term evaluation and evaluation across more conditions and measures may reveal more, but this study has indicated that such programs may have a positive role.
DOI	http://dx.doi.org/10.1089/pop.2012.0027

Clinical effectiveness of a patient decision aid to improve decision quality and glycaemic control in people with diabetes making treatment choices: a cluster randomised controlled trial (PANDAs) in general practice
Mathers N, Ng CJ, Campbell MJ, Colwell B, Brown I, Bradley A
BMJ Open 2012;2:6 e001469

The Treatment of cardiovascular Risk in Primary care using Electronic Decision suppOrt (TORPEDO) study: intervention development and protocol for a cluster randomised, controlled trial of an electronic decision support and quality improvement intervention in Australian primary healthcare
Peiris D, Usherwood T, Panaretto K, Harris M, Hunt J, Patel B, Zwar N, Redfern J, MacMahon S, Colaguiri S, Hayman N, Patel A
BMJ Open 2012;2:e002177

Notes	A pair of articles on studies involving shared decision-making and risk communication. Research is continuing to support the need for patients and carers to be included in, and assisted to make, decisions about their own care. **Shared decision-making involves the integration of best available evidence about benefits, risks and uncertainties associated with treatment with a patient's goals and concerns to achieve high quality decisions about medical care.** Research is showing that shared decision-making leads to greater satisfaction with care and improved adherence to treatment plans. The first study is a cluster RCT of 49 general practices in the UK. The study failed to achieve its planned sample size as a result of recruitment difficulties and, given the intervention, had no blinding. In the intervention group, clinicians received brief training on the use of the PANDAs decision aid – a tool developed to facilitate shared decision-making between clinicians and patients when making decisions about the treatment of their type 2 diabetes mellitus. The patient participants in the intervention group were given the PANDAs decision aid to read before their consultation, and had their consultation facilitated by the use of the PANDAs. Researchers measured decisional conflict at the point of consultation based on the Decisional Conflict Scale score, and glycaemic control (glycosolated haemoglobin, HbA1c) at 6 months, and found that while the use of PANDAs **improved decision quality by reducing decisional conflict, improving knowledge and promoting realistic expectations**, it had **no demonstrable effect on glycaemic control**. The second paper outlines the intervention development and protocol for another cluster RCT, this time in Australia. These researchers intend to apply their recently developed HealthTracker, a multi-faceted electronic decision support and quality improvement intervention to improve the management of cardiovascular disease (CVD) risk, to 40 general practices and 20 Aboriginal Community Controlled Health Services in the Sydney region. The HealthTracker **incorporates point of care decision support, risk communication and resources for patients, health service audit tools and use of data for supporting QI initiatives**. The inclusion of a patient-oriented risk communication interface complements the electronic decision support, as the authors highlight that **"CVD-risk assessment and treatment work best when negotiated as part of a shared decision-making approach"**. Researchers hope to see an increased proportion of patients receiving appropriate (guideline-indicated) measurements of their CVD risk factors, and those at high risk receiving guideline-indicated prescriptions for the management of their CVD risk.

| DOI | Mathers et al http://dx.doi.org/10.1136/bmjopen-2012-001469 |
| | Peiris et al http://dx.doi.org/10.1136/bmjopen-2012-002177 |

Attitude is everything?: The impact of workload, safety climate, and safety tools on medical errors: A study of intensive care units
Steyrer J, Schiffinger M, Huber C, Valentin A, Strunk G
Health Care Manage Rev 2012.

Notes	This paper examined a number of factors to examine their relation with medical errors in intensive care units. The take-home message is that **safety culture counts**, or as is attributed to Peter Drucker 'culture eats strategy for breakfast'.
	This study sought understand to what "extent production pressure (i.e., increased staff workload and capacity utilization) and safety culture (consisting of safety climate among staff and safety tools implemented by management) influence the occurrence of medical errors and if/how safety climate and safety tools interact."
	The authors undertook a prospective, observational, 48-hour cross-sectional study was conducted in 57 intensive care units, focusing on errors affecting the 378 patients treated.
	The authors report "**Increased workload and capacity utilization increase the occurrence of medical error**, an effect that can be **offset by a positive safety climate** but not by formally implemented safety procedures and policies."
DOI	http://dx.doi.org/10.1097/HMR.0b013e318272935a

Errors in Palliative Care: Kinds, Causes, and Consequences: A Pilot Survey of Experiences and Attitudes of Palliative Care Professionals
Dietz I, Borasio GD, Med DP, Molnar C, Muller-Busch C, Plog A, et al.
Journal of Palliative Medicine 2012 [epub].

Notes	Report of a Bavarian survey of the experiences and attitudes of palliative care professionals regarding errors. The study surveyed 168 specialist palliative care facilities (with 70 responding). Survey respondents indicated that issue of errors in palliative is a highly relevant problem (median 8 on a 10-point numeric rating scale). Most respondents experienced a **moderate frequency of errors** (1-10 per 100 patients). Errors in **communication** were estimated to be more common than those in symptom control. The causes most often mentioned were deficits in communication or organisation. Interestingly, it was the effect on the clinician – "moral and psychological problems" that were seen as more frequent than consequences for the patient. Ninety percent of respondents declared that they disclose errors to the harmed patient.
	The findings led to the conclusion that palliative care professionals recognise that errors occur, particularly in communication, but that the issue has been neglected in training and research.
DOI	http://dx.doi.org/10.1089/jpm.2012.0272

Multiple conditions: exploring literature from the consumer perspective in Australia
Walker C
Health Expectations 2012 [epub].

Notes	The number of people with multiple conditions caused by either the presence of multiple unrelated illnesses, conditions caused by treatments of another, or conditions caused by adverse events continues to increase. Multiple conditions present challenges for integration of care between settings and providers, this literature search has identified some deficiencies. Exploratory work is

	recommended, beginning with accurate definitions and the establishment of a data collection mechanism is recommended to enable policy development catering to the needs of this patient group. It may be that genuinely patient-centred care delivered by a team of clinicians dealing with individual patient's particular constellation of conditions so as to deliver more appropriate and co-ordinated care is what will be able to make a significant difference for patients. The challenge is how to envisage and create such personalised approaches.
DOI	http://dx.doi.org/10.1111/hex.12015

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

BMJ Quality and Safety online first articles

	BMJ Quality and Safety has published a number of 'online first' articles, including:
Notes	• A case report of evaluating a large-scale health systems improvement project in an uncontrolled setting: a quality improvement initiative in KwaZulu-Natal, South Africa (Kedar S Mate, Wilbroda Hlolisile Ngidi, Jennifer Reddy, Wendy Mphatswe, Nigel Rollins, Pierre Barker) • Overarching goals: a strategy for improving healthcare quality and safety? (Karen C Nanji, Timothy G Ferris, David F Torchiana, Gregg S Meyer)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

	International Journal for Quality in Health Care has published a number of 'online first' articles, including:
Notes	• Continuing differences between health professions' attitudes: the saga of accomplishing systems-wide interprofessionalism (Jeffrey Braithwaite, Mary Westbrook, Peter Nugus, David Greenfield, Joanne Travaglia, W Runciman, A R Foxwell, R A Boyce, T Devinney, and J Westbrook) • Quality and safety of hospital discharge: a study on experiences and perceptions of patients, relatives and care providers (Gijs Hesselink, Lisette Schoonhoven, Marieke Plas, Hub Wollersheim, and M Vernooij-Dassen)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources
[USA] TeamSTEPPS® Long-Term Care Version
http://www.ahrq.gov/TeamSTEPPStools/longtermcare/
The Long-Term Care version of TeamSTEPPS adapts the core concepts of the TeamSTEPPS program to reflect the environment of nursing homes and other long-term care settings such as assisted living and continuing care retirement communities. The toolkit includes resources to aid in implementing TeamSTEPPS in long-term care, including an instructor guide and training videos.

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