AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

Issue 422
24 June 2019

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On the Radar
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Strategies to identify patient risks of prescription opioid addiction when initiating opioids for pain: A systematic review
Klimas J, Gorfinkel L, Fairbairn N, Amato L, Ahamad K, Nolan S, et al
JAMA Network Open. 2019;2(5):e193365-e.

DOI	http://doi.org/10.1001/jamanetworkopen.2019.3365
Notes	The "opioid epidemic' has led to considerations of the risks of prescribing opioids. This paper reports on a systematic review that sought to identify risk factors for opioid addiction and thus contribute to identifying which patients are at risk or, conversely, may be considered to be at lesser risk. The review found that factors that may confer risks for opioid addition include prior history of substance use disorder, prescription of psychiatric medications, certain mental health diagnoses, higher daily opioid doses, and prescription of opioids for 30 days or more may confer risk for opioid addiction. They found that a factor associated with a lower risk of opioid use disorder was the absence of a mood disorder. However, the authors observed that 'no symptoms, signs, or screening tools were particularly useful for identifying those at lower risk.'

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

Lives Lost, Lives Saved: An Updated Comparative Analysis of Avoidable Deaths at Hospitals Graded by The Leapfrog Group
Austin M, Derk J
Washington D.C.: The Leapfrog Group; 2019. p. 10.

A decade of preventing harm
Woeltje KF, Olenski LK, Donatelli M, Hunter A, Murphy D, Hall BL, et al
The Joint Commission Journal on Quality and Patient Safety. 2019 [epub].

DOI	Austin and Derk https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/LivesLost Woeltje et al. https://doi.org/10.1016/j.jcjq.2019.04.007
Notes	A pair of items that reflect on the success – or otherwise – of efforts to address safety and quality issues. Austin and Derk offer an analysis of the performance of hospitals that were graded using the Leapfrog Group processes to examine the apparent relationship between such recognition and preventable harm. The Leapfrog Group process grades hospitals (A to F) and this analysis suggests that 'an estimated 160,000 lives are lost annually from the avoidable medical errors that are accounted for in the Leapfrog Hospital Safety Grade, a significant improvement from 2016, when researchers estimated 205,000 avoidable deaths. The analysis also found that D and F hospitals carry nearly twice the risk of mortality of A hospitals. Over 50,000 lives could be saved if all hospitals performed at the level of A graded hospitals.' The analysis also observed that 'While hospitals with a Hospital Safety Grade of "A" have better performance than hospitals with lower grades, they still have significant opportunities for improvement.' Woeltje et al. offer the view from one US health system (with 15 hospitals). This system implanted a quality improvement program that utilised benchmarks, surveillance, multidisciplinary teams, and evidence-based practices to target pressure ulcers, adverse drug events, falls, health care–associated infections, and venous thromboembolism. The paper describes the major improvements achieved in the initial 5-year period (51.6% reduction in total harm events) with further gains in the subsequent 5 years (a 74.9% reduction since 2009).

Responding to health information technology reported safety events: insights from patient safety event reports
Adams KT, Kim TC, Fong A, Howe JL, Kellogg KM, Ratwani RM
Journal of Patient Safety and Risk Management. 2019 [epub].

DOI	https://doi.org/10.1177/2516043519847330
Notes	There are many sources of information that can be tapped to gain understanding of safety and quality issues. This paper examines how patient safety event reports can illuminate some of the issues with health information technology with a focus on how the issues were resolved. The authors noted that of the health information technology events in their database of over 1.7 million patient safety event report, most (64%) did not include a resolution of the issue. For those events that did have a resolution recorded, training/education was the most commonly reported single or component of a multi-pronged solution (55%), followed by information technology (45%). As the authors observe, this is 'despite the recognized limitations of training and education in resolving these events'. They also noted that 'Few events suggested multiple resolution methods. Ensuring health information technology-related events are resolved and incorporate effective solutions should be a continued focus area for healthcare systems.'

Patient and visitor aggression in healthcare: a survey exploring organisational safety culture and team efficacy
Heckemann B, Hahn S, Halfens RJG, Richter D, Schols JMGA
Journal of Nursing Management. 2019 [epub].

DOI	http://doi.org/10.1111/jonm.12772
Notes	Incidents of aggression in healthcare settings happen more frequently than is widely understood, even while there have been some high profile (and tragic) cases. This study reports on a study involving an online survey of nurse managers at 446 psychiatric and general hospitals in Switzerland, Austria and Germany. Issues such as the physical design and layout of facilities and the organisational culture and attitudes to patient and visitor aggression and workplace safety were seen as important.

BMJ Quality & Safety
June 2019 - Volume 28 - 7

URL	https://qualitysafety.bmj.com/content/28/7
Notes	A new issue of *BMJ Quality & 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 & Safety* include: • Editorial: Strategies to reduce **potentially avoidable hospitalisations** among long-term care facility residents (Joseph Ouslander) • **Quality measurement and nursing homes**: measuring what matters (Robert E Burke, Rachel M Werner) • Relationship between **nursing home quality indicators and potentially preventable hospitalisation** (Dongjuan Xu, Robert Kane, Greg Arling) • 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) • Effect of two behavioural 'nudging' interventions on **management decisions for low back pain**: a randomised vignette-based study in general practitioners (Jason Soon, Adrian C Traeger, Adam G Elshaug, Erin Cvejic, Chris G Maher, Jenny A Doust, Stephanie Mathieson, Kirsten McCaffery, Carissa Bonner) • Variation in the delivery of **telephone advice by emergency medical services**: a qualitative study in three services (Rachel O'Hara, Lindsey Bishop-Edwards, Emma Knowles, Alicia O'Cathain) • Decisions and repercussions of **second victim experiences for mothers in medicine** (SAVE DR MoM) (Kiran Gupta, Sarah Lisker, Natalie A Rivadeneira, Christina Mangurian, Eleni Linos, Urmimala Sarkar) • Patient-reported complications related to **peripherally inserted central catheters**: a multicentre prospective cohort study (Sarah L Krein, Sanjay Saint, Barbara W Trautner, L Kuhn, J Colozzi, D Ratz, E Lescinskas, V Chopra) • Ten tips for advancing a **culture of improvement in primary care** (Tara Kiran, Noor Ramji, M B Derocher, R Girdhari, S Davie, M Lam-Antoniades) • 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)

Diagnosis
Volume 6, Issue 2 (June 2019)

URL	https://www.degruyter.com/view/j/dx.2019.6.issue-2/issue-files/dx.2019.6.issue-2.xml
Notes	A new issue of *Diagnosis* has been published as a special issue with the theme '**Health Professions Education**'. Articles in this issue of *Diagnosis* include: • Editorial: **Diagnosis education** – an emerging field (A P J Olson, G Singhal, G Dhaliwal) • **Morning report innovation**: Case Oriented Report and Exam Skills (A Goyal, B Garibaldi, G Liu, S Desai, R Manesh) • Integrating **Bayesian reasoning into medical education** using smartphone apps (B Kinnear, P A Hagedorn, M Kelleher, C Ohlinger, J Tolentino) • A simulation-based approach to **training in heuristic clinical decision-making** (G Altabbaa, A D Raven, J Laberge) • **Pediatric faculty knowledge and comfort discussing diagnostic errors**: a pilot survey to understand barriers to an educational program (J A Grubenhoff, S I Ziniel, L Bajaj, D Hyman) • A workshop to train medicine faculty to **teach clinical reasoning** (V Schaye, M Janjigian, K Hauck, N Shapiro, D Becker, P Lusk, K Hardowar, S Zabar, A Dembitzer) • Development and evaluation of a **clinical reasoning curriculum** as part of an Internal Medicine Residency Program (S Iyer, E Goss, C Browder, G Paccione, J Arnsten) • **Diagnostic uncertainty**: from education to communication (L Santhosh, C L Chou, D M Connor) • Use of **clinical reasoning tasks by medical students** (E McBee, C Blum, T Ratcliffe, L Schuwirth, E Polston, A R Artino, S J Durning) • Scaffolding **clinical reasoning of medical students** with virtual patients: effects on diagnostic accuracy, efficiency, and errors (L T Braun, K F Borrmann, C Lottspeich, D A Heinrich, J Kiesewetter, M R Fischer, R Schmidmaier) • **Understanding diagnosis through ACTion**: evaluation of a **point-of-care checklist** for junior emergency medical residents (M Kilian, J Sherbino, C Hicks, S D Monteiro) • **Internal medicine residents' evaluation of fevers overnight** (J Howard-Anderson, K E Schwab, S Chang, H Wilhalme, C J Graber, R Quinn) • Implementation of a **clinical reasoning curriculum for clerkship-level medical students**: a pseudo-randomized and controlled study (E Bonifacino, W P Follansbee, A H Farkas, K Jeong, M A McNeil, D J DiNardo) • **Diagnostic error, quality assurance, and medical malpractice/risk management education** in emergency medicine residency training programs (J J Lewis, C L Rosen, Carlo L. A V Grossestreuer, E A Ullman, N Dubosh) • **Teaching novice clinicians how to reduce diagnostic waste and errors** by applying the Toyota Production System (N S Radhakrishnan, H Singh, F S Southwick)

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: • Can a patient-directed video improve **inpatient advance care planning**? A prospective pre-post cohort study (Rajesh Nair, Samuel Abuaf Kohen) • **Patient safety superheroes in training**: using a comic book to teach patient safety to residents (Theresa Camille Maatman, Heather Prigmore, Joni Strom Williams, Kathlyn E Fletcher)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-articles
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • 'Adiós Bacteriemias': a multi-country quality improvement collaborative project to reduce the incidence of **CLABSI in Latin American ICUs** (Jafet Arrieta, Carola Orrego, Dolores Macchiavello, Nuria Mora, Pedro Delgado, Carolina Giuffré, Ezequiel García Elorrio, Viviana Rodriguez)