AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

Issue 668
30 September 2024

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On the Radar
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Status report Medication without harm – WHO Global Patient Safety Challenge: Australia's response

Australian Commission on Safety and Quality in Health Care. Status report Medication without harm – WHO Global Patient Safety Challenge. Australia's response. Sydney: ACSQHC; 2024. p. 48.
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/status-report-medication-without-harm-who-global-patient-safety-challenge-australias-response

Priority Action Status Summary Medication without harm WHO Global Patient Safety Challenge: Australia's response

Australian Commission on Safety and Quality in Health Care
Sydney: ACSQHC; 2024. p. 7.
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/priority-action-status-summary-medication-without-harm-who-global-patient-safety-challenge-australias-response

The Australian Commission on Safety and Quality in Health Care has released the *Medication without harm – WHO Global Patient Safety Challenge Status Report*. The Status report reviewed data through to 30 June 2023, and published papers and reports through to February 2024 to identify the progress towards reducing medication-related harm.

The Status report demonstrates:

- Significant improvements and steps towards reducing medication-related harms,
- Progress for some priority actions and metrics has been challenging,
- Data and knowledge gaps have been identified, and
- The importance of Quality Use of Medicines and medicines safety as Australia's 10th National Health Priority Area.

To support ongoing efforts, a *Priority Action Status Summary* has also been developed, offering a clear overview of our progress and the current status of activities.

Real-Time Prescription Monitoring resources

https://www.safetyandquality.gov.au/our-work/e-health-safety/real-time-prescription-monitoring

Real-Time Prescription Monitoring resources (RTPM) is a digital health tool that captures episodes of prescribing and dispensing of selected high-risk Schedule 4 and Schedule 8 medicines (monitored medicines) for all patients. It is designed to reduce harm associated with monitored medicines by providing important information to prescribers and pharmacists in real-time to support clinical decision-making.

As noted in the recent *Status report Medication without harm* there was a 38% reduction in deaths due to overdose from oxycodone, morphine and codeine between 2016 and 2021. This reduction is attributed to several factors including the implementation of RTPM.

Monitored medicines are not limited to opioids and include benzodiazepines and other hypnotics like zolpidem and zopiclone. States and territories have some variation in their list of monitored medicines and other legislative differences. It is important for clinicians to ensure they are familiar with all legal and professional obligations related to RTPM.

Despite the widely recognised benefits of RTPM in harm minimisation, the RTPM systems do have some limitations including some instances of prescribing and dispensing that may not be captured in RTPM. The circumstances or scenarios that might trigger an alert in RTPM also differ between jurisdictions. Clinicians can ensure best practice by:

- Checking the full patient record in RTPM before prescribing or dispensing a monitored medicine;
- Conducting a risk assessment that includes information from a variety of sources in addition to RTPM;
- Ensuring that clinical decisions are person-centred and uphold the values of patient safety and continuity of care.

To support prescribers and pharmacist with the use of RTPM in clinical practice, the Commission has published a suite of implementation resources. The resources include a fact sheet, a risk management guide and a conversation guide. These are available to download from the Commission's website at https://www.safetyandquality.gov.au/our-work/e-health-safety/real-time-prescription-monitoring, which also provides an overview of state and territory RTPM systems and monitored medicines lists.

Reports

Victorian Safety Culture Guide
Safer Care Victoria
Melbourne: SCV; 2024.

URL	https://www.safercare.vic.gov.au/publications/victorian-safety-culture-guide
Notes	Safer Care Victoria has released this, their first *Victorian Safety Culture Guide* (VSCG). The Guide is intended to support healthcare leaders to measure and monitor their organisation's safety culture. According to the SCV, the Guide: • facilitates proactive measurement and monitoring to prevent harm and promote safer, continuously improving health care • offers actionable strategies, practical approaches, and best practices for improving safety culture across all Victorian healthcare services • allows leaders to make data-driven decisions to support the implementation of targeted changes to improve safety culture • uses a variety of existing methods and approaches widely available in most Victorian health services. 

Morbidity and Mortality meetings – Framework and toolkit
Safer Care Victoria
Melbourne: SCV; 2024.

URL	https://www.safercare.vic.gov.au/publications/morbidity-and-mortality-meetings-framework-and-toolkit
Notes	Safer Care Victoria has also released this framework and toolkit to promote a structured review process for Morbidity & Mortality (M&M) meetings in Victoria. The toolkit includes a number of templates for structuring, documenting and reporting on M&M meetings. According to the SCV, using the framework and toolkit will help health services to: • improve the quality and consistency of M&M meetings • improve staff psychological safety in meetings • develop stronger recommendations to improve quality and safety of care.

Electronic patient record systems: Putting patient safety at the heart of implementation
Patient Safety Learning
London: Patient Safety Learning; 2024. p. 31.

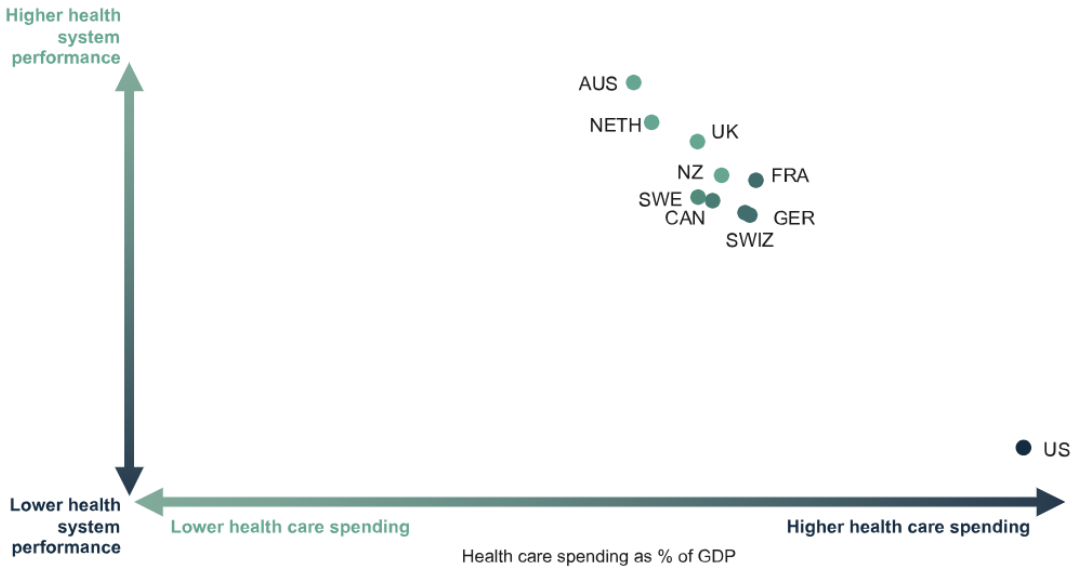
URL	https://www.pslhub.org/learn/patient-safety-learning/electronic-patient-record-systems-putting-patient-safety-at-the-heart-of-implementation-patient-safety-learning-31-july-2024-r11859/
Notes	The UK charity Patient Safety Learning have produced this report that looks into the implementation of electronic patient record systems, particularly in the UK context. Drawing on a roundtable event, the report examines the potential patient safety risks such systems may allow. The report identified ten principles for safe EPR system implementation: • There should be robust standards for ensuring safety in EPR implementation and operationalisation. These standards should be accompanied by strong quality assurance and accountability mechanisms. • Patients should be engaged and involved in each stage of the implementation and delivery of EPR systems. • EPR system implementations should be planned and delivered as major organisational change programmes, not simply technical IT projects. • Healthcare professionals and those who will be the primary users of EPR systems should be involved in each stage of their design, planning and implementation. • There should be Board-level and senior leadership champions for EPR implementation programmes. These staff should be properly trained and experienced with the expertise to guide, support, and if necessary, challenge. • Communities of practice in EPR system implementation should be established to share knowledge, provide support and access to guidance. • Human factors experts should have a central role in EPR implementation, from design through to product selection and operationalisation. • Clinical Safety Officers, who play a key role in the success of EPR implementations, need to be expertly trained, resourced and supported. • Incident reporting and investigations should capture EPR-related safety issues and this should inform improvement in the future design and implementation of EPR systems. • Learning from EPR implementations should be shared transparently and widely across the healthcare system to ensure that risks are mitigated and managed, and to inform safety improvements. This relates to both NHS and independent sector organisations as well as with suppliers and procurement staff.

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System: Comparing Performance in 10 Nations
Blumenthal D, Gumas ED, Shah A, Gunja MZ, Williams II RD
New York: The Commonwealth Fund; 2024.

DOI	https://doi.org/10.26099/ta0g-zp66
Notes	The latest iteration of the Commonwealth Fund's comparative survey of health systems sought to compare the performance of their health care systems has been released. As has been the case in most of these surveys, the USA performs poorly against its peers while Australia generally compares well. In this case 10 nations were assessed on 70 health system performance measures in five areas: access to care, care process, administrative efficiency, equity, and health outcomes. The report notes that 'The top three countries are Australia, the Netherlands, and the United Kingdom, although differences in overall performance between most countries are relatively small. The only clear outlier is the U.S., where health system performance is dramatically lower.'

EXHIBIT 4 — *Performance vs. Spending*

Health Care System Performance Compared to Spending



Notes: GDP = gross domestic product. Health care spending as a percentage of GDP. Performance scores are based on standard deviation calculated from the nine-country average that excludes the US. See "How We Conducted This Study" for more detail.

Data: Spending data are from OECD for the year 2022 and 2023 (updated in July 2024).

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024).

Journal articles

What is safety leadership? A systematic review of definitions
Adra I, Giga S, Hardy C, Leka S
Journal of Safety Research. 2024;90:181-191.

DOI	https://doi.org/10.1016/j.jsr.2024.04.001
Notes	Paper reviewing the literature on 'safety leadership'. The review found 37 'primary definitions' of which 'seven conceptual definitions were found to be evidence-based'. As noted in an AHRQ PSnet summary (https://psnet.ahrq.gov/issue/what-safety-leadership-systematic-review-definitions) 'Three themes were derived from the definitions: 1) safety leadership improves safety performance; 2) safety leaders lead by influence and example, not authority; and 3) safety leadership can be practiced by leaders at all levels of the organization.'

Journal of Patient Safety
Volume 20, Issue 7, October 2024

URL	https://journals.lww.com/journalpatientsafety/toc/2024/10000
Notes	A new issue of the *Journal of Patient Safety* has been published Articles in this issue of the *Journal of Patient Safety* include: • Using a Patient Portal to Screen Patients for **Symptoms After Starting New Medications** (Sonam Shah, Alejandra Salazar, Samuel Bennett, Aneesha Fathima, Renuka Kandikatla, Tewodros Eguale, Maria Mirica, Pamela Garabedian, Lynn A Volk, Adam Wright, Gordon D. Schiff) • The Nature of **Adverse Events in Dentistry** (Bunmi Tokede, Alfa Yansane, Muhammad Walji, D Brad Rindal, Donald Worley, Joel White, E Kalenderian) • Comparing Guidelines to Daily Practice When **Screening Older Patients for the Risk of Functional Decline in Hospitals**: Outcomes of a Functional Resonance Analysis Method (FRAM) Study (Meggie D Meulman, Hanneke Merten, Barbara van Munster, Cordula Wagner) • Implementation and Evaluation of **Clinical Decision Support for Apixaban Dosing** in a Community Teaching Hospital (Rebecca Cope, Maram Sarsour, Evan Sasson, Hasan Badran, Ka Yeun Kim, Rachel Quinn) • **Care Home Safety Incidents** and Safeguarding Reports Relating to Hospital to Care Home Transitions: A Retrospective Content Analysis (Craig Newman, Stephanie Mulrine, Katie Brittain, Pamela Dawson, Celia Mason, Michele Spencer, Kate Sykes, Lesley Young-Murphy, Justin Waring, Jason Scott) • **Introduction of a Novel Patient Safety Advisory**: Evaluation of Perceived Information With a Modified QPP Questionnaire—A Case-Control Study (Bojan Tubic, Margareta Bånnsgård, Susanne Gustavsson, My Engström, Johanna Moreno, Caterina Finizia) • Development and Psychometric Analysis of a **Patient-Reported Measure of Diagnostic Excellence** for Emergency and Urgent Care Settings (Kelly T Gleason, Vadim Dukhanin, Susan K Peterson, Natalia Gonzalez, J M Austin, K M McDonald) • Situations and Risk Factors of **Unplanned Extubation of Nasogastric Tubes** in Inpatients: A Retrospective Study (Wen-Pei Chang, Yen-Kuang Lin) • **Patient Harm Events and Associated Cost Outcomes** Reported to a Patient Safety Organization (Susanne Miller, David C Stockwell, the Pascal Metrics PSO Collaborative)

	• Translation and Comprehensive Validation of the Hebrew Survey on **Patient Safety Culture** (HSOPS 2.0) (Yaffa Ein-Gal, Roni Sela, Dana Arad, Martine Szyper Kravitz, Shuli Hanhart, N Goldschmidt, E Kedmi-Shahar, Y Bitan) • **Compensation After Surgical Treatment for Hallux Valgus**: A Review of 369 Claims to the Norwegian System of Patient Injury Compensation 2010–2020 (Per-Henrik Randsborg, Tommy Frøseth Aae, Ida Rashida Khan Bukholm, Rune Bruhn Jakobsen) • Defects in Value Associated With **Hospital-Acquired Conditions**: How Improving Quality Could Save U.S. Healthcare $50 Billion (William V Padula, Peter J Pronovost) • Estimating the Effect of **Disclosure of Patient Safety Incidents in Diagnosis-Related Patient Safety Incidents**: A Cross-sectional Study Using Hypothetical Cases (Noor Afif Mahmudah, Dasom Im, Minsu Ock) • The Relationship Between Work Environment and **Missed Nursing Care** in Nurses: The Moderator Role of Profession Self-Efficacy (Cennet Çiriş Yildiz, Seda Değirmenci Öz, Berra Yilmaz Kuşakli, Irem Korkmaz) • From Theory to Policy in Resilient Health Care: Policy Recommendations and Lessons Learnt From the **Resilience in Health Care Research Program** (Siri Wiig, Hilda Bø Lyng, Veslemøy Guise, Eline Ree, Birte Fagerdal, Heidi Dombestein, Lene Schibevaag, Jeffrey Braithwaite, C Haraldseid-Driftland)

The Joint Commission Journal on Quality and Patient Safety
Volume 50, Issue 10, October 2024

URL	https://www.sciencedirect.com/journal/the-joint-commission-journal-on-quality-and-patient-safety/vol/50/issue/10
Notes	A new issue of *The Joint Commission Journal on Quality and Patient Safety* has been published. Articles in this issue of *The Joint Commission Journal on Quality and Patient Safety* include: • Editorial: Will **Ambulatory Safety Nets** Go Viral? (Lawrence Lurvey, Lyn Yasumura, Elena Martinez) • Reducing the Risk of **Delayed Colorectal Cancer Diagnoses** Through an Ambulatory Safety Net Collaborative (Rachel Moyal-Smith, Meagan Elam, J Boulanger, R Balaban, J E Cox, R Cunningham, P Folcarelli, M C Germak, K O'Reilly, M Parkerton, N W Samuels, F Unsworth, L Sato, E Benjamin) • Effective Use of **Interpreter Services for Diverse Patients** in a Safety-Net Hospital: Provider Perceptions of Barriers and Solutions (Ian R Slade, Aspen D Avery, C Gonzalez, C Chung, Q Qiu, Y M Simpson, C Ector, M S Vavilala) • A Review of Modifiable Health Care Factors Contributing to **Inpatient Suicide**: An Analysis of Coroners' Reports Using the Human Factors Analysis and Classification System for Healthcare (P Sweeting, M Finlayson, D Hartz) • Reducing **Inappropriate Stat Echocardiograms**: A Quality Improvement Initiative (RISE-QI) (Christopher Scoma, Nidhi Patel) • Developing, Implementing, Evaluating **Electronic Apparent Cause Analysis** Across a Health Care System (C A Oster, E Woods, J Mumma, D J Murphy) • **Multi-Team Shared Expectations Tool (MT-SET)**: An Exercise to Improve Teamwork Across Health Care Teams (Jill A Marsteller, Michael A Rosen, Rhonda Wyskiel, Bickey H Chang, Yea-Jen Hsu, David A Thompson, George Kim, Kathleen Speck, Mayowa Ijagbemi, Shu Huang, Ayse P Gurses) • The Joint Commission Journal on Quality and Patient Safety 50th Anniversary Article Collections: **Quality Improvement in Non-Hospital Settings**

BMJ Leader
Volume 8, Number 3

DOI	https://bmjleader.bmj.com/content/8/3
Notes	A new issue of *BMJ Leader* has been published. Articles in this issue of *BMJ Leader* include: • Protecting patients and learners: **educational leadership on the fringes** (Sanjiv Ahluwalia, Elizabeth Hughes) • **Reducing unwarranted variation**: can a 'clinical dashboard' be helpful for hospital executive boards and top-level leaders? (Ole Tjomsland, Christian Thoresen, Tor Ingebrigtsen, Eldar Søreide, Jan C Frich) • **Inclusive leadership** in the health professions and health professions education (Rashmi A Kusurkar) • Integrating **leadership into the undergraduate medical curriculum** in the UK: a systematic review (Zeynab Hemmati, Susan Harris) • Calculator for predicting the **probability of faculty promotion** in an academic medical centre (May May Yeo, Shih-Hui Lim, Anshul Kumar, Anne W Thompson) • Investigating the influence of selected **leadership styles on patient safety and quality of care**: a systematic review and meta-analysis (Ankit Singh, Rajiv Yeravdekar, Sammita Jadhav) • UK **trainees' perceptions of leadership** and leadership development (Iain Snelling, Hilary Brown, Louise Hardy, Lara Somerset, Samantha Bosence, Jane Thurlow) • Evaluation of the **promotion criteria** in an academic medical centre in Singapore (May May Yeo, Shih-Hui Lim, Anshul Kumar, Anne W Thompson) • **Gender and ethnicity intersect to reduce participation** at a large European hybrid HIV conference (Alice Howe, Yize I Wan, Yvonne Gilleece, Karoline Aebi-Popp, Rageshri Dhairyawan, Sanjay Bhagani, Sara Paparini, Chloe Orkin) • Rethinking **leadership approaches for community-wide opioid crisis intervention**: harnessing positive inquiry to unearth front-line insight (Thomas Patrick Huber) • Insights for **enhancing resilience in prolonged crises**: impact of COVID-19 pandemic on nurses' quality of life (Saleh Salimi, Selman Özel) • **Inequitable barriers and opportunities for leadership and professional development**, identified by early-career to mid-career allied health professionals (Laura Mizzi, Patrick Marshall) • Association between **servant leadership and nurses' turnover intention**: evidence from Jordan (Main Naser Alolayyan, Farid T Nusairat, Serien A Abualhuda, Suad Azar) • **Leadership development as part of quality improvement** in district general hospitals (Patrick Cook, Akul Purohit) • Health and social care professional standards need to be updated to advance **leadership and action for environmental sustainability and planetary health** (Sarah Walpole, Aneka Popat, Emma Pascale Blakey, Eleanor Holden, Ben Whittaker, Ravijyot Saggu, Amarantha Fennell-Wells, Kirsten Armit, Daljit Hothi) • Introducing a framework to support the identification and tackling of **health inequalities within specialised services** (Shaun McGill, Nathan Davies, Dianne Addei, Dhiren Bharkhada, Rebecca Elleray, Robert Wilson, Matthew Day)

BMJ Quality & Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality &Safety* has published a number of 'online first' articles, including: • Prevention in adults of **transmission of infection with multidrug-resistant organisms**: an updated systematic review from Making Healthcare Safer IV (Sean McCarthy, Aneesa Motala, Paul G Shekelle)

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: • **Optimizing Warfarin and Dual Oral Anticoagulation Practices** in an Academic Clinic During a Merger Amid the COVID-19 Pandemic in a Marginalized Population (Ronak Bahuva et al) • The Future of Global **Graduate Training in Quality Improvement and Patient Safety** (Yash B Shah et al)

Online resources

Australian Living Evidence Collaboration
https://livingevidence.org.au/

[USA] AHRQ Perspectives on Safety
https://psnet.ahrq.gov/psnet-collection/perspectives
The US Agency for Healthcare Research and Quality (AHRQ) publishes occasional Perspectives on Safety essays. Recent essays include:

- *Zero Harm: Striving to Reduce Preventable Harms – Point, Counterpoint, and Areas of Agreement*
  https://psnet.ahrq.gov/perspective/zero-harm-striving-reduce-preventable-harms-point-counterpoint-and-areas-agreement

COVID-19 resources

https://www.safetyandquality.gov.au/covid-19

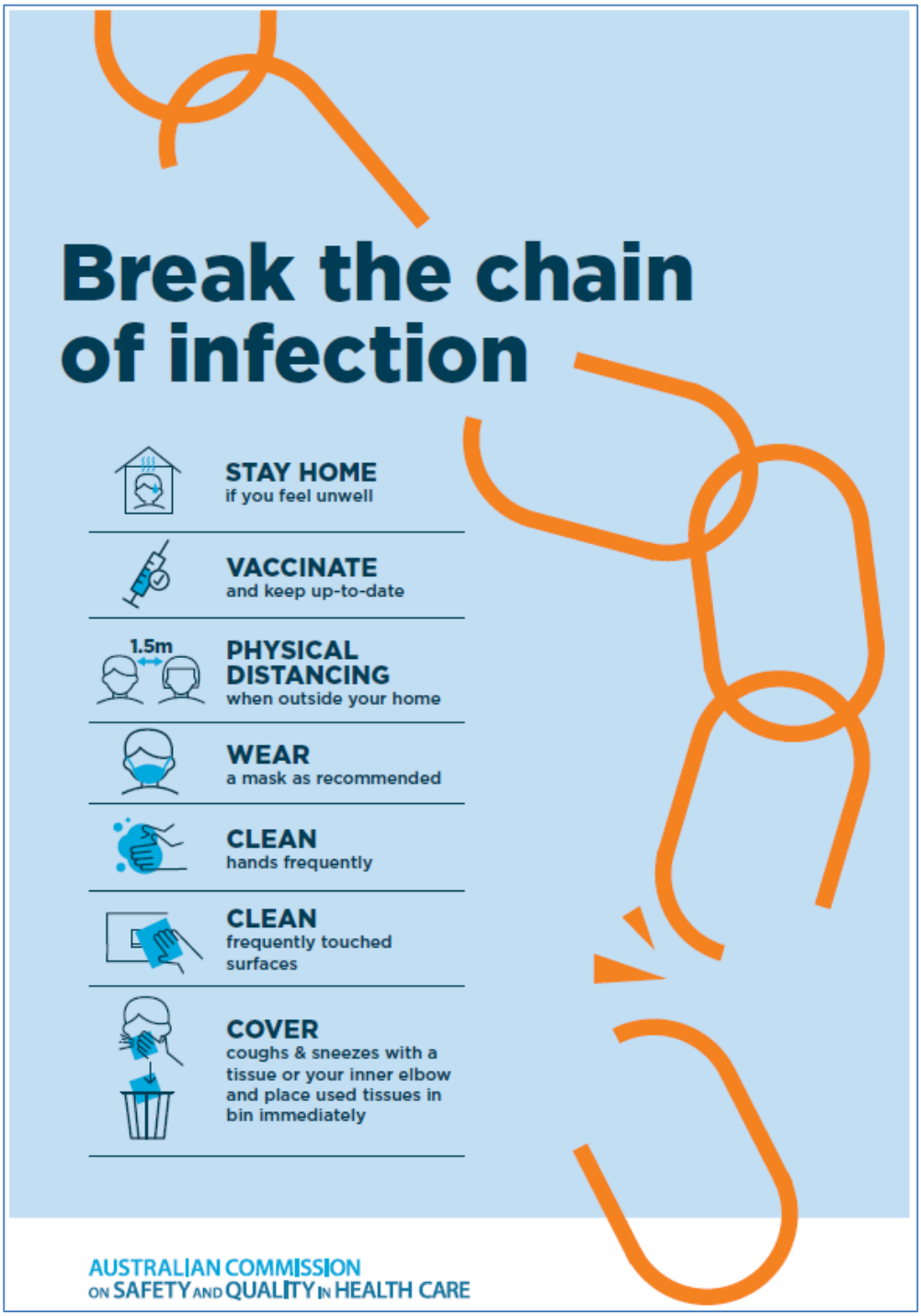
The Australian Commission on Safety and Quality in Health Care has developed a number of resources to assist healthcare organisations, facilities and clinicians. These and other material on COVID-19 are available at https://www.safetyandquality.gov.au/covid-19

These resources include:

- *Poster – Combined contact and droplet precautions*
  https://www.safetyandquality.gov.au/publications-and-resources/resource-library/infection-prevention-and-control-poster-combined-contact-and-droplet-precautions

- *Poster – Combined airborne and contact precautions*
  https://www.safetyandquality.gov.au/publications-and-resources/resource-library/infection-prevention-and-control-poster-combined-airborne-and-contact-precautions

- *Environmental Cleaning and Infection Prevention and Control* www.safetyandquality.gov.au/environmental-cleaning
- *COVID-19 infection prevention and control risk management – Guidance* https://www.safetyandquality.gov.au/publications-and-resources/resource-library/covid-19-infection-prevention-and-control-risk-management-guidance
- *Safe care for people with cognitive impairment during COVID-19* https://www.safetyandquality.gov.au/our-work/cognitive-impairment/cognitive-impairment-and-covid-19
- *Break the chain of infection* poster https://www.safetyandquality.gov.au/publications-and-resources/resource-library/break-chain-infection-poster



- *COVID-19 and face masks – Information for consumers*
  https://www.safetyandquality.gov.au/publications-and-resources/resource-library/covid-19-and-face-masks-information-consumers

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

INFORMATION
for consumers

COVID-19 and face masks

Should I use a face mask?

Wearing face masks may protect you from droplets (small drops) when a person with COVID-19 coughs, speaks or sneezes, and you are less than 1.5 metres away from them. Wearing a mask will also help protect others if you are infected with the virus, but do not have symptoms of infection.

Wearing a face mask in Australia is recommended by health experts in areas where community transmission of COVID-19 is high, whenever physical distancing is not possible. Deciding whether to wear a face mask is your personal choice. Some people may feel more comfortable wearing a face mask in the community.

When thinking about whether wearing a face mask is right for you, consider the following:

- Face masks may protect you when it is not possible to maintain the 1.5 metre physical distance from other people e.g. on a crowded bus or train
- Are you older or do you have other medical conditions like heart disease, diabetes or respiratory illness? People in these groups may get more severe illness if they are infected with COVID-19
- Wearing a face mask will reduce the spread of droplets from your coughs and sneezes to others (however, if you have any cold or flu-like symptoms you should stay home)
- A face mask will not provide you with complete protection from COVID-19. You should also do all of the other things listed below to prevent the spread of COVID-19.

What can you do to prevent the spread of COVID-19?

Stopping the spread of COVID-19 is everyone's responsibility. The most important things that you can do to protect yourself and others are to:

- Stay at home when you are unwell, with even mild respiratory symptoms
- Regularly wash your hands with soap and water or use an alcohol-based hand rub
- Do not touch your face
- Do not touch surfaces that may be contaminated with the virus
- Stay at least 1.5 metres away from other people (physical distancing)
- Cover your mouth when you cough by coughing into your elbow, or into a tissue. Throw the tissue away immediately.

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