AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

Reports

Which way to quality? Key perspectives on quality improvement in Canadian health care systems
Health Council of Canada
Toronto: Health Council of Canada, 2013.

Notes	This report highlights the range of approaches to measuring and improving quality being used across Canada based upon interviews with senior health system leaders. The report also calls for the establishment of common and measureable goals to achieve quality improvement.
URL	http://healthcouncilcanada.ca/rpt_det.php?id=455
TRIM	77404

Journal articles

Surviving sepsis campaign: international guidelines for management of severe sepsis and septic shock: 2012
Dellinger RP, Levy MM, Rhodes A, Annane D, Gerlach H, Opal SM, et al.
Critical Care Medicine 2013;41(2):580-637.

Notes	Updated guidelines on sepsis treatment and management to guide care for patients with sepsis based on recommendations following an international consensus process.
DOI / URL	http://dx.doi.org/10.1097/CCM.0b013e31827e83af Full free text http://www.sccm.org/Documents/SSC-Guidelines.pdf

The effect of a checklist on the quality of post-anaesthesia patient handover: a randomized controlled trial
Salzwedel C, Bartz H-J, Kühnelt I, Appel D, Haupt O, Maisch S, et al.
International Journal for Quality in Health Care 2013;25(2):176-181.

Notes	Checklists have been recommended, developed and enhanced in many areas of care. This article reports on the use of a checklist in post-anaesthesia handover. The authors examined whether a checklist for handover between anaesthesiologist and post-anaesthesia care unit nurse would increase the amount of information transfer. The study examined 120 post-anaesthesia patient handovers – 40 prior to the implementation of the checklist and 80 after and measured the number of items handed over, handover of specific items and duration of the handover. It is reported that use of a checklist led to the overall items handed over increasing from a median of 32.4 to 48.7%. The duration of handover increased from a median of 86s to 121 seconds. This led the authors to argue that "that the **use of a checklist for post-anaesthesia handover might improve the quality of patient handover** by increasing the information handed over."
DOI	http://dx.doi.org/10.1093/intqhc/mzt009

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

A theory-driven, longitudinal evaluation of the impact of team training on safety culture in 24 hospitals
Jones KJ, Skinner AM, High R, Reiter-Palmon R
BMJ Quality & Safety 2013 [epub].

Notes	The importance of teams in healthcare delivery and thus of team training has garnered much attention in recent years. This paper examined whether team training had an impact on the safety culture in 24 US hospitals. The key finding is that team training can have an impact but the environment has to be conducive. The authors concluded "**Team training can result in transformational change in safety culture** when the work environment supports the transfer of learning to new behaviour."
DOI	http://dx.doi.org/10.1136/bmjqs-2012-000939

Creating an Infrastructure for Safety Event Reporting and Analysis in a Multicenter Pediatric Emergency Department Network
Chamberlain JM, Shaw KN, Lillis KA, Mahajan PV, Ruddy RM, Lichenstein R, et al
Pediatric Emergency Care 2013;29(2):125-130.

Notes	This study describes how a network of US hospital emergency departments combined to develop a network-wide incident reporting (and learning) mechanism. The authors report that from 18 sites a total of 3,106 incident reports were submitted, with reporting rates ranged more than 50-fold from 0.12 to 6.13 per 1000 patients across the hospitals. Data were sufficient to determine type of error (90% of IRs), severity (79%), staff involved (82%), and contributing factors (82%). However, contributing factors were clearly identified in only 44% of IRs and required extrapolation by investigators in 38%. The **most common incidents** were related to **laboratory specimens** (25.5%), **medication administration** (19.3%), and **process variance**, such as delays in care (14.4%). The authors conclude that "Incident reporting provides qualitative data concerning safety events. Perceived legal barriers to sharing confidential data can be addressed. Large variability in reporting rates and low rates of providing contributing factors suggest a need for standardization and improvement of safety event reporting."
DOI	http://dx.doi.org/10.1097/PEC.0b013e31828043a5

Peer Review Comments Augment Diagnostic Error Characterization and Departmental Quality Assurance: 1-Year Experience From a Children's Hospital.
Iyer RS, Swanson JO, Otto RK, Weinberger E.
American Journal of Roentgenology 2013;200(1):132-137.

Notes	The issue of errors in diagnosis has been attracting a degree of attention. This article describes how a peer review process may be used to identify radiology diagnosis errors. The study involved analysing all 427 "randomly entered radiology peer review comments" at a US children's hospital in 2011. The authors report that the comments could be classified into one of seven broad categories: **errors of observation** (25.5%), **errors of interpretation** (5.6%), **inadequate patient data gathering** (3.7%), **errors of communication** (9.6%), **inter-observer variability** (21.3%), informational and educational **feedback** (23.0%), and complimentary (11.2%). The authors suggest that such a process could have a number of benefits as "Comment-enhanced peer review expands traditional diagnostic error classification, may identify errors that were underscored, provides continuous educational feedback for participants, and promotes a collegial environment."
DOI	http://dx.doi.org/10.2214/AJR.12.9580 http://www.ajronline.org/doi/abs/10.2214/AJR.12.9580

A Pilot Project Using Evidence-Based Clinical Pathways And Payment Reform In China's Rural Hospitals Shows Early Success
Cheng T-M.
Health Affairs 2013 [epub].

Notes	It has been suggested that researchers, policy makers, etc can have too narrow a range of sources of evidence. Conversely there is an argument that evidence has to be transferable to your context. Notwithstanding these arguments is this piece on hospital health reform in China, the abstract of which reads: "Reforming China's public hospitals to curb widespread overtreatment and

	improve the quality and affordability of care has been the most challenging aspect of that nation's ambitious health reform, which began in 2009. This article describes a pilot project under way in several of China's provinces that combines payment reform with the implementation of evidence-based clinical pathways at a few hospitals serving rural areas. Results to date include reduced length-of-stay and prescription drug use and higher patient and provider satisfaction. These early results suggest that the pilot may be achieving its goals, which may have far-reaching and positive implications for China's ongoing reform." Such challenges are not unique to China; however the sustainability and the transferability of such approaches to other contexts are clearly out of scope for this paper.
DOI / URL	http://dx.dio.org/10.1377/hlthaff.2012.0640 http://content.healthaffairs.org/content/early/2013/04/01/hlthaff.2012.0640.abstract

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • **Parent perceptions of children's hospital safety climate** (Elizabeth D Cox, Pascale Carayon, Kristofer W Hansen, Victoria P Rajamanickam, Roger L Brown, Paul J Rathouz, Lori L DuBenske, M M Kelly, L A Buel)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • **Ventilator-associated pneumonia** prevention by education and two combined bedside strategies (William Nascimento Viana, Cristiane Bragazzi, José Eduardo Couto de Castro, Mariane Branco Alves, and José Rodolfo Rocco) • **Patient safety incident-reporting** items in Korean hospitals (Jee-In Hwang, Sang-Il Lee, and Hyeoun-Ae Park) • Afghanistan's **national strategy for improving quality** in health care (Mirwais Rahimzai, Mirwais Amiri, Nadera Hayat Burhani, Sheila Leatherman, Simon Hiltebeitel, and Ahmed Javed Rahmanzai)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

Connect and Engage with Continuous Quality Improvement (CQI) Network – CQIconnect
The Lowitja Institute is pleased to announce the establishment of a Continuous Quality Improvement (CQI) network under the institute's Research Program 1: Healthy Start Healthy Life. The CQIconnect network is one of the 'yarning places' in the Australian Indigenous HealthInfoNet. CQIconnect is a space where health and community workers, researchers, policy makers and anyone working on CQI in Aboriginal and Torres Strait Islander primary health care can stay connected, discuss common interests, exchange ideas and ask questions. It also aims to feed the HealthInfoNet bibliography with grey literature from members' suggestions.
The Lowitja Institute would like to invite you and your colleagues to become a member of CQIconnect. To do so, first go to the Australian Indigenous HealthInfoNet yarning places (http://yarning.org.au/) to become a member, and then navigate to the CQIconnect yarning place and click 'join'.

[USA] Engaging Patients in Improving Ambulatory Care
http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/03/engaging-patients-in-improving-ambulatory-care.html?
The (US) Robert Wood Johnson Foundation has put together this 'toolkit' showing how primary care practices are involving patients in quality improvement efforts as part of their Aligning Forces for Quality (AF4Q) project. The toolkit features videos and a "compendium of adaptable resources from three AF4Q alliances—Maine, Oregon, and Humboldt County, Calif.—to introduce the concept of partnering with patients and families in primary care and share lessons learned". The resources includes a variety of tools that health care organisations in these communities have used in their efforts to engage patients. These tools can help recruit, orient, and train patients; clarify roles and responsibilities; and put a structure in place to foster relationships. The accompanying video segments offer lessons and tips for effectively working with patients to improve care.

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