AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Books

Resilient Health Care
Hollnagel E, Braithwaite J, Wear RL, editors
Ashgate, 2013.

Notes	From the publisher's website: "Health care is …under tremendous pressure with regard to efficiency, safety, and economic viability … and has responded by eagerly adopting techniques that have been useful in other industries, such as quality management, lean production, and high reliability. This has on the whole been met with limited success because health care as a non-trivial and multifaceted system differs significantly from most traditional industries. In order to allow health care systems to perform as expected and required, it is necessary to have concepts and methods that are able to cope with this complexity. Resilience engineering provides that capacity because its focus is on a system's overall ability to sustain required operations under both expected and unexpected conditions rather than on individual features or qualities. Resilience engineering's unique approach emphasises the usefulness of performance variability, and that successes and failures have the same aetiology.

	This book contains contributions from acknowledged international experts in health care, organisational studies and patient safety, as well as resilience engineering. Whereas current safety approaches primarily aim to reduce or eliminate the number of things that go wrong, *Resilient Health Care* aims to increase and improve the number of things that go right. Just as the WHO argues that health is more than the absence of illness, so does *Resilient Health* Care argue that safety is more than the absence of risk and accidents. This can be achieved by making use of the concrete experiences of resilience engineering, both conceptually (ways of thinking) and practically (ways of acting)."
URL	http://www.ashgate.com/isbn/9781409469780

Reports

Partnering with patients to drive shared decisions, better value, and care improvement: Workshop proceedings
Institute of Medicine
Washington D.C. The National Academies Press, 2013.

Notes	The (US) Institute of Medicine's Roundtable on Value & Science-Driven Health Care held a workshop, titled Partnering with Patients to Drive Shared Decisions, Better Value, and Care Improvement, on 25–26 February, 2013. The workshop focused on identifying and exploring issues, attitudes, and approaches to increasing patient engagement in and demand for the following: shared decision making and better communication about the evidence in support of testing and treatment options; the best value from the health care they receive; and the use of data. The workshop hoped to build awareness and demand from patients and families for better care at lower costs and to create a health care system that continuously learns and improves. Participants included members of the medical, clinical research, health care services research, regulatory, health care economics, behavioural economics, health care delivery, payer, and patient communities. *Partnering with Patients to Drive Shared Decisions, Better Value, and Care Improvement Workshop Proceedings* provides a summary of the 2-day workshop.
URL	http://www.nap.edu/catalog.php?record_id=18397
TRIM	85664

Proactive Risk Assessment of Surgical Site Infections in Ambulatory Surgery Centers. Final Report
Slonim, AD, Bish, EK, Steighner, LA, Zeng, X, & Crossno, R.
(Prepared by the American Institutes of Research under Contract No. 290-06-00019i-12).
AHRQ Publications No. 12-0045-EF.
Rockville, MD: Agency for Healthcare Research and Quality. March 2012.

Notes	Report produced for the US Agency for Healthcare Research and Quality (AHRQ) that examines the use of a proactive risk assessment to identify hazards that can lead to surgical site infections (SSIs) in the ambulatory surgery centre setting. The report describes the use of a tool, the Socio-Technical Probabilistic Risk Assessment (ST-PRA), to estimate the risk of SSI in the ambulatory surgery environment, examines single point failures as well as combinations of events that lead to the outcome of interest, and proposes an intervention for future deployment.
URL	http://www.ahrq.gov/research/findings/final-reports/stpra/stpra.pdf

Journal articles

Parent willingness to remind health care workers to perform hand hygiene
Buser GL, Fisher BT, Shea JA, Coffin SE
American Journal of Infection Control 2013;41(6):492-496.

Notes	It has been suggested that one way to encourage/prompt health workers to achieve higher rates of hand hygiene is for patients/consumers to prompt or challenge their health workers. However, for many patients this is a daunting prospect, including concerns about the relationship with the health worker. This particular study interviewed 115 parents of hospitalised children in a US children's hospital. The authors report that "84% were aware of [healthcare care associated infection] HAI. Most parents (78%) perceived [hand hygiene] HH as the most important practice to prevent HAI. However, only 67% would definitely remind a HCW to perform HH. Importantly, 92% said that an invitation from a HCW would make them more likely to remind a HCW to do HH in the future." This is another example of how engagement of patients and consumers may enhance the safety and quality of care delivery.
DOI	http://dx.doi.org/10.1016/j.ajic.2012.08.006

For more information on the Commission's work on healthcare associated infection, see
http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/
Also see Hand Hygiene Australia's website at http://www.hha.org.au/

Reducing cardiac arrests in the acute admissions unit: a quality improvement journey
Beckett DJ, Inglis M, Oswald S, Thomson E, Harley W, Wilson J, et al
BMJ Quality & Safety 2013 [epub].

Notes	Article documenting how a Scottish hospital's (Stirling Royal Infirmary) acute admissions unit successfully reduced its rate of cardiac arrests. Following a needs assessment, three initiatives to improve cardiac arrest rate: were undertaken: (1) structured response to deteriorating patients; (2) analysis of adverse events; and (3) improved end-of-life decision-making. A failure modes effects analysis to identify reasons for the failure of early recognition and response was also undertaken. Weekly safety meetings to engage unit staff and promote a safety culture of continuous improvement were held. Later, a ward-based clinical team structure with twice daily consultant ward rounds was implemented. The authors report that over 17 months, **cardiac arrests** per 1000 admissions **fell from** a baseline of **2.8/1000 admissions to 0.8/1000 admissions** (**71%** reduction), referrals to palliative care increased by 22 to 37/1000 admissions per month (68% increase) and the **30-day mortality** of patients admitted to the AAU **fell from 6.3% to 4.8%** (24% relative reduction). The authors conclude that "Through adoption of a **shared goal**, application of **improvement methodology** including the model for improvement to test new innovations, and promotion of a **safety culture** in the AAU, **cardiac arrests were successfully reduced** to <1/1000 admissions per month with an associated significant **fall in mortality**. This was achieved with **negligible cost**."
DOI	http://dx.doi.org/10.1136/bmjqs-2012-001404

What is quality primary dental care?
Campbell S, Tickle M
British Dental Journal 2013;215(3):135-139.

Notes	Establishing what is quality care is not a trivial task in any domain. This article, in the *British Dental Journal*, notes that here is a little agreement in the literature as to what quality really means in primary dental care and asserts that without a true understanding it is difficult to measure and improve quality in a systematic way. 'Quality' of healthcare in dentistry may mean different things to practitioners, policy makers and patients but it is suggested that a framework could be modelled on other definitions within different healthcare sectors, with focus on access, equity and overall healthcare experience.
DOI	http://dx.doi.org/10.1038/sj.bdj.2013.740

Patient Safety in Hospitals – A Bayesian analysis of unobservable hospital and speciality level risk factors
Zhang X, Hauck K, Zhao X
Health Economics 2013 [epub].

Notes	Administrative (morbidity) data is regarded as a potentially useful source of information on safety and quality. This paper reports on a further analysis of a Victorian admitted patient data set from 2005/06 containing a 'condition onset flag' to denote diagnoses acquired during an episode of care. In this study, Bayesian hierarchical modelling was used to analyse these data for 35 hospitals across 16 specialties to: • determine in what clinical area, and at what organisational level, there is greatest scope for potential improvements in the quality of hospital care • interpret the unobservable hospital and specialty level effects as an indication of hospital managers and medical staff's potential in improving patient safety at organisational level. The results suggest that variation in the aggregate complications is greater for elective than emergency patients, suggesting **greater scope for improvement in elective care**. In terms of **specialties**, higher than expected complication rates as well as a greater level of variation in these between hospitals) was found in **nephrology emergency** episodes. The reverse was true for elective general surgery and emergency orthopaedics, leading the authors to surmise that these specialties were unlikely to benefit as greatly from quality improvement efforts. The data were also used to examine which hospital can potentially improve safety and quality in which specialty. There was little consistency in performance across specialties within the same hospital – i.e. a hospital may perform well in one specialty yet worse than expected for its particular casemix in another. As with all such analyses there exist a number of assumptions and limitations, such as issues with casemix adjustment, coding, and 'preventability' as well as the existence of effective interventions to improve quality in various specialties. The authors advise that the results should not be "used to punish poorly performing hospitals". Nevertheless, this may be a useful method for management and policy makers to harness administrative data to provide a more detailed and nuanced picture of, and information on, performance.
DOI	http://dx.doi.org/10.1002/hec.2972

For more information on the Commission's joint project with the Independent Hospital Pricing Authority, see http://www.safetyandquality.gov.au/national-priorities/jwp-acsqhc-ihpa/

What attributes of patients affect their involvement in safety? A key opinion leaders' perspective
Buetow S, Davis R, Callaghan K, Dovey S
BMJ Open 2013, 3

Notes	This article identifies—from the perspective of key opinion leaders—the personal attributes of patients that may maximise their ability to partner safely in healthcare. Research was conducted in New Zealand using a Delphi study via a structured two-round survey, involving 11 invited internationally recognised experts on patient safety. The results identified **10 intellectual** and **three moral attributes** as being important for patients wanting to maximize their ability to be safe healthcare partners. The intellectual attributes include **vigilance, responsiveness, rationality, knowledge, humanity, conscientiousness, confidence, commitment to health, awareness** and **autonomy**. The highest rated attributes regarding autonomy included the ability to speak up, freedom to act, and ability to act independently. The highest rated attribute relating to knowledge include knowing who, when and how to call for help. Whereas current study emphases attributes of professionals, this study was important in its ability to identify the patient attributes which key opinion leaders believe can maximise the capability of patients to partner safely in healthcare.
DOI	http://dx.doi.org/10.1136/bmjopen-2013-003104

BMJ Quality and Safety
September 2013, Vol 22, Issue 9

Notes	A new issue of *BMJ Quality and 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 and Safety* include: • Editorial: **Patient bedside observations**: what could be simpler? (Michael Buist, Stella Stevens) • Editorial: **Medication safety**: opening up the black box (Barbara Mintzes) • Toward the **modelling of safety violations** in healthcare systems (Ken Catchpole) • Surgical technology and **operating-room safety** failures: a systematic review of quantitative studies (R A Weerakkody, N J Cheshire, C Riga, R Lear, M S Hamady, K Moorthy, A W Darzi, C Vincent, C D Bicknell) • Patterns in the recording of vital signs and early warning scores: compliance with a **clinical escalation** protocol (Chris Hands, Eleanor Reid, Paul Meredith, Gary B Smith, D R Prytherch, P E Schmidt, P I Featherstone) • Speaking the same language? **International variations in the safety information** accompanying top-selling prescription drugs (Aaron S Kesselheim, Jessica M Franklin, Jerry Avorn, Jon D Duke) • An observational study of **nurse staffing ratios and hospital readmission** among children admitted for common conditions (Heather L Tubbs-Cooley, Jeannie P Cimiotti, Jeffrey H Silber, Douglas M Sloane, Linda H Aiken) • The **Patient-Reported Incident in Hospital Instrument (PRIH-I)**: assessments of data quality, test–retest reliability and hospital-level reliability (Oyvind Bjertnaes, Kjersti Eeg Skudal, Hilde Hestad Iversen, Anne Karin Lindahl)

	• A Dutch regional **trauma registry**: quality check of the registered data (D C Olthof, J S K Luitse, F M J de Groot, J C Goslings) • Anastomotic leakage as an outcome measure for quality of **colorectal cancer surgery** (H S Snijders, D Henneman, N L van Leersum, M ten Berge, M Fiocco, T M Karsten, K Havenga, T Wiggers, J W Dekker, R A E M Tollenaar, M W J M Wouters) • The **Housestaff Incentive Program**: improving the timeliness and quality of **discharge summaries** by engaging residents in quality improvement (Kara Bischoff, Aparna Goel, Harry Hollander, Sumant R Ranji, M Mourad • Labelling of **diathermy consoles** when multiple systems are used: should this be part of the WHO checklist? (Nadine Hachach-Haram, Samer Saour, Reza Alamouti, Joannis Constantinides, Pari-Naz Mohanna) • Organising a **manuscript reporting quality improvement** or patient safety research (Christine G Holzmueller, Peter J Pronovost)
URL	http://qualitysafety.bmj.com/content/vol22/issue9/

BMJ Quality and Safety
September 2013, Vol 22, Supplement 1

Notes	A Supplement to the *BMJ Quality and Safety* has been published to mark the G-I-N (Guidelines International Network) Conference being held in San Francisco. The supplement/Conference Proceedings lists the presentations and other events at the meeting:
	• Plenary 1: Strengthening the link between guidelines & systematic reviews
	  o Collaboration on evidence synthesis to support health care recommendations: what works, what doesn't and what's next (Holger Schunemann)
	  o Systematic Reviews; the policy maker's dilemma (Sarah Garner)
	• Plenary 2: Guidelines and performance measures
	  o Clinical Guidelines: The Supply Chain to Performance Measurement (Helen Burstin)
	  o Guidelines and Performance (Daniel Keenan)
	  o Do guidelines guide the clinical practice? (Sang il Lee)
	• Plenary 3: Challenges and solutions for updating guidelines
	  o Updating Practice Guidelines (Paul Shekelle)
	  o Keeping a programme of clinical guidelines up-to-date (Roberta James)
	  o Keeping cancer guidelines current using a wiki approach (Ian Olver)
	• Plenary 4: Developing implementable guidelines
	  o Guideline Implementability: Learning from great thinkers like Picasso, the Dalai Lama and Anonymous (Melissa Brouwers)
	  o Developing and evaluating communication strategies to support informed decisions and practice based on evidence (DECIDE) for health professionals (Pablo Alonso)
	  o Success and challenges from over 5 years of the National Stroke Foundation's StrokeLink program. An example of a comprehensive implementation program linking stroke guidelines to current practice in Australia (Kelvin Hill)
	• Plenary 5: Successful or new implementation strategies for guidelines
	  o The HER (Wiley Chan)

	○ Using networks to facilitate international guideline implementation: allergic rhinitis as an example (Jean Bousquet) ○ Guideline Implementation in a 21st Century Health System (Brian Mittman) • Panel Sessions and Interactive Workshops • Interactive workshops • Short Oral Presentations • Posters
URL	http://qualitysafety.bmj.com/content/vol22/Suppl_1/

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • **Home care**: more than just a visiting nurse (Katrina M Romagnoli, Steven M Handler, Harry Hochheiser) • Advancing the research agenda for **diagnostic error** reduction (Laura Zwaan, Gordon D Schiff, Hardeep Singh) • Effects of a team-based assessment and intervention on **patient safety culture in general practice**: an open randomised controlled trial (B Hoffmann, V Müller, J Rochon, M Gondan, B Müller, Z Albay, K Weppler, M Leifermann, C Mießner, C Güthlin, D Parker, G Hofinger, F M Gerlach) • When **diagnostic testing** leads to harm: a new outcomes-based approach for laboratory medicine (Paul L Epner, Janet E Gans, Mark L Graber) • Teaching about how doctors think: a longitudinal **curriculum in cognitive bias and diagnostic error** for residents (James B Reilly, Alexis R Ogdie, Joan M Von Feldt, Jennifer S Myers)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

Notes	The *International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Is early treatment of acute chest pain provided sooner to patients who speak the **national language**? (Marco Santos, Annica Ravn-Fischer, Thomas Karlsson, Johan Herlitz, and Bo Bergman) • Quality of physical resources of **health facilities in Indonesia**: a panel study 1993–2007 (Aly Diana, Samantha A Hollingworth, and G C Marks) • **Health services accreditation**: what is the evidence that the benefits justify the costs? (Virginia Mumford, Kevin Forde, David Greenfield, Reece Hinchcliff, and Jeffrey Braithwaite)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc