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On the Radar

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On the Radar
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Consultation on the Draft Clinical Care Standards

In collaboration with consumers, clinicians, researchers and health organisations, the Commission has developed draft **Clinical Care Standards** for **Acute Coronary Syndrome** and **Antimicrobial Stewardship**.

A Clinical Care Standard provides a small number of quality statements that describe the clinical care that a patient should be offered for a specific condition.

The Commission is now inviting feedback on these draft Clinical Care Standards from healthcare professionals, peak healthcare and consumer organisations, consumers and any other interested parties. Feedback can be provided through completing a brief survey or by making a written submission.

Further details on the consultation are available at http://www.safetyandquality.gov.au/our-work/clinical-care-standards/consultation/

Journal articles

Impact of a regionalised clinical cardiac support network on mortality among rural patients with myocardial infarction.
Tideman PA, Tirimacco R, Senior DP, Setchell JJ, Huynh LT, Tavella R, et al.
Med J Aust 2014;200(3):157-160

Notes	Geographic remoteness can contribute to variation in health outcomes, for a whole range of factors. This paper reports on the success of a South Australian clinical cardiac network in reducing (though not eliminating) differences between rural and metropolitan patients in mortality rates after myocardial infarction. The network focussed on supporting primary care with early expert risk stratification, and efficient transfer systems for patients requiring expert intervention such as coronary revascularisation. The paper highlights key aspects of enabling evidence-based care for patients presenting with symptoms of acute coronary syndrome, regardless of location.
DOI	http://www.mja.com.au/doi/10.5694/mja13.10645

Evaluation of medium-term consequences of implementing commercial computerized physician order entry and clinical decision support prescribing systems in two 'early adopter' hospitals
Cresswell KM, Bates DW, Williams R, Morrison Z, Slee A, Coleman J, et al.
Journal of the American Medical Informatics Association 2014 [epub].

Notes	One of the 'great hopes' in medication safety in recent years has been the application of technologies that might reduce medication errors. There have been papers on the (relatively) short-term implementation of such systems. This is paper reports on the medium-term experience gained by two 'early adopter' hospitals in the USA. These hospitals had implemented commercial computerised physician order entry (CPOE) systems, one with rudimentary decision support functionality, the other with a more sophisticated approach, and had been using these for more than two years. This study, based on interviews, observations and document reviews found three major themes: 1. impacts on individual users, including **greater legibility of prescriptions**, but also some accounts of **increased workloads** 2. the introduction of **perceived new safety risks** related to accessibility and usability of hardware and software, with users expressing concerns that some problems such as duplicate prescribing were more likely to occur 3. realising organizational benefits through secondary uses of data.
DOI	http://dx.doi.org/10.1136/amiajnl-2013-002252

For information about the Commission's work on medication safety, including safety in electronic medication management systems and medication reconciliation, see http://www.safetyandquality.gov.au/our-work/medication-safety/

Impact of a Clinical Pharmacy Admission Medication Reconciliation Program on Medication Errors in "High-Risk" Patients
Buckley MS, Harinstein LM, Clark KB, Smithburger PL, Eckhardt DJ, Alexander E, et al.
Annals of Pharmacotherapy 2013;47(12):1599-1610.

Notes	Another change or intervention that has attracted a degree of interest (and hope) in medication safety has been that of the medication reconciliation. Here a patient's medications are reviewed, particularly at transitions of care, most often on hospital discharge and/or admission. This paper reports on a single-centre, prospective, observational study conducted at a major teaching medical institution in the USA. In the 517 patients (involving 5006 medications) the study found that more than **25%** (n = 132) of patients **had at least 1 error** associated with a medication ordered on hospital admission. The authors report that the pharmacists resolved a total of 467 admission medication errors (3.5 ± 2.3 errors/patient). The most **common** type of medication **error** resolved was **medication omission** (79.6%). 46% of medication errors were considered significant or serious. The authors conclude that "Clinical pharmacist involvement …during the admission medication reconciliation process demonstrated a significant improvement in patient safety and an economic benefit."
DOI	http://dx.doi.org/10.1177/1060028013507428

Patient-centered community health worker intervention to improve posthospital outcomes: A randomized clinical trial
Kangovi S, Mitra N, Grande D, White ML, McCollum S, Sellman J, et al.
JAMA Internal Medicine 2014 [epub].

Notes	Co-ordination of care is not always easily achieved. For some patients it can be particularly elusive. This paper reports on a intervention that sought to improve coordination of care for poorer patients after discharge from hospital. The study was conduct at 2 US urban, academically affiliated hospitals between 10 April 2011 and 30 October 2012. 446 general medical inpatients (ie, low-income, uninsured, or Medicaid) were enrolled and randomly assigned to study arms ('normal' care and the intervention of a community health worker(CHW). During hospital admission, CHWs worked with patients to create action plans for achieving patients' stated goals for recovery. The CHWs provided support tailored to patient goals for a minimum of 2 weeks. The intervention saw those patients attending timely **post-hospital primary care at a higher rate**. Those patient also reported better **high-quality discharge communication** (91.3% vs 78.7%), greater **improvements in mental health** and **patient activation**. There were no significant differences between groups in physical health, satisfaction with medical care, or medication adherence. Similar proportions of patients in both arms experienced at least one 30-day readmission; however, intervention patients were **less likely to have multiple 30-day readmissions** (2.3% vs 5.5%;). Among the subgroup of 63 readmitted patients, recurrent readmission was reduced from 40.0% vs 15.2%. The authors point to the broader issues when they note that "Health systems may leverage the CHW workforce to improve posthospital outcomes by addressing behavioral and socioeconomic drivers of disease"
DOI	http://dx.doi.org/10.1001/jamainternmed.2013.14327

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: • Feasibility of using **administrative data to compare hospital performance** in the EU (O Groene, S Kristensen, O A Arah, C A Thompson, P Bartels, R Sunol, N Klazinga, and on behalf of the DUQUE Project) • **Improving mental health outcomes**: achieving equity through quality improvement (Alan J Poots, Stuart A Green, Emmi Honeybourne, John Green, Thomas Woodcock, Ruth Barnes, and Derek Bell) • Is having quality as an item on the executive board agenda associated with the **implementation of quality management systems** in European hospitals: a quantitative analysis (Daan Botje, N S Klazinga, R Suñol, O Groene, H Pfaff, R Mannion, A Depaigne-Loth, O A Arah, M Dersarkissian, C Wagner, and on behalf of the Duque Project Consortium) • Identification of serious and reportable **events in home care**: a Delphi survey to develop consensus (Diane M Doran, G Ross Baker, Cathy Szabo, Julie Mcshane, and Jennifer Carryer) • Using simulation to improve **root cause analysis** of **adverse surgical outcomes** (Douglas P Slakey, Eric R Simms, Kelly V Rennie, Meghan E Garstka, and James R Korndorffer, Jr) • Building a composite score of **general practitioners' intrinsic motivation**: a comparison of methods (Jonathan Sicsic, Marc Le Vaillant, and Carine Franc) • Feasibility of a **virtual learning collaborative** to implement an obesity QI project in 29 pediatric practices (Tamara John, Michaela Morton, Mark Weissman, Ellen O'Brien, Ellen Hamburger, Y Hancock, and R Y Moon) • Training and nutritional components of PMTCT programmes associated with **improved intrapartum quality of care** in Mali and Senegal (Catherine Mclean Pirkle, Alexandre Dumont, M Traoré, and Maria-Victoria Zunzunegui)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

[UK] NICE Evidence Updates
https://www.evidence.nhs.uk/about-evidence-services/bulletins-and-alerts/evidence-updates
The UK's National Institute for Health and Care Excellence (NICE) uses its Evidence Updates site to highlight new evidence relating to published accredited guidance. The Evidence Updates are based on the scope of the particular guidance they relate to and provide a commentary on a selection of new articles published since the guidance was issued. In particular, Evidence Updates highlight key points from the new evidence and provide a commentary describing its strengths and weaknesses.

[USA] Patient Safety. It takes a team
http://orthoinfo.aaos.org/topic.cfm?topic=A00684
The American Academy of Orthopaedic Surgeons has produced this page on their site to aid patients in understanding and being engaged in their care. The "Patient Safety: It Takes a Team" campaign promotes the "cooperation between doctor, patient, nurses, and hospital staff that is necessary for safe, successful surgeries. There are many things patients can do to become active members of their healthcare teams, like:

- Ask questions — be sure to speak up when you need more information from your doctor
- Involve a friend or family member in your care
- Be able to discuss your medical history — such as past surgeries, major illnesses, and family history of medical problems
- Keep a complete, accurate list of all your medications, including over-the-counter medications, vitamins, and nutritional supplements
- Tell your healthcare team about your allergies and any past reactions to anesthesia or medications
- Ask your doctor for educational resources to help you better understand your condition and treatment options."

[UK] National Patient Safety Alerting System
http://www.england.nhs.uk/ourwork/patientsafety/psa/national-psa-system/
January 2014 saw the launch of the National Patient Safety Alerting System (NPSAS) in England. This system is meant to ensure the rapid dissemination of urgent patient safety alerts to healthcare providers via the Central Alerting System (CAS). This alerting system can also provide useful educational and implementation resources to support providers to put appropriate measures in place to prevent harm and encourage and share best practice in patient safety.
The three stages of NPSAS alerts are:
Stage One Alert: Warning – warning organisations of emerging risk. It can be issued very quickly once a (new) risk has been identified to allow rapid dissemination of information.
Stage Two Alert: Resource – can consist of:
- sharing of relevant local information identified by providers following a stage one alert;
- sharing of examples of local good practice that mitigates the risk identified in the stage one alert;
- access to tools and resources that help providers implement solutions to the stage one alert; and
- access to learning resources that are relevant to all healthcare workers and can be used as evidence of continued professional development.

Stage Three Alert: Directive – requires organisations to confirm they have implemented specific solutions or actions to mitigate the risk. A checklist will be issued of required actions to be signed-off in a set timeframe.

[USA] Priorities in Action
http://www.ahrq.gov/workingforquality/priorities.htm
This webpage describes (and links to) a number of programs/systems that are attempting to implement the US National Quality Strategy priorities. The six priorities are:
- Making care safer by **reducing harm** caused in the delivery of care.
- Ensuring that each **person and family are engaged** as partners in their care.
- Promoting **effective communication and coordination** of care.
- Promoting the most **effective prevention and treatment** practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable **healthy living**.
- **Making quality care more affordable** for individuals, families, employers, and governments by developing and spreading new health care delivery models.

The projects, programs and entities described include:
- Camden Coalition of Healthcare Providers
- Colorado Beacon Consortium
- Healthy Hawaii Initiative
- Michigan Health and Hospital Association Keystone Center

- Reversing the Trend: New York State Health Foundation's Diabetes Campaign
- The Patient Safety and Clinical Pharmacy Services Collaborative
- AHRQ's Patient-Centered Medical Home (PCMH) Resource Center.

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