AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Draft Clinical Care Standard for Stroke

In collaboration with consumers, clinicians, researchers and health organisations, the Commission has developed the draft *Clinical Care Standard for Stroke*.
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 currently seeking feedback on the draft *Clinical Care Standard for Stroke* from healthcare professionals, peak healthcare and consumer organisations, consumers and any other interested parties. Public consultation on this draft *Clinical Care Standard for Stroke* is open until 23 May 2014. Feedback can be provided in the form of written submissions or via an online survey. Copies of the draft *Clinical Care Standard for Stroke*, along with information about its development and the consultation process are available at http://www.safetyandquality.gov.au/our-work/clinical-care-standards/consultation/

Reports

Perspectives on context
The Health Foundation
London: The Health Foundation, 2014.

Notes	Over the various issues of *On the Radar* the issue—and importance—of context has been something of a recurring theme. The Health Foundation in this collection of essays has also identified context as a significant factor. The Health Foundation ask leading academics in the field to discuss the following questions: How do you define and frame context? What do you see as the key conceptual and empirical literature in the field? How would you identify the main unanswered questions about context and improvement? The essays provide a fascinating range of insights into the importance – and challenges – of context. The essays include **Context is everything** (Paul Bate) **The role of context in successful improvement** (Glenn Robert and Naomi Fulop) **How does context affect quality improvement?** (John Øvretveit) **The problem of context in quality improvement** (Mary Dixon-Woods)
URL	http://www.health.org.uk/publications/perspectives-on-context/
TRIM	TRIM D14-13895

Journal articles

The Relationship Between Patient Safety Culture and Patient Outcomes: A Systematic Review
Dicuccio MH
Journal of Patient Safety 2014.

Notes	This article reports on a systematic review that sought examine the evidence linking safety culture and "nurse-sensitive patient outcomes", including patient satisfaction, falls, readmission rates, medication errors, and mortality. The study only considered English language research articles and also required that the articles directly measured patient outcomes in relationship to patient safety culture in hospitals involving registered nurses as a participant. The authors report that "Evidence of **relationships between patient safety culture and patient outcomes exist** at the hospital and nursing unit level of analysis".
DOI	http://dx.doi.org/10.1097/PTS.0000000000000058

Rapid learning of adverse medical event disclosure and apology
Raemer DB, Locke S, Walzer TB, Gardner R, Baer L, Simon R
Journal of Patient Safety 2014 [epub].

Notes	This paper reports on the impact of a program in which obstetricians and labour nurses were provided with a best practices guideline. They then displayed better performance in a standardised disclosure-and-apology discussion simulation than other colleagues. Such guides or 'cognitive aids' can assist clinicians in working through what can be difficult and important conversations.
DOI	http://dx.doi.org/10.1097/PTS.0000000000000080

For information about the Commission's work on open disclosure, including the *Australian Open Disclosure Framework*, see http://www.safetyandquality.gov.au/our-work/open-disclosure/

Multistate Point-Prevalence Survey of Health Care–Associated Infections
Magill SS, Edwards JR, Bamberg W, Beldavs ZG, Dumyati G, Kainer MA, et al.
New England Journal of Medicine 2014;370(13):1198-1208.

Notes	In the absence of a national surveillance system for healthcare associated infections, this point prevalence study was undertaken in 10 geographically diverse US states to determine the prevalence of healthcare associated infections in acute care hospitals and generate updated estimates of the national burden of such infections. Surveys were conducted in 183 hospitals across the 10 state. Of 11,282 patients, 452 (**4.0%**) **had 1 or more healthcare associated infections**. Of 504 such infections, the **most common types** were **pneumonia** (21.8%), **surgical-site infections** (21.8%), and **gastrointestinal** infections (17.1%). ***Clostridium difficile*** was the most commonly reported pathogen (causing 12.1% of health care–associated infections). Device-associated infections (i.e., central-catheter–associated bloodstream infection, catheter-associated urinary tract infection, and ventilator-associated pneumonia) accounted for 25.6% of such infections. The authors estimated that there were 648,000 patients with 721,800 health care associated infections in U.S. acute care hospitals in 2011.
DOI	http://dx.doi.org/10.1056/NEJMoa1306801

For information about the Commission's work on healthcare associated infection, see http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

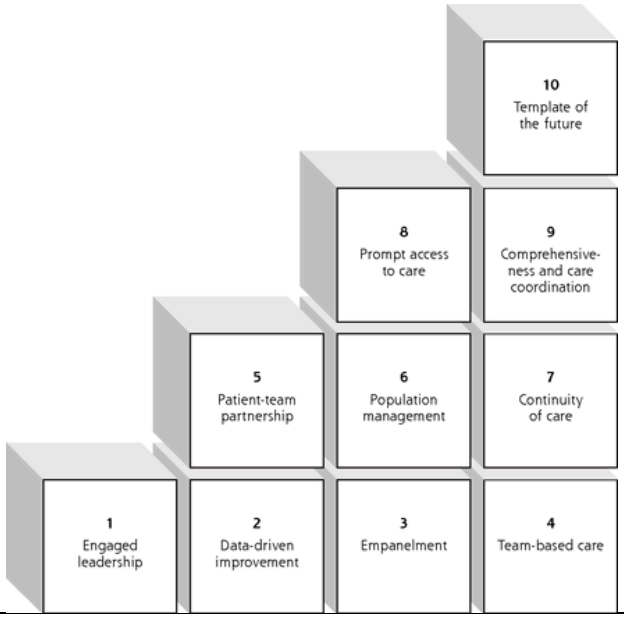
Characterization of Adverse Events Detected in a Large Health Care Delivery System Using an Enhanced Global Trigger Tool over a Five-Year Interval
Kennerly DA, Kudyakov R, da Graca B, Saldaña M, Compton J, Nicewander D, et al.
Health Services Research 2014 [epub].

Notes	This paper reports on the use of the Global Trigger Tool (GTT) in a large US health care organisation where the GTT was applied to 9,017 randomly selected patient records from 8 eight acute hospitals over five years where the patients had stays of 3 or more days to identify adverse events (AEs). From this analysis the authors report that they found AE rates of: 61.4 AEs/1,000 patient-days, 38.1 AEs/100 discharges, and **32.1 percent of patients with ≥1 AE**. Many of these AEs were deemed **preventable or possibly preventable**: **87.6%** of those **present on admission** and **70.8%** of those **hospital acquired**. They also noted that voluntary reports and PSIs captured <5 percent of encounters with hospital-acquired AEs. The GTT has previously been shown to markedly increase the estimated incidence of events. For example, Classen et al wrote "'Global Trigger Tool' Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured".
DOI	Kennerly et al http://dx.doi.org/10.1111/1475-6773.12163 Classen et al http://dx.doi.org/10.1377/hlthaff.2011.0190

Using triggers in primary care patient records to flag increased adverse event risk and measure patient safety at clinic level
Eggleton KS, Dovey SM
New Zealand Medical Journal 2014;127(1390):45-52.

Notes	The use of trigger tools is quite widespread in acute care. This New Zealand study examined such tools in the primary care setting to identify adverse events and gain some insight into the patient safety in primary care. The study examined 36 triggers that had been identified in the literature. Using 109.6 years of records for 170 patients the study identified **harm in the records of** 46 patients (**27.1%**). They noted **7 occurrences of harm per 100 consultations** (a harm rate per consultation of 0.07) and **41 occurrences per 100 consulting patient years**. **All** the harms identified were **related to medication use**. Of the 36 triggers, all were sensitive but many had low specificity. The authors suggest that their final 8 triggers offer a "useful way of measuring progress towards safer care…in primary care." The final 8 triggers in their "refined primary care trigger tool' were adverse drug reaction documented in the record, ≥2 consultations with a GP in the same practice in a week, cessation of medication, reduction in medication dose, ≥6 medications prescribed, attending the emergency department or an after hours provider within 2 weeks of having seen a GP, estimated glomerular filtration rate (eGFR) <35, and death.
URL	http://journal.nzma.org.nz/journal/127-1390/6014/

The 10 Building Blocks of High-Performing Primary Care
Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K
The Annals of Family Medicine 2014;12(2):166-171.

Notes	This US paper describes what its authors suggest are the key components for high performing primary health care. The authors discern four foundational elements: **engaged leadership**, **data-driven improvement**, **empanelment**, and **team-based care**. These enable the implementation of the remaining building blocks: **patient-team partnership**, **population management**, **continuity of care**, prompt **access** to care, **comprehensiveness** and **care coordination**, and a **template of the future**. 
DOI	http://dx.doi.org/10.1370/afm.1616

International Journal for Quality in Health Care
Vol. 26, No. 2
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Notes	A new issue of *International Journal for Quality in Health Care has* been published. Many of the papers in this issue have been referred to in previous editions of On the Radar (when they released online). Articles in this issue of *International Journal for Quality in Health Care* include: • **Standardization in patient safety**: the WHO High 5s project (Agnès Leotsakos, Hao Zheng, Rick Croteau, Jerod M. Loeb, Heather Sherman, Carolyn Hoffman, Louise Morganstein, Dennis O'Leary, C Bruneau, P Lee, M Duguid, C Thomeczek, E van der Schrieck-De Loos, and B Munier) • The use of **modern quality improvement approaches** to strengthen African health systems: a 5-year agenda (James Heiby) • Is it worth engaging in **multi-stakeholder health services research collaborations**? Reflections on key benefits, challenges and enabling mechanisms (Reece Hinchcliff, David Greenfield, and Jeffrey Braithwaite) • Editor's choice: The **association of hospital quality ratings with adverse events** (Joel S Weissman, Lenny López, Eric C Schneider, Arnold M Epstein, Stu Lipsitz, and Saul N Weingart) • 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) • The **Warwick Patient Experiences Framework**: patient-based evidence in clinical guidelines (Sophie Staniszewska, Felicity Boardman, L Gunn, J Roberts, D Clay, K Seers, J Brett, L Avital, I Bullock, and N O' Flynn) • Factors associated with **healthcare professionals' intent to stay in hospital**: a comparison across five occupational categories (Ingrid Gilles, Bernard Burnand, and Isabelle Peytremann-Bridevaux) • Building a composite score of **general practitioners' intrinsic motivation**: a comparison of methods (Jonathan Sicsic, Marc Le Vaillant, and C Franc) • Training and nutritional components of PMTCT programmes associated with **improved intrapartum quality of care** in Mali and Senegal (Catherine Mclean Pirkle, A Dumont, M Traoré, and M-V Zunzunegui) • Development of an instrument to evaluate **intrapartum care quality** in Senegal: evaluation quality care (Adama Faye, Alexandre Dumont, Papa Ndiaye, and Pierre Fournier) • **Physician communication behaviors** from the perspective of adult HIV patients in Kenya (Juddy Wachira, Susan Middlestadt, Michael Reece, Chao-Ying Joanne Peng, and Paula Braitstein) • **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) • 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, E Hamburger, Y Hancock, and R Y Moon)
URL	http://intqhc.oxfordjournals.org/content/26/2?etoc

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Computerised provider order entry combined with clinical decision support systems to improve **medication safety**: a narrative review (Sumant R Ranji, Stephanie Rennke, Robert M Wachter) • An observational study: associations between nurse-reported **hospital characteristics and estimated 30-day survival** probabilities (Christine Tvedt, Ingeborg Strømseng Sjetne, Jon Helgeland, Geir Bukholm)
URL	http://qualitysafety.bmj.com/content/early/recent

Online resources

Ethical Considerations in Quality Assurance and Evaluation Activities
http://www.nhmrc.gov.au/guidelines/publications/e111
The NHMRC has released two items that can be relevant to those undertaking work in the safety and quality areas.
The *Ethical Considerations in Quality Assurance and Evaluation Activities* is a short document (6 pages) intended to assist in determining the appropriate level of oversight for quality assurance (QA) and evaluation. It provides guidance for the consideration of ethical issues and assists in identifying triggers for the consideration of ethical review. This guidance does not impose any additional restrictions to the conduct of QA/evaluation activities.

Inclusion of advice on an opt-out approach, in the National Statement on Ethical Conduct in Human Research, 2007 (Chapter 2.3)
http://www.nhmrc.gov.au/health-ethics/human-research-ethics/inclusion-advice-opt-out-approach-national-statement-ethical-con
The issue of opt-out consent for a range of safety and quality activities, for example clinical quality registries, has been an area of continuing discussion. The NHRMC has updated Chapter 2.3 of the *National Statement on Ethical Conduct in Human Research, 2007* to provide guidance for the use of the opt-out approach. The guidance has been positioned in Chapter 2.3 before guidance on waiver of consent to encourage researchers and HRECs to consider employing an opt-out approach in preference to waiver in circumstances where participants may be able to be contacted so as to afford them an opportunity to decline to participate in the proposed research.

[Canada] Choosing Wisely Canada
http://www.choosingwiselycanada.org/
Following the lead of the US Choosing Wisely program (www.choosingwisely.org), the Canadian Medical Association and other partners have launched the Choosing Wisely Canada initiative: "A campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures". Nine Canadian medical organisations released lists of a total of 40 tests, treatments and procedures that patients do not need in all circumstances.

[USA] We are all part of the patient experience
https://www.youtube.com/watch?v=iBLQnThJ6w0&feature=youtu.be
A conference opening video reminding us that everyone in a health organisation is contributing to (or detracting from) the patient experience.
It is true. The inept administration of a patient that leads to a breakdown in communication or care co-ordination can be as significant in a poor patient experience as a clinician who makes a clinical error.

[UK] An alternative guide to the urgent and emergency care system in England
http://www.kingsfund.org.uk/projects/urgent-emergency-care/alternative-guide-urgent-and-emergency-care-system-england
A brief animation that explains some of options and intricacies of A&E. Possibly useful for those of us in different settings to reflect on to see how different our own systems may and could be.

GS1 Recallnet Healthcare
http://www.gs1au.org/services/recallnet/recallnet-healthcare.asp
GS1 Recallnet Healthcare – an electronic product recall notification management system went live on 1st April 2014.
GS1 Recallnet Healthcare has been developed over 4 years by GS1 Australia in association with the National E-Health Transition Authority (NEHTA), the Therapeutic Goods Administration (TGA), state and territory health departments and a number of medical device and pharmaceutical suppliers. The system allows healthcare suppliers to create recall and non-recall notifications following the requirements of the uniform recall procedure for therapeutic goods, submit the recall notification and supporting documentation to the TGA for review, and issue the recall notification to all affected trading partners.
