AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Refreshing Radar
On the Radar has been given a new look, along with a slight re-arrangement of the content.
As part of the refresh it is also an appropriate time to update our subscription lists. As part of this, along with our pruning out-of-date email addresses, we'd like to encourage you to forward *On the Radar* on to colleagues who may be interested and find it relevant.

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/

Consultation on training and competencies for recognising and responding to clinical deterioration in acute care
Consultation now open

The Commission is seeking advice about what should be the minimum requirements for training and competencies for recognising and responding to physiological deterioration in acute care. The Commission is interested in the application of these minimum requirements for doctors, nurses and allied health professionals.

This consultation process is being conducted in the context of the National Safety and Quality Health Service (NSQHS) Standards which require the clinical workforce to be trained and proficient in basic life support. The Commission has received feedback which questions whether such training ensures adequate competency in the skills required to recognise, escalate and respond to clinical deterioration. Currently there are varied approaches to providing education and training about recognising and responding to clinical deterioration, and a lack of clear guidance about what knowledge should be required as a minimum for all clinicians.

To provide clarity to the requirements of the NSQHS Standards and ensure patients are protected from harm, the Commission is now seeking further advice on this issue.

A consultation paper, *National Safety and Quality Health Service Standards: Training and Competencies for Recognising and Responding to Clinical Deterioration in Acute Care* is available at http://www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/training-and-competencies/

Information about the process of making a submission is included in the paper and the Commission will accept submissions until Friday 27 June 2014.

The contact person for this consultation is Ms Jennifer Hill, Senior Project Officer, Recognising and Responding to Clinical Deterioration Program. Ms Hill can be contacted on (02) 9126 3527 or via email at rrconsultation@safetyandquality.gov.au.

Reports

The NHS productivity challenge: Experience from the front line
Appleby J, Galea A, Murray R
London: The King's Fund, 2014.

URL	http://www.kingsfund.org.uk/publications/nhs-productivity-challenge
Notes	This report from the UK's King's Fund describes how six NHS trusts have been grappling with the productivity challenge that has come about with the slowdown in the growth of funding. The NHS has seen pay restraint, cuts in central budgets, and the abolition of some tiers of management. The strongest pressures have been applied at the front line, by hospitals and other local service providers, faced with squeezing more and more value. This report discusses the productivity challenge and its implications at various scales.
TRIM	D14-17633

Building a leadership team for the health care organization of the future
Health Research & Educational Trust
Chicago IL. Health Research & Educational Trust, 2014.

URL	http://www.hpoe.org/resources/hpoehretaha-guides/1613
Notes	The (US) Hospitals in Pursuit of Excellence (HPOE) have published this short (30-odd page) report to suggest how 'health care organizations' can cope with the move towards a value-based payment model by developing management skills that "encourage systems thinking and align clinical and operational resources to improve outcomes and efficiencies." The HPOE suggests that in this environment "Today's leaders must implement strategies to: • Improve cost management and efficiency • Increase clinical integration and expand coordinated care • Improve quality and patient safety • Integrate information systems • Foster innovation and change management • Increase patient engagement

Journal articles

Disclosing Adverse Events to Patients: International Norms and Trends
Wu AW, McCay L, Levinson W, Iedema R, Wallace G, Boyle DJ, et al.
Journal of Patient Safety 2014 [epub].

DOI	http://dx.doi.org/10.1097/pts.0000000000000107
Notes	This paper reviews and summarises current approaches and trends on disclosure, focusing on the USA, UK, Canada, New Zealand, and Australia. The authors identified 5 key challenges: 1) challenge of putting policy into large-scale practice 2) conflict between patient safety theory and patient expectations 3) conflict between legal privilege for quality improvement and open disclosure 4) challenge of aligning open disclosure with liability compensation, and 5) challenge of measurement related to disclosure. The authors propose "Potential solutions include **health worker education** coupled with incentives to embed policy into practice, **better communication** about approaches beyond the punitive, **legislation** that allows both disclosure to patients and quality improvement protection for institutions, **apology protection** for providers, **comprehensive disclosure programs** that include patient compensation, delinking of patient compensation from regulatory scrutiny of disclosing physicians, legal and contractual requirements for disclosure, and better measurement of its occurrence and quality. A longer-term solution involves **educating the public and health care workers about patient safety**."

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

Safe and Appropriate Use of Insulin and Other Antihyperglycemic Agents in Hospital
Cornish W
Canadian Journal of Diabetes 2014;38(2):94-100.

DOI	http://dx.doi.org/10.1016/j.jcjd.2014.01.002
Notes	Insulin is widely used (and its usage is likely to increase with growing numbers of people with diabetes) but there are risks in its use. This paper argues that a reduction in the "risk for medication error requires close attention to the many detailed steps in the various phases of the medication-use process. …Treatment needs to be more closely linked to patients' nutritional status, and nursing staff should be empowered to initiate prompt reversal of hypoglycemia. … **Strategies for improvement** of glycemic control include **education of care providers** on the safe and appropriate use of insulin, establishment of **standardized protocols (**i.e. order sets) for insulin use and provision of **clinical decision aids** at the point of care to guide prescribers. Considering the challenges and obstacles faced by hospitals, establishment of a multidisciplinary committee is recommended for the purpose of directing efforts at quality improvement of diabetes care within the hospital."

For information on the Commission's work on medication safety, see
http://www.safetyandquality.gov.au/our-work/medication-safety/

Burnout in the NICU setting and its relation to safety culture
Profit J, Sharek PJ, Amspoker AB, Kowalkowski MA, Nisbet CC, Thomas EJ, et al.
BMJ Quality & Safety 2014 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2014-002831
Notes	Burnout in clinicians is not uncommon and, as this paper discusses, its impact on safety and safety culture can be marked. This study sought to 1) test the psychometric properties of a brief four-item burnout scale 2) provide neonatal intensive care unit (NICU) burnout and resilience benchmarking data across different units and caregiver types 3) examine the relationships between caregiver burnout and patient safety culture. 2,073 nurses, nurse practitioners, respiratory care providers and physicians in 44 NICUs responded to the survey. The burnout scale was found reliable and appropriate for aggregation. The percentage of respondents in each NICU reporting **burnout ranged from 7.5% to 54.4% (mean=25.9%)**. The authors found that burnout varied significantly between NICUs, but was less prevalent in physicians compared with non-physicians. **NICUs with more burnout had lower teamwork climate, safety climate, job satisfaction, perceptions of management and working conditions**. Addressing clinician burnout is thus an obvious step in enhancing safety culture.

Locating Errors Through Networked Surveillance: A Multimethod Approach to Peer Assessment, Hazard Identification, and Prioritization of Patient Safety Efforts in Cardiac Surgery
Thompson DA, Marsteller JA, Pronovost PJ, Gurses A, Lubomski LH, Goeschel CA, et al.
Journal of Patient Safety 2014 [epub].

DOI	http://dx.doi.org/10.1097/pts.0000000000000059
Notes	Paper describing how a multidisciplinary team (incorporating organisational sociology, organisational psychology, applied social psychology, clinical medicine, human factors engineering, and health services researchers,) developed a method or model for evaluating patient safety in complex settings (in this instance cardiovascular operating rooms) and prioritising improvement. In the cardiac surgery setting the priority **hazard themes** that emerged included **safety culture**, **teamwork and communication**, **infection prevention**, **transitions of care**, **failure to adhere** to practices or policies, and operating room **layout and equipment**. The authors suggest that their method may be translatable to other clinical settings.

Governing board, C-suite, and clinical management perceptions of quality and safety structures, processes, and priorities in U.S. hospitals
Vaughn T, Koepke M, Levey S, Kroch E, Hatcher C, Tompkins C, et al
Journal of Healthcare Management 2014;59(2):111-128.

URL	http://ache.org/pubs/jhm/jhm_index.cfm
Notes	It has been argued that getting safety and quality on the agenda of the boards and senior management is a key to improving safety and quality in a health organisation. This study reports on reports on the development of the **Hospital Leadership and Quality Assessment Tool** (HLQAT) to measure organisational commitment to safety and quality across six **key domains** (**commitment** of senior leaders, a **vision** of exemplary quality, a supportive **culture**, **accountable leadership**, appropriate **organisational structures**, and **adaptive capability**). The authors report that from a sample of 300 US hospitals, higher HLQAT scores for each respondent group were associated with better hospital performance on the Centers for Medicare & Medicaid Services Core Measures. They also noted that "Leaders in higher-performing hospitals appear to be more effective at conveying their vision of quality care and creating a culture that supports an expectation that staff and leadership will work across traditional boundaries to improve quality."

Intraocular Lens Confusions: A Preventable "Never Event"—The Royal Victorian Eye and Ear Hospital Protocol
Zamir E, Beresova-Creese K, Miln L
Survey of Ophthalmology 2012;57(5):430-447.

DOI	http://dx.doi.org/10.1016/j.survophthal.2011.12.003
Notes	This paper provides a practical case study of clinical leadership in identification, analysis and amelioration of a safety and quality issue. The paper summarises some of the current concepts of medical error and 'never' events and then applies these to cataract surgery, which is the most common surgical procedure performed in ophthalmology. A detailed analysis of types of errors relating to intra-ocular lenses is provided and an approach to investigating these errors is described. The authors describe how this issue was examined in their hospital and the approach to introducing a new safety protocol to reduce these types of adverse event.

The Effectiveness of Management-By-Walking-Around: A Randomized Field Study
Tucker AL, Singer SJ
Production and Operations Management 2014 [epub].

DOI	http://dx.doi.org/10.1111/poms.12226
Notes	The message from this paper is that **walk-arounds work – when senior management takes ownership of any issues found**. The article reports on a study of an improvement program based on 'Management-by-walking-around' (MBWA) in 56 work areas in a number of hospitals over 18 months. MBWA had senior managers observe frontline employees, solicit ideas about improvement opportunities, and work with staff to resolve the issues. The authors report that the MBWA program had a negative impact on performance. From further analysis the authors suggest that prioritising easy-to-solve problems was associated with improved performance, possibly as a consequence of greater action-taking. Prioritising high-value problems was apparently not successful. The authors suggest that making senior managers responsible for ensuring that identified problems get resolved produces better performance. As the authors conclude, "senior managers' physical presence in their organizations' front lines was not helpful unless it enabled active problem solving."

Patient Experience Journal
Volume 1, Issue 1 (2014)

URL	http://pxjournal.org/journal/
Notes	The inaugural issue of the *Patient Experience Journal* (PXJ) has been published. PXJ is an international, multidisciplinary, and multi-method, open-access, peer-reviewed journal focused on the research and proven practices around understanding and improving patient experience. PXJ is designed to share ideas and research, and reinforce key concepts that impact the delivery of service, safety and quality and their influence on the experience of patients and families across healthcare settings. Articles in this first issue include: • Expanding the dialogue on **patient experience** (Jason A Wolf) • Concern for the **patient's experience** comes of age (Irwin Press) • **Defining Patient Experience** (Jason A Wolf; Victoria Niederhauser; Dianne Marshburn; and Sherri L LaVela) • How does **patient experience fit into the overall healthcare picture**? (Karen Luxford and Sue Sutton) • **Evaluation and measurement of patient experience** (Sherri L LaVela and Andrew S Gallan) • "Working the system": The **experience of being a primary care patient** (Michelle L A Nelson, M G Torchia, J B Mactavish, and R E Grymonpre) • A daughter's frustration with the **dearth of patient- and family-centered care** (Cindy Brach) • **Patients and families as partners** in safety, quality, and experiences of care (Amy Jones and Kathy Dutton) • **Transforming the patient experience**: Bringing to life a patient- and family-centred interprofessional collaborative practice model of care at Kingston General Hospital (Anndale McTavish and Cynthia Phillips) • Improving the patient experience through **provider communication skills** building (Denise M Kennedy, John P Fasolino, and David J Gullen) • **Physician-led patient experience improvement efforts**: The CONNECT program, an emerging innovation (Harris P Baden and Jennifer E Scott)

	• The impact of the **resident duty hour regulations** on surgical patients' perceptions of care (Shital Shah; Mary Katherine Krause; Francis Fullam; Susan Vanderberg-Dent; and Amie E Solber) • Patient care experiences and perceptions of **the patient-provider relationship**: A mixed method study (Jennifer Tabler; Debra L Scammon; Jaewhan Kim; T Farrell; A Tomoaia-Cotisel; and M K Magill) • **Veterans' experiences** of patient-centered care: Learning from guided tours (Sara M Locatelli; Stephanie Turcios; and Sherri L LaVela) • Factors in **patients' experience of hospital care**: Evidence from California, 2009–2011 (Edmund R Becker; Jason M Hockenberry; Jaeyong Bae; Ariel C Avgar; Sandra S Liu; Ira Wilson; and Arnold Milstein) • Psychometric properties of the new **Patients' Expectations Questionnaire** (Ann Bowling and Gene Rowe) • **What matters most to patients?** Participative provider care and staff courtesy (Andrew H Van de Ven) • **Patients' experiences in the UK**: Future strategic directions (Sophie Staniszewska and Neil Churchill) • The **role of governing boards** in improving patient experience: Attitudes and activities of health service boards in Victoria, Australia (Marie Bismark, Susan Biggar, Catherine Crock, J M Morris, and D M Studdert) • Caregiving and the experience of health and illness in children **living with HIV/AIDS** in Gulu District Northern Uganda: An ethnographic research narrative (Constantine S.L. Loum)

For 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/

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • **Regulating and legislating safety**: the case for candour (Oliver Quick) • Interventions employed to improve **intrahospital handover**: a systematic review (Eleanor R Robertson, Lauren Morgan, Sarah Bird, Ken Catchpole, Peter McCulloch) • Book review: Visualising **healthcare practice improvement**: innovation from within (Myles Leslie)

International Journal for Quality in Health Care online first articles

DOI	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • **Is quality improvement sustainable**? Findings of the American college of cardiology's guidelines applied in practice (A B Olomu, M Stommel, M M Holmes-Rovner, A R Prieto, W D Corser, V Gourineni, and K A Eagle) • **Harnessing implementation science** to improve care quality and patient safety: a systematic review of targeted literature (Jeffrey Braithwaite, Danielle Marks, and Natalie Taylor)

Online resources

[UK] Promising practice: enabling better access to primary care for vulnerable populations
https://www.gov.uk/government/publications/good-practice-in-improving-care-for-vulnerable-groups
The UK Department of Health has released this brief independent report for the National Inclusion Board. The report provides examples of good practice and explains why the chosen approaches are successful in improving access to primary care.
