



## On the Radar

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### On the Radar

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### Reports

#### *National Statement on Health Literacy*

Sydney, Australian Commission on Safety and Quality in Health Care, 2014.

URL	<a href="http://www.safetyandquality.gov.au/publications/health-literacy-national-statement/">http://www.safetyandquality.gov.au/publications/health-literacy-national-statement/</a>
Notes	<p>The Australian Commission on Safety and Quality in Health Care has released the <i>National Statement on Health Literacy</i>. Almost 60% of Australians have a low level of individual health literacy. This is important to the safety, quality and effectiveness of health care. Low levels of individual health literacy contribute to poorer health outcomes, increased risk of an adverse event and higher healthcare costs. People with low levels of health literacy may not understand their medication instructions, be able to interpret nutrition labels on food, or be able to understand the risks associated with different treatment options enough to make an informed choice.</p> <p>The Commission has been working with healthcare professionals, consumers, policy makers and researchers to explore the role that health literacy plays in safe and high-quality care and to develop a national approach as a basis for coordinated and collaborative action.</p>

	<p>The National Statement on Health Literacy proposes a coordinated approach to health literacy based on:</p> <ul style="list-style-type: none"> <li>• embedding health literacy into systems</li> <li>• ensuring effective communication</li> <li>• integrating health literacy into education.</li> </ul> <p>This has now been endorsed by Australian, state and territory Health Ministers as the national approach to health literacy.</p>
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*Optimizing Scopes of Practice: New Models for a New Health Care System*

Nelson S, Turnbull J, Bainbridge L, Caulfield T, Hudon G, Kendel D, et al.

Ottawa, Ontario: Canadian Academy of Health Sciences; 2014.

URL	<a href="http://www.cahs-acss.ca/optimizing-scopes-of-practice-new-models-of-care-for-a-new-health-care-system/">http://www.cahs-acss.ca/optimizing-scopes-of-practice-new-models-of-care-for-a-new-health-care-system/</a>
Notes	<p>The Canadian Academy of Health Sciences has published this report examining the question of ‘What are the scopes of practice that will be most effective to support innovative models of care for a transformed health care system to serve all Canadians?’</p> <p>During the course of the work it emerged that “<b>optimizing scopes of practice</b>, paired with <b>evolving models of shared care</b> can provide a multidimensional approach to <b>shift the health care system</b> from one that is characteristically siloed to one that is <b>collaborative and patient-focused</b>.” Key aspects for this vision are: “<b>flexibility</b>– empowering the collaborative practice team to determine the relative responsibilities of the different practitioners based upon community need. <b>accountability</b>– ensuring the optimization of scopes of practice through an accreditation process within a professional regulatory environment.”</p>

**Journal articles**

*Patient-Safety-Related Hospital Deaths in England: Thematic Analysis of Incidents Reported to a National Database, 2010–2012*

Donaldson LJ, Panesar SS, Darzi A

PLoS Med. 2014;11(6):e1001667.

DOI	<a href="http://dx.doi.org/10.1371/journal.pmed.1001667">http://dx.doi.org/10.1371/journal.pmed.1001667</a>
Notes	<p>This paper reports on an analysis of deaths in English hospitals that had patient safety implications. The (adult) deaths were recorded in the UK National Health Service and covered 2,010 incidents involving patients aged 16 and over in acute hospital settings. The deaths were reported after mandatory reporting of such incidents was introduced.</p> <p>The aim of the study was to classify reports of deaths due to unsafe care into broad areas of systemic failure capable of being addressed by stronger policies, procedures, and practices.</p> <p>The types of incident were aggregated into six areas of apparent systemic failure: <b>mismanagement of deterioration</b> (35%), <b>failure of prevention</b> (26%), <b>deficient checking and oversight</b> (11%), <b>dysfunctional patient flow</b> (10%), <b>equipment-related errors</b> (6%), and other (12%).</p> <p>The most common incident types were failure to act on or recognise <b>deterioration</b> (23%), inpatient <b>falls</b> (10%), <b>healthcare-associated infections</b> (10%), <b>unexpected per-operative death</b> (6%), and poor or inadequate <b>handover</b> (5%).</p> <p>This list is not in itself particularly surprising and in many of these areas there are known interventions and methods for addressing these types of incident.</p>

*Medical service redesign shares the load saving 6000 bed days and improving morale*

Toomath R, Szecket N, Nahill A, Denison T, Spriggs D, Lay C, et al.

Internal Medicine Journal. 2014 Aug;44(8):785-90.

DOI	<a href="http://dx.doi.org/10.1111/imj.12477">http://dx.doi.org/10.1111/imj.12477</a>
Notes	<p>This paper reports on how a New Zealand hospital split its staff into teams to deal with patients expected to have short stays and those expected to have longer stays. The authors report that in the 18 months from “the introduction of the new model, the average <b>length of stay has fallen</b> from 3.7 to 3.2 days (14%) and the median length of stay by 28%, resulting in a saving of 6000 bed days per year.” However, they also note that readmission, inpatient and 30-day mortality rates were unchanged.</p> <p>The authors identify the following factor for the success of the intervention: <b>management support; iterative engagement</b> of a range of staff; provision of <b>timely data analysis</b>; increases in senior medical officer <b>staffing</b> and <b>reorganisation</b> leading to more predictable and fair work practices.</p> <p>They also identify that discontinuity (whether between doctors and patients or within the medical team.) is a challenge.</p>

*The influence of organizational factors on patient safety: Examining successful handoffs in health care*

Richter JP, McAlearney AS, Pennell ML

Health Care Manage Rev. 2014 [epub].

DOI	<a href="http://dx.doi.org/10.1097/HMR.0000000000000033">http://dx.doi.org/10.1097/HMR.0000000000000033</a>
Notes	<p>This study sought to examine how perceptions of organisational factors influencing patient safety are associated with perceptions of successful patient handovers/handoffs and which factors have the greatest influence and whether perceptions of these factors differ for management and clinical staff. The study used survey responses from 515,637 respondents at 1,052 hospitals in (US) Hospital Survey on Patient Safety Culture.</p> <p>The authors report that “perceived <b>teamwork</b> across units was the most significant predictor of perceived successful handoffs. Perceptions of <b>staffing</b> and <b>management support</b> for safety were also significantly associated with perceived successful handoffs for both management and clinical staff. For management respondents, perceptions of <b>organizational learning</b> or <b>continuous improvement</b> had a significant positive association with perceived successful handoffs, whereas the association was negative for clinical staff. Perceived communication <b>openness</b> had a significant association only among clinical staff.”</p>

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

*Racial and Ethnic Disparities in Patient Safety*

Okoroh JS, Uribe EF, Weingart S

Journal of Patient Safety.2014 [epub]

DOI / URL	<a href="http://dx.doi.org/10.1097/PTS.0000000000000133">http://dx.doi.org/10.1097/PTS.0000000000000133</a> <a href="http://pdfs.journals.lww.com/journalpatientsafety/9000/00000/Racial_and_Ethnic_Disparities_in_Patient_Safety_.99726.pdf">http://pdfs.journals.lww.com/journalpatientsafety/9000/00000/Racial_and_Ethnic_Disparities_in_Patient_Safety_.99726.pdf</a>
Notes	This American study examined the literature (1991 to 1 May 2013) for studies on racial and ethnic disparities in patient safety.

	<p>The study sought to explore differences in reporting race/ethnicity in studies on disparities in patient safety; assess adjustment for socioeconomic status, comorbidity, and disease severity; and make recommendations on the inclusion of race/ethnicity for future studies on adverse events.</p> <p>They report relatively few studies, with 24 being fully reviewed and that what evidence there was on the existence of disparities in adverse events was mixed. They noted that “Poor stratification of outcomes by race/ethnicity and consideration of geographic and hospital-level variations explain the inconclusive evidence. “</p>
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*American Journal of Medical Quality*  
September 2014; 29 (5)

URL	<a href="http://ajm.sagepub.com/content/29/5?etoc">http://ajm.sagepub.com/content/29/5?etoc</a>
Notes	<p>A new issue of the <i>American Journal of Medical Quality</i> has been published. Articles in this issue of the <i>American Journal of Medical Quality</i> include:</p> <ul style="list-style-type: none"> <li>• <b>Identifying Hospital-Wide Harm: A Set of ICD-9-CM-Coded Conditions Associated With Increased Cost, Length of Stay, and Risk of Mortality</b> (Richard A Bankowitz, Barbara Doyle, M Duan, E Kroch, and J Martin)</li> <li>• <b>Using NSQIP to Investigate SCIP Deficiencies in Surgical Patients With a High Risk of Developing Hospital-Associated Urinary Tract Infections</b> (Amber W Trickey, Moira E Crosby, Fran Vasaly, Jean Donovan, John Moynihan, and H David Reines)</li> <li>• <b>A Multifaceted Initiative to Improve Clinician Awareness of Pain Management Disparities</b> (Stephen J Beganich, Nathan Wanner, Scott Junkins, K Mahoney, K A Kahn, C A Berry, S A Stowell, and A J Gardner)</li> <li>• <b>An Evaluation of Ventilator-Associated Pneumonia Process Measure Sampling Strategies in a Surgical ICU</b> (Nishi Rawat, Ting Yang, Kathleen Speck, Jennifer Helzer, Cathleen Barenski, and Sean Berenholtz)</li> <li>• <b>Health Care Quality Improvement Publication Trends</b> (Gordon H Sun, Mark P MacEachern, R J Perla, J M Gaines, M M Davis, and W H Shrank)</li> <li>• <b>A Survey of Handoff Practices in Emergency Medicine</b> (Chad Kessler, Faizan Shakeel, H G Hern, J S Jones, J Comes, C Kulstad, F A Gallahue, B D Burns, B J Knapp, M Gang, M Davenport, B Osborne, and L I Velez)</li> <li>• <b>Patient-Reported Missed Nursing Care Correlated With Adverse Events</b> (Beatrice J. Kalisch, Boqin Xie, and Beverly Waller Dabney)</li> <li>• <b>Medical ICU Admissions During Weekday Rounds Are Not Associated With Mortality: A Single-Center Analysis</b> (Heath E Latham, Aaron Pinion, Luis Chug, S K Rigler, A R Brown, J D Mahnken, and A O’Brien-Ladner)</li> <li>• <b>Primary Care Units in Emilia-Romagna, Italy: An Assessment of Organizational Culture</b> (Valerie P Pracilio, Scott W Keith, John McAna, Giuseppina Rossi, Ettore Brianti, Massimo Fabi, and Vittorio Maio)</li> <li>• <b>Use of Data Envelopment Analysis to Quantify Opportunities for Antibacterial Targets for Reduction of Health Care–Associated <i>Clostridium difficile</i> Infection</b> (Amy L Pakyz and Yasar A Ozcan)</li> <li>• <b>The Development of a Validated Checklist for Femoral Venous Catheterization: Preliminary Results</b> (Lee Ann Riesenber, Katherine Berg, Dale Berg, Joshua Davis, A Schaeffer, E M Justice, and G Tinkoff)</li> <li>• <b>Motivating Physicians to Improve Quality: Light the Intrinsic Fire</b> (Kurt R Herzer and Peter J Pronovost)</li> </ul>

	<ul style="list-style-type: none"> <li>• Much Work Still to Be Done to Prevent <b>Central Line–Associated Bloodstream Infections</b> (Kevin T Kavanagh, Lindsay E Calderon, and Daniel M Saman)</li> <li>• The Multiple Benefits of Inserting <b>Interdisciplinary Quality Improvement Teams</b> Led by Medical Students Into a Faculty Practice Primary Care Clinic (Aniesa D Slack, Megan A Dingwall, Jeffrey C Stone, Melissa Gaines, and Robert G Badgett)</li> <li>• <b>Inpatient Glycemic Control</b> in the Chinese Population: Preliminary Data From an Academic Teaching Hospital (Shi-Dou Lin, Maw-Soan Soon, Shih-Te Tu, Hui-Fang Hsiao, Jung-Min Chen, Ke-Hong Lin, Mei-Jung Lin, Jeng-Fu Kuo, Ya-Leng Jhang, and Ming-Chia Hsieh)</li> </ul>
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#### BMJ Quality and Safety online first articles

URL	<a href="http://qualitysafety.bmj.com/content/early/recent">http://qualitysafety.bmj.com/content/early/recent</a>
Notes	<p>BMJ Quality and Safety has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• A systematic review of <b>behavioural marker systems</b> in healthcare: what do we know about their attributes, validity and application? (Aaron S Dietz, Peter J Pronovost, Kari N Benson, Pedro Alejandro Mendez-Tellez, Cynthia Dwyer, Rhonda Wyskiel, Michael A Rosen)</li> <li>• Cost and turn-around time display decreases <b>inpatient ordering of reference laboratory tests</b>: a time series (Daniel Z Fang, Gurmeet Sran, Daniel Gessner, Pooja D Loftus, Ann Folkins, J Y Christopher III, L Shieh)</li> </ul>

#### 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) has published an update on their Evidence Updates site. The new update is on ‘**acute upper gastrointestinal bleeding**’.

The new Evidence Updates focus on a summary of selected new evidence relevant to NICE clinical guideline 141 ‘Acute upper gastrointestinal bleeding: management’ (2012).

An Evidence Update Advisory Group, comprised of topic experts, reviewed the prioritised evidence and provided a commentary.

##### [USA] Improving Global Health: Focusing on Quality and Safety

<https://www.edx.org/course/harvardx/harvardx-ph555x-improving-global-health-1679>

*Improving Global Health: Focusing on Quality and Safety* is an eight-week massive open online course (MOOC) presented by HarvardX. Ashish Jha, MD, a Professor of Health Policy at the Harvard School of Public Health, will lead the free online course, which starts on 16 September.

The course covers issues including:

- The importance of focusing on quality for improving population health
- A framework for understanding healthcare quality
- Approaches to quality measurement
- The role of information and communication technology in quality improvement
- Tools and contextual knowledge for quality improvement

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