



On the Radar

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On the Radar

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National Antimicrobial Prescribing Survey 2014

<http://www.naps.vicniss.org.au/Default.aspx>

Now open

Coinciding with [Antibiotic Awareness Week](#) (17–23 November), the Melbourne Health National Health and Medical Centre for Antimicrobial Stewardship is coordinating the [National Antimicrobial Prescribing Survey](#) (NAPS). The Survey went live on 10 October. More than 500 individual users and 390 hospitals have already registered for the Survey.

The Survey is supported by the Commission as effective antimicrobial stewardship (AMS) is a key plank of the Commission's national work to prevent and contain antimicrobial resistance (AMR). The NAPS results can also be used as evidence to support the AMS criteria of the [National Safety and Quality Health Service \(NSQHS\) Standard 3: Preventing and Controlling Healthcare Associated Infections](#).

The Commission encourages acute health care services of all sizes, public and private, across the country, to participate in the Survey. For rural sites – which may not have specialist infectious diseases advice or an antimicrobial pharmacist – special assistance may be provided. For details on this assistance, refer to the *Communique on NAPS 2014 for Rural Health Service Providers*.

For more information on NAPS, please refer to the Commission’s Communique:
Communique on NAPS 2014 ([PDF 164 KB](#)) ([MS Word 186 KB](#))
Communique on NAPS 2014 for Rural Health Service Providers ([PDF 165 KB](#)) ([MS Word 186 KB](#))

For information on the Commission’s work on the antimicrobial resistance and antibiotic usage, please visit <http://www.safetyandquality.gov.au/national-priorities/amr-and-au-surveillance-project/>

Reports

People in control of their own health and care: The state of involvement

Foot C, Gilbert H, Dunn P, Jabbal J, Seale B, Goodrich J, et al.

London: The King’s Fund; 2014 November 2014.

URL	http://www.kingsfund.org.uk/publications/people-control-their-own-health-and-care
TRIM	D14-40197
Notes	<p>This report from the UK’s King’s Fund, examines the apparent lack of progress in fully involving people in their own health and care, the reasons behind this, and considers how the cause of making person-centred care the core of health and care reform can be advanced.</p> <p>1 Engaging people in keeping healthy</p> <p>2 Shared decision-making</p> <p>3 Supported self-management</p> <p>4 Personal health and social care budgets</p> <p>5 Involving families and carers</p> <p>6 Choice of provider</p> <p>7 Participation in research</p> <p>8 Evaluating services through feedback</p> <p>Eight priorities to transform individual involvement in health and care</p>

Using hospital mortality indicators to improve patient care: A guide for Boards and Chief Executives

Australian Commission on Safety and Quality in Health Care
Sydney: ACSQHC; 2014.

URL	http://www.safetyandquality.gov.au/our-work/information-strategy/indicators/core-hospital-based-outcome-indicators/
Notes	<p>The Australian Commission on Safety and Quality in Health Care supports the use of hospital mortality indicators as a safety and quality screening tool. Health Ministers have agreed that each state and territory’s hospital mortality data should be gathered and presented to their respective hospitals for regular review, along with infection rates, readmission rates and patient experience survey results. The mortality indicators are:</p> <ul style="list-style-type: none"> • hospital-standardised mortality ratios (HSMRs) • deaths in low mortality diagnosis related groups (DRGs) • in-hospital mortality for four specified conditions. <p>To support the use of hospital mortality indicators the Commission has developed the publication <i>Using hospital mortality indicators to improve patient care: A guide for Boards and Chief Executives</i>. The Guide provides information on how hospital mortality indicators can be used to screen for potential safety and quality issues through existing clinical governance processes.</p>

Variation in the Care of Surgical Conditions: End-Stage Renal Disease. A Dartmouth Atlas of Health Care Series

Zarkowsky D, Freeman R, Axelrod D, Malas M, Goodney PR, Dzebisashvili N, et al.
Hanover, NH: The Dartmouth Institute for Health Policy and Clinical Practice; 2014. p. 50.

URL	http://www.dartmouthatlas.org/downloads/reports/ESRD_report_11_11_14.pdf
TRIM	D14-40080
Notes	<p>This is the fifth in a series of six reports into surgical variation in the USA (the first four being on obesity, cerebral aneurysms, diabetes and peripheral arterial disease, and spinal stenosis, the final report will cover surgical treatments for prostate cancer).</p> <p>According to the Foreword, the report “details the issues surrounding dialysis access surgery, access to transplantation and transplant related care, and the impact of transplantation on patient-related outcomes. As in previous Atlas analyses, the authors emphasize geographic practice variation in rates of dialysis access surgery and transplantation. However, the report also takes a broader view, describing the resources necessary to help patients make the best decisions for their complex care.”</p>

For information on the Commission’s work on variation in health care, see <http://www.safetyandquality.gov.au/our-work/variation-in-health-care/>

Protecting resources, promoting value: a doctor’s guide to cutting waste in clinical care

Academy of Medical Royal Colleges
London: Academy of Medical Royal Colleges; 2014.

URL	http://www.aomrc.org.uk/doc_download/9793-protecting-resources-promoting-value.html
Notes	It has been established that a considerable proportion of resources devoted to health care are wasted, and not deployed towards the best potential use. This report,

written by two clinicians for the Academy of Medical Royal Colleges, provides a framework to “think critically about waste from a clinical perspective and provides examples of doctors improving value of health care by reducing waste”. It draws heavily on the ‘Lean’ method, first developed 50 years ago to improve efficiency and productivity in car manufacturing. Here, waste is defined as any activity that does not add value from the patient perspective. Waste is synonymous with inefficiency. There are two main types of efficiency in health care: technical and allocative.

Technical (or productive) efficiency minimises the use of excess resources to deliver an outcome. Allocative efficiency focuses on optimal resource allocation among a set of competing options, with the aim of investing in clinical activities that deliver maximum patient benefit (high value), and disinvesting in low-value ones (e.g. unnecessary tests). In allocative terms, the waste is opportunity cost – the benefit forgone from alternative deployment. Essentially, technical efficiency is about doing something well, while allocative efficiency is about ensuring the right things are done. Both are important; performing an unnecessary procedure extremely efficiently is wasteful, as is doing the right thing inefficiently. Both combined achieve the best possible patient outcomes at the least possible cost – the definition of value. The ‘saving’ in a system like the NHS is the creation of additional capacity to generate more benefits to patients and to society - a better return on investment.

This is an important report. The rationale and concepts are presented well, and practical examples of waste from the patient viewpoint are provided. A pertinent set of fundamental attributes of value-promoting doctors are listed:

1. A skilled diagnostician
2. Patient-centred
3. A good collaborator
4. An agent for change
5. Focus on health (promotion)

Economists may criticise the lack of discussion of marginal (incremental) costs and benefits, but this may have been too technical in such a document.

Drawing on manufacturing methods, as this report does, may be met with disapproval. However, ‘Lean’ was a principally a philosophy. It was the resulting change in company culture that drove manufacturing processes towards higher productivity. The report recognises that **“a cultural shift is required which calls upon doctors and other clinicians to ask, not if a treatment or procedure is possible, but whether it provides real value to the patient and genuinely improves the quality of their life or their prospects for recovery.”** Culture is the heart of the matter. Collectively, healthcare professionals are the most important stewards of how resource allocation for in the end, efficiency and value are the aggregate of individual clinical decisions and processes. There are many influences of clinical decision making including “individual practices, defensive practices, time pressures, and responding to senior or patient pressures”. The recent and future fiscal constraints on healthcare systems have brought this into sharp focus, and **“[r]ealignment of clinical decision-making is required – where patient benefit and patient preference are balanced against patient harm and resource usage.”**

Without leadership and collective change at clinical level, efficiency and value in health care will not improve. This report, by an influential clinical organisation, is an important step in the right direction.

Journal articles

Nursing bedside clinical handover – an integrated review of issues and tools

Anderson J, Malone L, Shanahan K, Manning J

Journal of Clinical Nursing. 2014 [epub].

DOI	http://dx.doi.org/10.1111/jocn.12706
Notes	Article reporting on a review of nursing handover literature covering 45 articles. The authors report a lack of literature on the transfer of responsibility and accountability during clinical handover and auditing practices of the clinical handover process. Apparently, nurses are more concerned about confidentiality issues than patients. The use of a structured tool was strongly supported; however, no one singular tool was considered suitable for all clinical areas. This in some ways aligns with the argument that any tool needs to be assessed (and modified) for the local context.

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

Improving the effectiveness of multidisciplinary team meetings for patients with chronic diseases: a prospective observational study

Raine R, Wallace I, Bhaird C, Xanthopoulou P, Lanceley A, Clarke A, et al

Health Services and Delivery Research. 2014 2014/10/27;2(37).

DOI	http://dx.doi.org/10.3310/hsdr02370
Notes	Paper examining how multidisciplinary team (MDT) meetings can be utilised for managing chronic diseases in the UK, particularly seeking to identify the key characteristics of chronic disease MDT meetings that are associated with decision implementation, a measure of effectiveness, and to derive a set of feasible modifications to MDT meetings to improve decision-making. The study was a mixed-methods prospective observational study of 12 MDTs that included observation of 370 MDT meetings, interviews with 53 MDT members and 20 patients, and review of 2654 patients’ medical records. The authors report that greater multi-disciplinarity is not necessarily associated with more effective decision-making and MDT decisions (as measured by decision implementation). They also noted decisions were less likely to be implemented for patients living in more deprived areas. 21 indications of good practice for improving the effectiveness of MDT meetings were identified.

Multidisciplinary in-hospital teams improve patient outcomes: A review

Epstein N

Surgical Neurology International. 2014 August 1, 2014;5(8):S295-303.

DOI	http://dx.doi.org/10.4103/2152-7806.139612
Notes	This review of multidisciplinary teams – in the context of surgical teams in hospitals – is somewhat more positive on the value and impact of multidisciplinary teams. It may be that these teams have greater clarity of their roles than may have been the case in the chronic disease case discussed previously. The author stresses “the critical need to keep multidisciplinary teams together , so that they can continue to operate their “well-oiled machines” enhancing the quality/safety of patient care, while enabling “staff” to optimize their performance and enhance their job satisfaction.”

The efficient use of the maternity workforce and the implications for safety and quality in maternity care: a population-based, cross-sectional study

Sandall J, Murrells T, Dodwell M, Gibson R, Bewley S, Coxon K, et al.

Health Services and Delivery Research. 2014 2014/10/29;2(38).

DOI	http://dx.doi.org/10.3310/hsdr02380
Notes	<p>Paper reporting on a study that sought to understand the relationship between organisational factors, maternity workforce staffing and skill mix, cost and indicators of safe and high-quality care.</p> <p>The study draw data from 143 NHS trusts in England in 2010–11 (656,969 delivery records), NHS Workforce Statistics, England, 2010–11, Care Quality Commission Maternity Survey of women’s experiences 2010 and NHS reference costs 2010/11.</p> <p>The authors noted that wide variations in outcomes remained after adjustment for socio-demographic and clinical risk, and organisational factors</p> <p>The conclusions reported included: staffing levels have positive and negative effects on some outcomes; deployment of doctors and midwives where they have most beneficial impact is important; managers may wish to exercise caution in increasing the number of support workers who care for higher-risk women; and there also appear to be limited opportunities for role substitution.</p>

Benefits and Risks of Using Smart Pumps to Reduce Medication Error Rates: A Systematic Review

Ohashi K, Dalleur O, Dykes P, Bates D

Drug Safety. 2014 2014/10/08:1-10.

DOI	http://dx.doi.org/10.1007/s40264-014-0232-1
Notes	<p>Paper reviewing the literature on ‘smart’ medication pumps that sought to identify the impact of smart pumps on error reduction and on medication administration, and strategies to maximize the benefits of smart pumps.</p> <p>Focusing on 22 papers, the review found benefits and negative effects. Benefits included the interception of errors (such as the wrong rate, wrong dose, and pump setting errors), reduction of adverse drug event rates, practice improvements, and cost effectiveness. Issues or negative effects related to using smart pumps were lower compliance rates of using smart pumps, the overriding of soft alerts, non-intercepted errors, or the possibility of using the wrong drug library.</p> <p>The authors also identified opportunities for improvement, including upgrading drug libraries, developing standardised drug libraries, decreasing the number of unnecessary warnings, and developing stronger approaches to minimise workarounds. The authors also argue that “as with other clinical information systems, smart pumps should be implemented with the idea of using continuous quality improvement processes to iteratively improve their use.”</p>

For information on the Commission’s work on medication safety, see

www.safetyandquality.gov.au/our-work/medication-safety/

Invisible Risks, Emotional Choices — Mammography and Medical Decision Making

Rosenbaum L

New England Journal of Medicine. 2014;371(16):1549-52.

DOI	http://dx.doi.org/10.1056/NEJMms1409003
Notes	<p>The complexity involved in many medical decisions: dealing with uncertainty; complex trade-offs; and the tension between emotions and risk assessment are explored here through the example of mammography screening.</p>

	<p>In the US, despite changes that recommend that women under 50 years of age not have mammography screening and women aged 50–75 are screened less frequently, screening rates have held steady or increased.</p> <p>Rosenbaum explores the powerful role that emotions, attitudes and intuition play in risk perception and the challenges that this can present for clinicians grappling with how to balance respect for patients’ values and preferences with their perceived professional responsibility to translate clinical science into improved population health.</p>
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For information on the Commission’s work on shared decision making, see <http://www.safetyandquality.gov.au/our-work/shared-decision-making/>

Antimicrobial stewardship activities: a survey of Queensland hospitals

Avent ML, Hall L, Davis L, Allen M, Roberts JA, Unwin S, et al

Australian Health Review. 2014;38(5):557-63.

DOI	http://dx.doi.org/10.1071/AH13137
Notes	<p>This article presents the first survey of Queensland public hospital and health services activities related to national Safety and Quality Health Service Standard 3 – <i>Preventing and Controlling Healthcare-Associated Infections</i>. As part of the Commission’s National Safety and Quality Health Service Standards, all hospitals should implement an Antimicrobial Stewardship program. This is to ensure the appropriate prescribing of antimicrobials to prevent and manage healthcare associated infections and improve patient safety and quality of care. The particular value of this article lies in the evaluation of Queensland Health’s current activities and the identification of a number of areas for improvement (including increased managerial support, prescriber feedback, auditing, education and training). It concludes with a bold statement questioning the achievability of standard 3 in Queensland given current local implementation resources.</p>

For information on the Commission’s work on healthcare associated infection, including antimicrobial stewardship, see <http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/>

Increases in Emergency Department Occupancy Are Associated With Adverse 30-day Outcomes

McCusker J, Vadeboncoeur A, Lévesque J-F, Ciampi A, Belzile E

Academic Emergency Medicine. 2014;21(10):1092-100.

DOI	http://dx.doi.org/10.1111/acem.12480
Notes	Correction: In the previous issue of <i>On the Radar</i> the DOI for this item was shown correctly but the link was malformed.

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Better-than-average and worse-than-average hospitals may not significantly differ from average hospitals: an analysis of Medicare Hospital Compare ratings (Susan M Paddock, John L Adams, Fernando Hoces de la Guardia) • Development and testing of an objective structured clinical exam (OSCE) to assess socio-cultural dimensions of patient safety competency (Liane R Ginsburg, Deborah Tregunno, Peter G Norton, Sydney Smees, Ingrid de Vries, S S Sebok, EG Van Den Kerkhof, M Luctkar-Flude, J Medves)

Online resources

BMJ Quality Improvement Reports

<http://qir.bmj.com/>

BMJ Quality Improvement Reports is a new searchable repository of global quality improvement evidence and best practice. It aims to help healthcare professionals improve healthcare by providing a new structured format for healthcare professionals to document innovations and excellence in care.

BMJ Quality

<http://quality.bmj.com/>

This is an online platform which provides a simple framework and supporting learning resources (interactive workbooks, learning modules, tools, and other resources) for healthcare professionals to conduct their own quality improvement projects. Once projects are completed, they can be submitted for inclusion in *BMJ Quality Improvement Reports*.

Patient experience is not patient satisfaction-understanding the fundamental differences

<http://isqua.org/education/webinars/november-2014-webinar-with-subashnie-devkaran>

Webinar presented by Dr. Subashnie Devkaran (Manager – Accreditation, Quality and Patient Safety Institute, Cleveland Clinic Abu Dhabi, UAE and Vice President, American College of Healthcare Executives, MENA region)

This webinar will explore the criticisms of patient satisfaction as a measurement of quality; the differences between patient satisfaction and patient experience and the way forward to patient-centred care.

[UK] Putting person-centred care into practice - learning from experience

https://event.webcasts.com/starthere.jsp?ei=1047796&dm_i=4Y2,2YYXO,G85JNT,APH1X,1

At 1300 UTC on 28 November (midnight Sydney, 1130pm Adelaide, 11pm Brisbane, Perth 9pm), the UK's Health Foundation is hosting a webinar titled *Putting person-centred care into practice - learning from experience*.

The webinar will explore what the evidence tells us about what works in implementing shared decision making and self-management support in mainstream health care services.

Register at Register at

https://event.webcasts.com/starthere.jsp?ei=1047796&dm_i=4Y2,2YYXO,G85JNT,APH1X,1

[UK] Staff Engagement resources

<http://nhsemployers.org/your-workforce/retain-and-improve/staff-experience/staff-engagement/nih-rr-staff-engagement-in-the-nhs-resources>

From the UK's NHS Employers and the National Institute of Health Research (NIHR) these guides are aimed at workforce leaders and cover engagement for HR, senior leaders and line managers as well as case studies and a guide on the measurement of engagement.

[UK] Healthier Lives: Diabetes, Hypertension and NHS Health Check

<http://healthierlives.phe.org.uk/>

Public Health England has produced this new online tool that reveals large variation in the prevalence and treatment of diabetes and high blood pressure, and in the provision of the NHS Health Check across England. The interactive 'heat map' includes information on prevalence of the conditions and their complications, levels of care provided and the quality of care achieved in each area by local authority (LA), clinical commissioning group (CCG) and general practice, compared to the England average.

For information on the Commission's work on variation in health care, see <http://www.safetyandquality.gov.au/our-work/variation-in-health-care/>

[UK] *Making your stay with us safe*

<http://harmfreecare.org/Patient+safety+briefing+film+launched+> Guy's and St Thomas' NHS Trust developed an award-winning 'airline style' patient safety card. This card is now available for all NHS trusts to use. Designed as part of an inpatient Welcome Pack, the safety card supports our commitment to patient safety and enables patients to play an active role in their care. A short film – akin to an airline video – has also been developed.



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