



On the Radar

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On the Radar

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Reports

Acute Coronary Syndromes Clinical Care Standard

Australian Commission on Safety and Quality in Health Care

Sydney: ACSQHC; 2014

URL	http://www.safetyandquality.gov.au/our-work/clinical-care-standards/acute-coronary-syndromes-clinical-care-standard/
Notes	Acute coronary syndromes affect thousands of Australians. Coronary heart disease (the main cause of acute coronary syndromes) contributed to 15 per cent of all deaths in Australia in 2011. Despite well-developed guidelines for managing acute coronary syndromes, there are regional variations in treatment interventions across Australia. The Australian Commission on Safety and Quality in Health Care, in collaboration with consumers, clinicians, researchers and health organisations, has developed the <i>Acute Coronary Syndromes Clinical Care Standard</i> to ensure patients receive optimal treatment from the onset of symptoms through to discharge from hospital. This includes recognition of an acute coronary syndrome, rapid assessment, early management and early initiation of a tailored rehabilitation plan.

Variation in the Care of Surgical Conditions: Prostate Cancer. A Dartmouth Atlas of Health Care Series

Hyams ES, Goodney PR, Dzebisashvili N, Goodman DC and Bronner KK

Hanover, NH: The Dartmouth Institute for Health Policy and Clinical Practice, 2014, p. 50.

URL	http://www.dartmouthatlas.org/downloads/reports/Prostate_cancer_report_12_03_14.pdf
TRIM	TRIM D14-42647
Notes	<p>This is the final in a series of six reports into surgical variation in the USA (the first five being on obesity, cerebral aneurysms, diabetes and peripheral arterial disease, spinal stenosis, and end-stage renal disease).</p> <p>This study examines the uncertainties-and resulting variation-surrounding screening and treatment for prostate cancer in the United States. Despite many years of attention and study, variation in the diagnosis and treatment of prostate cancer persists. The report notes “there is wide variation in screening and treatment practices for prostate cancer. While the lack of consensus on optimal practices will likely continue, the degree of variation also presents an opportunity to improve the quality of care for men.”</p> <p>The report also discusses how shared decision making may help address the variation in care, noting that it may be “used for prostate cancer treatment decisions given the uncertainties regarding benefits and harms of treatment for low-risk cancer.”</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/>

For information on the Commission’s work on shared decision making, see www.safetyandquality.gov.au/our-work/shared-decision-making/

Journal articles

Reimagining Quality Measurement

McGlynn EA, Schneider EC and Kerr EA

New England Journal of Medicine. 2014; 371: 2150-3.

DOI	http://dx.doi.org/10.1056/NEJMp1407883
Notes	<p>Arguing that existing approaches to quality measurement are “troubled” the authors of this paper propose a new approach.</p> <p>This approach would be guided by three principles:</p> <ol style="list-style-type: none"> 1. quality measurement should be integrated with care delivery 2. it should acknowledge and address the challenges that confront doctors every day 3. it should reflect individual patients' preferences and goals for treatment and health outcomes and enable ongoing development of evidence on treatment heterogeneity. <p>The authors suggest that such a system would have three components:</p> <ol style="list-style-type: none"> 1. a comprehensive inventory of each patient's health and health care needs 2. a mechanism for matching potential evidence-based interventions to those needs 3. an assessment of patients' health goals and preferences.

	<p>The quality score that such a system may produce would “reflect both the appropriateness of individualized care plans and the degree to which they are being carried out effectively, both for individual patients and for the population cared for by a given physician, medical group, or health care system or within a particular community.”</p> <p>In the paper the authors proceed to provide an illustrative guide to what such a system might look like and six ‘work streams’ that might be needed to enable such a system.</p>
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Getting More Performance from Performance Measurement

Cassel CK, Conway PH, Delbanco SF, Jha AK, Saunders RS and Lee TH

New England Journal of Medicine. 2014; 371: 2145-7.

DOI	http://dx.doi.org/10.1056/NEJMp1408345
Notes	<p>Another item from the same issue of the <i>NEJM</i> also looking at measurement and how to enhance the value and utility of such measurement. The authors of this piece suggest that there are various ways to achieve gains. These include:</p> <ul style="list-style-type: none"> • focusing on patient health outcomes and improving value • increasing the use of electronic clinical information, clinical registries, and ‘big data’ sources to supplement or replace claims data and manual chart reviews; • using measurement at the right level of attribution within teams and systems. <p>The authors also note that “measurement can lead to improvement only in organizations that have a culture of accountability and a workforce skilled in quality-improvement science.”</p>

Approaches to surveillance of Staphylococcus aureus bacteraemia and Clostridium difficile infection in Australian states and territories

Hanley E and Quoye C

Healthcare Infection. 2014 [epub].

DOI	http://dx.doi.org/10.1071/HI14019
Notes	<p>This article reports findings from a survey conducted by the Commission during 2012-13 about state-based approaches to surveillance of healthcare-associated <i>Staphylococcus aureus</i> bacteraemia (SAB) and hospital-identified <i>Clostridium difficile</i> infection (CDI). The survey revealed that there is extensive support for surveillance of SAB and CDI in all states and territories, with jurisdictional surveillance well-established across Australia, and enhanced surveillance programs and systems in some jurisdictions. Despite local variations in systems and processes, there was considerable consistency in use of surveillance definitions, and consolidated processes for data validation and hospital-level reporting of HAI rates in states and territories.</p>

For information on the Commission’s work on healthcare associated infection, see

www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Do Clinicians Know Which of Their Patients Have Central Venous Catheters? A Multicenter Observational Study
 Do Clinicians Know Which of Their Patients Have Central Venous Catheters?
 Chopra V, Govindan S, Kuhn L, Ratz D, Sweis RF, Melin N, et al.
 Annals of Internal Medicine. 2014;161(8):562-7.

DOI	http://dx.doi.org/10.7326/M14-0703
Notes	Infections related to the use of catheters are relatively common, and many of these are preventable. One way to reducing infection is reducing unnecessary use. This study sought to determine whether inpatient physicians know which of their patients have central venous catheters (CVCs) in place by comparing physician response to direct observation of each patient for 990 patients in three US academic medical centres. In these patients the overall prevalence of CVCs was 21.1% (n = 209), of which 60.3% (126 of 209) were peripherally inserted central catheters (PICCs). A total of 21.2% (90 of 425) of clinicians interviewed were unaware of the presence of a CVC .

Geographic Variation in Cancer-Related Imaging: Veterans Affairs Health Care System Versus Medicare
 Cancer-Related Imaging in the VA Health Care System Versus Medicare
 McWilliams JM, Dalton JB, Landrum MB, Frakt AB, Pizer SD and Keating NL
 Annals of Internal Medicine. 2014; 161: 794-802.

DOI	http://dx.doi.org/10.7326/M14-0650
Notes	Paper reporting on a study that sought to compare average use and geographic variation in use of cancer-related imaging between fee-for-service (US) Medicare and the Department of Veterans Affairs (VA) health care system, covering 34 475 traditional Medicare beneficiaries and 6835 VA patients. The study measured per-patient count of imaging studies for which lung, colorectal, or prostate cancer was the primary diagnosis, and a direct measure of overuse—advanced imaging for prostate cancer at low risk for metastasis. The authors report that the “use of cancer-related imaging was lower in the VA health care system than in fee-for-service Medicare, but lower use was not associated with less geographic variation. Geographic variation in service use may not be a reliable indicator of the extent of overuse.” As is understood, variation can be complex and identifying what might be an appropriate level of service for a given population may not be a trivial exercise.

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

Medical errors in neurosurgery

Rolston J, Zygourakis C, Han S, Lau C, Berger M, Parsa A.
 Surgical Neurology International. 2014 October 1, 2014;5(11):435-40.

DOI	http://dx.doi.org/10.4103/2152-7806.142777
Notes	Different domains of practice can lend themselves to different forms and rates of errors. This paper offers a systematic review of the neurosurgical literature. Noting that the literature is limited, the authors report that “ errors were documented in anywhere from 12% to 88.7% of cases . These errors had many sources, of which only 23.7-27.8% were technical, related to the execution of the surgery itself, highlighting the importance of systems-level approaches to protecting patients and reducing errors.” They conclude that “the magnitude of medical errors in neurosurgery and the lack of focused research emphasize the need for prospective categorization of morbidity with judicious attribution. Ultimately, we must raise

	awareness of the impact of medical errors in neurosurgery, reduce the occurrence of medical errors, and mitigate their detrimental effects.”
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Establishing an international baseline for medication safety in oncology: Findings from the 2012 ISMP International Medication Safety Self Assessment® for Oncology

Greenall J, Shastay A, Vaida AJ, U D, Johnson PE, O’Leary J, et al.

Journal of Oncology Pharmacy Practice. 2014 October 30, 2014 [epub].

DOI	http://dx.doi.org/10.1177/1078155214556522
Notes	<p>Chemotherapy is a major facet of oncological treatments. This study describes the results from the Institute for Safe Medication Practices self-assessment for oncology that involved 352 organisations from 13 countries. The self-assessment was designed to assist oncology practitioners in hospitals, ambulatory care centres, and office practice settings throughout the world to evaluate safe practices related to medication use in the oncology setting and to identify opportunities for improvement.</p> <p>Key opportunities for improvement were identified in five areas:</p> <ul style="list-style-type: none"> • implementation of the World Health Organization recommendations for management of vinCRistine and other vinca alkaloids • safe management of oral chemotherapy • labeling of distal ends of intravenous tubing • implementation of technology-based safeguards, and • patient education.

Journal of Health Services Research & Policy

January 2015; Vol. 20, No. 1 suppl

URL	http://hsr.sagepub.com/content/20/1_suppl?etoc
Notes	<p>A new issue of <i>Journal of Health Services Research & Policy</i> has been published with the theme of patient safety. Articles in this issue of <i>Journal of Health Services Research & Policy</i> include:</p> <ul style="list-style-type: none"> • Editorial: Safety lessons: shifting paradigms and new directions for patient safety research (Tara Lamont and Justin Waring) • Overseeing oversight: governance of quality and safety by hospital boards in the English NHS (Russell Mannion, Huw Davies, Tim Freeman, Ross Millar, Rowena Jacobs, and Panos Kasteridis) • Managing competing organizational priorities in clinical handover across organizational boundaries (Mark A Sujan, Peter Chessum, Michelle Rudd, Laurence Fitton, Matthew Inada-Kim, M W Cooke, and P Spurgeon) • Developing effective feedback on quality of anaesthetic care: what are its most valuable characteristics from a clinical perspective? (Danielle M D’Lima, Joanna Moore, Alex Bottle, S J Brett, G M Arnold, and J Benn) • Understanding the occupational and organizational boundaries to safe hospital discharge (Justin Waring, Fiona Marshall, and Simon Bishop) • A qualitative study of systemic influences on paramedic decision making: care transitions and patient safety (Rachel O’Hara, Maxine Johnson, A Niroshan Siriwardena, Andrew Weyman, J Turner, D Shaw, P Mortimer, C Newman, E Hirst, M Storey, S Mason, T Quinn, and J Shewan) • Being open about unanticipated problems in health care: the challenges of uncertainties (Yvonne Birks, Vikki Entwistle, Reema Harrison, Kate Bosanquet, Ian Watt, and Rick Iedema)

Online resources

[UK] *Improving the experience of care for cancer patients: Using cancer patient experience survey (CPES) data to drive improvements*

<http://www.nhs.uk/resource-search/publications/improving-the-experience-of-care-for-cancer-patients.aspx>

NHS Improving Quality has published this guide to aid cancer teams and professionals at all levels to drive continual improvement in patient experience, using tried and tested tools and techniques. The NHSIQ suggest that the consistently high level of response to cancer patient experience surveys demonstrates how much patients value the opportunity to provide feedback and make their voices heard. It is vital that patients are seen as partners in improvement initiatives and this guide helps show how this can and is being done.

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