AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

# On the Radar

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**On the Radar**
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**Consultation: draft NSQHS Standards Guide for Dental Practices and Services**
http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/information-for-dental-practices/#National-Consultation-on-the-draft-NSQHS-Standards-Guide-for-Dental-Practices-and-Services
*Now open*

The Commission has collaborated with the Australian Dental Association and dental practitioners across the country to develop the draft *NSQHS Standards Guide for Dental Practices and Services*. The guide aims to assist dental practices and services to use the NSQHS Standards as a framework to improve the safety and quality of care. It provides information on preparing for accreditation, practical strategies to implement the Standards, and clinical scenarios highlighting how the Standards can be applied in dental settings.

Whether receiving dental care in a small private practice or a large corporate practice; a community health dental clinic or a large oral health service, accreditation to the NSQHS Standards provides a nationally consistent statement about the level of care consumers can expect.
Many dental practitioners from both the private and public sectors have freely given their time in the development of the guide, and the Commission appreciates the willingness of all concerned to share their expertise.

Download the draft guide here and let us know what you think.

You can provide feedback using the electronic survey from the webpage.
Submissions can also be sent by email to NSQHSStandards@safetyandquality.gov.au or by post.

The consultation period will close on **22 April 2015**.

For any queries about the guide, please contact Gillian Giles: telephone 02 9126 3634 or email gillian.giles@safetyandquality.gov.au

## Books

*Healthcare Reform, Quality and Safety: Perspectives, Participants, Partnerships and Prospects in 30 Countries*
Braithwaite J, Matsuyama Y, Mannion R, Johnson J, editors
Farnham, Surrey: Ashgate; 2015.

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| URL | http://www.ashgate.com/isbn/9781472451408 |
| Notes | This work provides a compilation of how 'healthcare reform' is being played out across many countries. The various chapters examine how reforms have developed, particularly the impact on the quality and safety of care. Recognising that each country has its own social, cultural, economic and developmental context and that these necessarily lead to varying emphases and approaches, the collection reveals similarities and variations. The editors have also attempted to draw the various themes emerging into a coherent 'lessons learned' summary. |

*Resilient Health Care, Volume 2: The Resilience of Everyday Clinical Work*
Wears RL, Hollnagel E, Braithwaite J, editors.
Farnham, Surrey: Ashgate; 2015.

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| URL | http://www.ashgate.com/isbn/9781472437822 |
| Notes | A second volume of examples and studies in resilience in health care. This volume, according to the publisher's website, analyses "everyday work situations in primary, secondary, and tertiary care to identify and describe the fundamental strategies that clinicians everywhere have developed and use with a fluency that belies the demands to be resolved and the dilemmas to be balanced. Because everyday clinical work is at the heart of resilience, it is essential to appreciate how it functions, and to understand its characteristics." |

## Reports

*Acute hospitals and integrated care: From hospitals to health systems*
Naylor C, Alderwick H, Honeyman M
London: The King's Fund; 2015 March 2015. 93 p.

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| URL | http://www.kingsfund.org.uk/publications/acute-hospitals-and-integrated-care |
| Notes | In the UK, the NHS' five year forward view envisages a change in the role of acute hospitals. In this report from the King's Fund five case studies where acute hospitals are working collaboratively with local partners to build integrated models of care are discussed. In this vision, hospital leaders are taking a shared responsibility for leadership of a local system and this necessitates a system-wide perspective and working closely with primary care, community services, social care and others. |

## Journal articles

*The challenge of overdiagnosis begins with its definition*
Carter SM, Rogers W, Heath I, Degeling C, Doust J, Barratt A
BMJ. 2015;350.

*How to prevent overdiagnosis*
Chioleroa A, Paccauda F, Aujeskyb D, Santschic V, Rodondib N
Swiss Medical Weekly. 2015;145:w14060.

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<tr><td>DOI</td><td>Carter et al http://dx.doi.org/10.1136/bmj.h869<br>Chioleroa et al http://dx.doi.org/10.4414/smw.2015.14060<br>http://www.smw.ch/content/smw-2015-14060/</td></tr>
<tr><td>Notes</td><td>Issues around diagnosis have been garnering attention in recent times. This has included misdiagnosis and, as in the case, overdiagnosis.<br>Carter and colleagues have taken a more precise, technical approach in arguing that there needs to more precise definitions of overdiagnosis for clinical and research purposes and that for the broader and advocacy purposes a broad term such as ‘too much medicine’ may be more useful and evocative. As they note, “Aspects of overdiagnosis overlap with existing movements in health policy and practice such as evidence based medicine, patient centred care, strategies for disinvestment, and quality and safety in healthcare, especially preventing iatrogenic illness and low value healthcare. A careful comparison with these better defined problems will allow those concerned about overdiagnosis to learn from related work, avoid redundant work, and better identify what is unique about overdiagnosis.”<br>By and large eschewing such arguments, Chiolero and colleagues offer some means of reducing or preventing overdiagnosis: “Preventing overdiagnosis requires increasing awareness of healthcare professionals and patients about its occurrence, the avoidance of unnecessary and untargeted diagnostic tests, and the avoidance of screening without demonstrated benefits. Furthermore, accounting systematically for the harms and benefits of screening and diagnostic tests and determining risk factor thresholds based on the expected absolute risk reduction would also help prevent overdiagnosis.”<br>Among the means for preventing overdiagnosis they include:<br>• Avoiding certain diagnostic tests or screening<br>• Reducing the frequency of screening test<br>• Targeted screening<br>• Informing patients of the possibility of overdiagnosis and the balance between the benefits and risks of screening; to help make an informed and shared decision<br>• Anticipating the consequences of abnormalities discovered following a diagnostic test or screening<br>• Screening with combined diagnostic and prognostic tools (biomarker, personalised medicine)<br>• Prognosis estimation to decide whether or not to screen and treat<br>• When assessing a risk factor, consider the absolute risk of disease associated with this factor and expected absolute risk reduction through intervention or treatment<br>• Avoiding conflicts of interests in guideline panel committees<br>• Changing terminology for conditions with a high probability of indolence to prevent overtreatment.</td></tr>
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*Effectiveness of a care bundle to reduce central line-associated bloodstream infections*
Entesari-Tatafi D, Orford N, Bailey MJ, Chonghaile MNI, Lamb-Jenkins J, Athan E
Medical Journal of Australia. 2015 Mar 16;202(5):247-9.

| DOI | http://dx.doi.org/10.5694/mja14.01644 |
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| Notes | Care bundles have been devised to address a number of health safety issues. This paper reports on a care bundle developed to address of central line-associated bloodstream infections (CLABSI) in intensive care units (ICUs).<br>The paper reports on a before-and-after study of CLABSI in adult patients admitted to a tertiary adult ICU in regional Victoria between 1 July 2006 and 30 June 2014, with the intervention implemented in 2009.<br>The care bundle introduced in 2009 included a line insertion procedure and a novel line maintenance procedure comprising Biopatch, daily 2% chlorhexidine body wash, daily ICU central line review, and liaison nurse follow-up of central lines.<br>The authors report that the average CLABSI rate fell from 2.2/1000 central line days during the pre-intervention period to 0.5/1000 central line days (including 0/1000 central line days from July 2012 to July 2014) during the post-intervention period. As the authors note, this intervention "can effectively **reduce the CLABSI rate and maintain it at zero** out to 2 years." |

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

*BMJ Quality and Safety*
April 2015, Vol. 24, Issue 4

| URL | http://qualitysafety.bmj.com/content/24/4 |
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| Notes | A new issue of *BMJ Quality and Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality and Safety* include:<br>• Editorial: **Electronic health records** and **patient safety**: should we be discouraged? (Thomas H Payne)<br>• Editorial: **Nurse staffing matters**: now what? (Anne Sales)<br>• Editorial: The future of **measuring patient safety**: prospective **clinical surveillance** (Eric J Thomas)<br>• 'The problem with…': a new series on **problematic improvements and problematic problems** in healthcare quality and patient safety (Kaveh G Shojania, Ken Catchpole)<br>• **Human factors** and **ergonomics** and **quality improvement science**: integrating approaches for safety in healthcare (Sue Hignett, Emma Leanne Jones, Duncan Miller, Laurie Wolf, Chetna Modi, Muhammad Waseem Shahzad, Peter Buckle, Jaydip Banerjee, Ken Catchpole)<br>• The quality of **hospital work environments** and **missed nursing care** is linked to **heart failure readmissions**: a cross-sectional study of US hospitals (J Margo Brooks Carthon, Karen B Lasater, D M Sloane, A Kutney-Lee)<br>• **Computerised physician order entry-related medication errors**: analysis of reported errors and vulnerability testing of current systems (G D Schiff, M G Amato, T Eguale, J J Boehne, A Wright, R Koppel, A H Rashidee, R B Elson, D L Whitney, T-T Thach, D W Bates, A C Seger)<br>• Application of a **trigger tool** in near real time to inform **quality improvement activities**: a prospective study in a general medicine ward |

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| | (Brian M Wong, Sonia Dyal, Edward E Etchells, Sandra Knowles, Lauren Gerard, Artemis Diamantouros, R Mehta, B Liu, G R Baker, K G Shojania)<br>• **Alarm system management**: evidence-based guidance encouraging direct measurement of informativeness to improve alarm response (Michael F Rayo, Susan D Moffatt-Bruce) |

## Online resources

*Clinical Communiqué: Case studies focusing on the issues of communication and decision-making at the bedside*
Victorian Institute of Forensic Medicine
Clinical Communiqué, Volume 2, Issue 1
March 2015
http://www.vifmcommuniques.org/wp-content/uploads/2015/03/Clinical-Communique-Vol2Issue1-March-2015.pdf
*Clinical Communiqué* is a newsletter written by clinicians, using a case-study approach to report on lessons learned from deaths investigated by the Coroners' Court.
This edition explores the issues around clinical handover, communication and decision-making at the bedside. Handover encompasses a broad range of information transfer, including each time a result is reported for a patient, when a patient's care is transferred to another speciality team, or when a person or team arrives to provide assistance in an emergency.
The three cases presented provide examples where gaps in clinical handover had an effect on the clinical decision(s) made at the time. Some of the key issues raised include the problems that arise when assumptions are made about the type of language or wording used in a handover, the challenges of handover between different specialities and between the ranks of junior and senior staff, and the impact of failing to communicate all relevant information in a critical situation.

For information on the Commission's work on Clinical Communications, including clinical handover, see http://www.safetyandquality.gov.au/our-work/clinical-communications/

*[USA] ARHQ Perspectives*
The (US) Agency for Healthcare Research and Quality (AHRQ) has published three new Perspectives pieces. The three Perspectives are:

- *Diagnostic Errors* –summarising recent literature around the scope of diagnostic errors, review causes such as interruptions and system factors, and discuss strategies to enhance diagnostic accuracy. http://psnet.ahrq.gov/perspective.aspx?perspectiveID=169
- *Handoffs and Transitions* – reviews the evidence on handover or handoff interventions, notably the study linking the use of I-PASS to error reduction, and explores the continuing challenge of improving care transitions. http://psnet.ahrq.gov/perspective.aspx?perspectiveID=170
- *Safety and Medical Education* – explores key elements of teaching patient safety in US medical schools, assessing safety skills among trainees, and ongoing efforts to study the impact of duty hour restrictions. http://psnet.ahrq.gov/perspective.aspx?perspectiveID=171

*[USA] Patient Safety Primers*
http://psnet.ahrq.gov/primerHome.aspx
The Patient Safety Primers from the (US) Agency for Healthcare Research and Quality (AHRQ) discuss key concepts in patient safety. Each primer defines a topic, offers background information on its epidemiology and context, and provides links to relevant materials. AHRQ have released two new primers:

- *Improving Communication Between Clinicians* – Clear and high-quality communication between all staff involved in caring for a patient is essential in order to achieve situational awareness. Breakdowns in communication are closely tied to preventable adverse events in hospitalized and ambulatory patients. http://psnet.ahrq.gov/primer.aspx?primerID=26
- *Radiation Safety* –Greater availability of advanced diagnostic imaging techniques has resulted in tremendous benefits to patients. However, the increased use of diagnostic imaging poses significant harm to patients through excessive exposure to ionizing radiation. http://psnet.ahrq.gov/primer.aspx?primerID=27

*[USA] Effective Health Care Program reports*
http://effectivehealthcare.ahrq.gov/
The US Agency for Healthcare Research and Quality (AHRQ) has an Effective Health Care (EHC) Program. The EHC has released the following final reports and updates:

- *Menopausal Symptoms: Comparative Effectiveness of Therapies* http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2051
- *Public Reporting of Cost Measures in Health* http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2053

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