AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Books

Patient safety tool kit
World Health Organization. Regional Office for the Eastern Mediterranean
Cairo, Egypt: World Health Organization. Regional Office for the Eastern Mediterranean; 2015.

URL	http://applications.emro.who.int/dsaf/EMROPUB_2015_EN_1856.pdf
TRIM	D15-17272
Notes	The Eastern Mediterranean Regional Office of the World Health Organisation has published a *Patient Safety tool kit*. This has been produced to meet a perceived regional need to "develop the capacities of health professionals with regard to developing a patient safety improvement programme at the operational level and implementing corrective measures, adapted to local settings" in the eastern Mediterranean. The tool kit is "intended to help health care professionals implementing patient safety improvement programmes. It describes the practical steps and actions needed to build a comprehensive patient safety improvement programme…The emphasis is on its practical value to health care leadership and management and front-line clinicians. It describes a systematic approach to identifying the "what" and the "how" of patient safety. It acknowledges that patient safety is one component of an overall quality strategy."

Journal articles

Back to basics: checklists in aviation and healthcare
Clay-Williams R, Colligan L
BMJ Quality & Safety. 2015 [epub].

The problem with checklists
Catchpole K, Russ S
BMJ Quality & Safety. 2015 [epub].

DOI	Clay-Williams and Colligan http://dx.doi.org/10.1136/bmjqs-2015-003957 Catchpole and Russ http://dx.doi.org/10.1136/bmjqs-2015-004431
Notes	Clay-Williams and Colligan's Viewpoint piece reviews the adoption of checklists into healthcare. The piece briefly discusses the design and use of checklists, including some of the pitfalls. While recognising some of the successes and utility of checklists in healthcare, the authors make some suggestions about making effective and appropriate use of checklists. This includes keeping checklists "for processes that are simple, easy to follow, standardised and (perhaps) time critical." They also warn that "Introduction of a[ny] new tool without full consideration of its purpose, benefits and limitations may actually increase risk to patients, providers and the system as a whole. Overimplementation of checklists may erode respect for long-standing healthcare cognitive aids that are effective, have been iteratively improved, and are well suited to specific purposes. Overreliance on checklists as a safety net can lead to omission of other safety practices that may better support safety through reliability and resilience. Checklists are excellent 'aides memoire' and directives to correct procedures, but they are not a panacea." Following on this Viewpoint is Catchpole and Russ' piece, *The problem with checklists*. Again, recognising the potential of checklists they also counsel care in design, implementation and use, reminding us that "**A checklist is a complex socio-technical intervention that requires careful attention to design, implementation and basic skills required for the task**."

Opioid Prescribing and Potential Overdose Errors Among Children 0 to 36 Months Old
Basco WT, Ebeling M, Garner SS, Hulsey TC, Simpson K
Clinical Pediatrics. 2015 July 1, 2015;54(8):738-44.

DOI	http://dx.doi.org/10.1177/0009922815586050
Notes	Following items in previous issues of *On the Radar* on harm to young patients, is this piece examining over-dosing in young children. The study used 11 years of (US) Medicaid outpatient prescription data to compare opioid dose dispensed (observed) versus expected dose. A potential overdose was defined as any preparation dispensed that was >110% of expected. The study found that **2.7%** of the 59 536 study drug prescriptions to children 0 to 36 months old contained **potential overdose** quantities, and the average excess amount dispensed was 48% above expected. Further, younger patients were associated with higher frequencies of potential overdose: there were potential overdose quantities in 8.9% of among infants 0 to 2, 5.7% among infants 3 to 5 months old, 3.6% among infants 6 to 11 months old, and 2.3% among children >12 months. The authors conclude that "**Opioid prescriptions** for infants and children **routinely** contained **potential overdose** quantities."

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

Improving medication safety during hospital-based transitions of care
Sponsler KC, Neal EB, Kripalani S
Cleveland Clinic Journal of Medicine. 2015 1 June;82(6):351-60.

URL	http://www.clevelandclinicmeded.com/online/journal/06_June-2015/0531375/
Notes	Transitions of care or handovers (also known as handoffs) are well-recognised as points where lapses in communication can be potentially harmful to patients. This paper focuses on the communication about medications when hospital patients are going through a transition of care. As has been seen elsewhere, standardised communication and tools to aid such standardisation can help provide a safer setting. In this instance such elements include medication reconciliation processes, patient-centred medication lists, post-discharge follow-up, etc.

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

Community representation in hospital decision making: a literature review
Murray Z
Australian Health Review. 2015;39:323-328

DOI	http://dx.doi.org/10.1071/AH14016
Notes	It is well accepted that partnering with the community is an essential aspect of hospital quality improvement strategies. This article references the National Safety and Quality Health Service Standards and places the responsibility for community involvement in planning for safety and quality with hospital senior executives and boards. The paper reports on an integrative literature review which explored articles about community representation in hospital governance. The analysis found limited published studies (33 articles were used for thematic analysis), but some key themes did emerge. Effectively utilising community representation in hospital decision making was challenging because of a number of factors. These included **ambiguity** around the role of consumer representatives; poor allocation of **resources** to support community engagement; **organisational cultural issues** and consumers feeling isolated or intimidated. The study suggested that establishing quality sub-committees to support boards are an important structure for involving community representation in governance around quality of care.

For information on the National Safety and Quality Health Service Standards, see http://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/

Australian Health Review
Volume 39 Number 3. June 2015

URL	http://www.publish.csiro.au/nid/270/issue/7469.htm
Notes	A new issue of *Australian Health Review* has been published, with a focus on allied health. Articles in this issue of *Australian Health Review* include: • **Strengthening the allied health workforce**: policy, practice and research issues and opportunities (Lucio Naccarella) • **Allied health: untapped potential** in the Australian health system (Kathleen Philip)

	• **Allied health: leaders in health care reform** (Donna Markham) • The Queensland Health Ministerial Taskforce on **health practitioners' expanded scope of practice**: consultation findings (Gretchen Young, Julie Hulcombe, Andrea Hurwood and Susan Nancarrow) • Future of **specialised roles in allied health practice**: who is responsible? (Elizabeth H Skinner, Kimberley J Haines, Kate Hayes, Daniel Seller, Jessica C Toohey, Julie C Reeve, Clare Holdsworth and Terry P Haines) • **Advanced allied health assistants**: an emerging workforce (Claire Pearce and Leanne Pagett) • **Patient experience** of expanded-scope-of-practice **musculoskeletal physiotherapy** in the emergency department: a qualitative study (Paula Harding, Jonathan Prescott, Lenore Block, A M O'Flynn and A T Burge) • Embedding **research culture and productivity** in hospital physiotherapy departments: challenges and opportunities (Elizabeth H Skinner, Cylie M Williams and Terry P Haines) • Implementing **antimicrobial stewardship** in the Australian private hospital system: a qualitative study (Menino O Cotta, Megan S Robertson, Caroline Marshall, Karin A Thursky, Danny Liew and Kirsty L Buising) • **Community representation in hospital decision making**: a literature review (Zoë Murray) • **Pressure injury in Australian public hospitals**: a cost-of-illness study (Kim-Huong Nguyen, Wendy Chaboyer and Jennifer A. Whitty) • Which mothers receive a **post partum home visit** in Queensland, Australia? A cross-sectional retrospective study (Wendy Brodribb and Yvette Miller) • Overcoming the **distance barrier** in relation to treatment for haematology patients: Queensland findings (Pam McGrath) • Thinking differently: **working together for better care** (Patrick Bolton, Hilary Crilly and Ketty Rivas)

Journal of Health Services Research & Policy
July 2015; Vol. 20, No. 3

URL	http://hsr.sagepub.com/content/20/3?etoc
Notes	A new issue of the *Journal of Health Services Research & Policy* has been published. Articles in this issue of the *Journal of Health Services Research & Policy* include: • Editorial: **Nursing and the future of 'care'** in health care systems (Davina Allen) • Changes in **inpatients' experiences of hospital care** in England over a 12-year period: a secondary analysis of national survey data (Rachel Reeves and Elizabeth West) • The dysfunctional consequences of a **performance measurement system**: the case of the Iranian national hospital grading programme (Aidin Aryankhesal, Trevor A Sheldon, Russell Mannion, and Saeade Mahdipour) • Variations in the persistence of **health expenditures** and the implications for the design of **capitation payments** in Taiwan (Li-Jung Elizabeth Ku, Meng-Jiun Chiou, and Li-Fan Liu) • **Integrating funds for health and social care**: an evidence review (Anne Mason, Maria Goddard, Helen Weatherly, and Martin Chalkley)

	• Who wants to live forever? **Organizational decline in health care** (Iestyn Williams) • Who should decide how much and what information is important in **person-centred health care**? (Mette Kjer Kaltoft, Jesper Bo Nielsen, Glenn Salkeld, and Jack Dowie)

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: • Editorial: **Surgical video analysis**: an emerging tool for improving surgeon performance (Justin B Dimick, Oliver A Varban) • **Patient and family engagement**: a survey of US hospital practices (Jeph Herrin, Kathleen G Harris, Kevin Kenward, Stephen Hines, Maulik S Joshi, Dominick L Frosch) • Emotional **harm from disrespect**: the neglected preventable harm (Lauge Sokol-Hessner, Patricia Henry Folcarelli, Kenneth E F Sands) • The **SQUIRE Guidelines**: an evaluation from the field, 5 years post release (Louise Davies, Paul Batalden, Frank Davidoff, David Stevens, G Ogrinc) • **Compromised communication**: a qualitative study exploring Afghan families and health professionals' experience of interpreting support in Australian maternity care (Jane Yelland, Elisha Riggs, Josef Szwarc, Sue Casey, Philippa Duell-Piening, Donna Chesters, Sayed Wahidi, Fatema Fouladi, Stephanie Brown) • The problem with **checklists** (Ken Catchpole, Stephanie Russ)

Online resources

Clinical Communiqué
Victorian Institute of Forensic Medicine
Clinical Communiqué, Volume 2, Issue 2
June 2015
http://www.vifmcommuniques.org/volume-2-issue-2-june-2015/
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 describes two cases of patient deterioration that resulted in the activation of a hospital Medical Emergency Team (MET). Many health services nationally and internationally have implemented their versions of the MET system, with their own sets of training guidelines, protocols and practices. Despite the ubiquity of MET systems, we are still learning, and as these cases highlight, we can still do better.

For information on the Commission's work on recognising and responding to clinical deterioration, see www.safetyandquality.gov.au/our-work/recognising-and-responding-to-clinical-deterioration/