



On the Radar

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On the Radar

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Consultation on a resource for community health services applying the NSQHS Standards

The Australian Commission on Safety and Quality in Health Care has developed a draft *NSQHS Standards Guide for Community Health Services*. The Commission is seeking feedback on this resource that has been developed to help community health services using the National Safety and Quality Health Service (NSQHS) Standards.

The draft Guide for community health services describes how the NSQHS Standards can be applied in community health services and suggests strategies to meet the NSQHS Standards. It also includes examples of evidence that community health services can use to demonstrate they are meeting the NSQHS Standards.

The guide was developed primarily for community health services that are in a Local Health Network or are part of a private hospital ownership group. However, it may be useful for other community health services using the NSQHS Standards.

Feedback is sought by Friday **24 July 2015**.

Find out about the consultation process and download the draft Guide at <http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/current-consultations>

Books

A guide to quality improvement methods

Fereday S

London: Healthcare Quality Improvement Programme; 2015 June 2015.

URL	http://www.hqip.org.uk/hqip-launches-free-quality-improvement-methods-guide
Notes	The (UK) Healthcare Quality Improvement Programme has previously published a Good Governance Handbook and the Clinical audit guide for NHS Boards. This 36-page booklet introduces twelve quality improvement (QI) methods, giving providing an overview and practical advice on how and when to implement them, with illustrative case examples. The methods covered include clinical audit; Plan, Do, Study, Act (PDSA); model for improvement; LEAN/Six Sigma; Root Cause Analysis (RCA); failure modes and effects analysis; performance benchmarking, process mapping and statistical process control. The booklet is intended for health professionals with an interest in QI.

Engaging with consumers: A guide for district health boards

Health Quality & Safety Commission

Wellington: Health Quality & Safety Commission; 2015 June 2015. 44 p.

URL	http://www.hqsc.govt.nz/our-programmes/consumer-engagement/publications-and-resources/publication/2162/
Notes	The Health Quality & Safety Commission in New Zealand have published this 44-page guide to aid district health boards (DHBs) and the health and disability services they fund, to engage better with consumers. It covers consumer engagement in the design and delivery of services, as well as the development of policy and governance procedures.

For information on the Commission's work on patient and consumer centred care, see www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Journal articles

The Global Comparators project: international comparison of 30-day in-hospital mortality by day of the week

Ruiz M, Bottle A, Aylin PP

BMJ Quality & Safety. 2015 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2014-003467
Notes	A journal article that has garnered interest (from those interested in such things) was this one that examined the 'weekend effect' by looking at in-hospital mortality by day of the week using data covering nearly 3 million patients from 28 hospitals (or possibly hospital groups or networks) in England, Australia, the Netherlands and the USA. The authors report that they found "a significant 'day of the week' effect for both emergency admissions and elective surgical procedures. " The pervasive nature of this across the multi-national dataset leads them to suggest that "this is a systematic phenomenon affecting healthcare providers across borders." From an Australian perspective there was the interesting finding that in the six Australian hospitals that was "no daily variation in adjusted 30-day mortality, but...weekend effect at 7 days post emergency admission".

Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis

Hogan H, Zipfel R, Neuburger J, Hutchings A, Darzi A, Black N
 BMJ. 2015;351.

DOI	http://dx.doi.org/10.1136/bmj.h3239
Notes	<p>The importance (or otherwise) of deaths in hospitals (and measures of such hospital mortality) has been fiercely debated in recent years. The publication of this article has attracted a deal of interest as it examined the association of two of the contentious measures (hospital standardised mortality ratio (HSMR) and the summary hospital level mortality indicator (SHMI) with observed ‘avoidable deaths’ in 34 English National Health Service Trusts. The study was a retrospective case record review of 100 randomly selected hospital deaths from each of the 34 Trusts. The authors reported the proportion of avoidable deaths was 3.6% and then concluded that “The small proportion of deaths judged to be avoidable means that any metric based on mortality is unlikely to reflect the quality of a hospital. The lack of association between the proportion of avoidable deaths and hospital-wide SMRs partly reflects methodological shortcomings in both metrics. Instead, reviews of individual deaths should focus on identifying ways of improving the quality of care, whereas the use of standardised mortality ratios should be restricted to assessing the quality of care for conditions with high case fatality for which good quality clinical data exist.” It perhaps serves to remind us that measures and indicators are not an end in themselves and may be more a starting point and more suited to showing where further investigation should be undertaken.</p>

For information on the Commission’s work on hospital-based outcome indicators, see <http://www.safetyandquality.gov.au/our-work/information-strategy/indicators/core-hospital-based-outcome-indicators/>

Expanding the scope of Critical Care Rapid Response Teams: a feasible approach to identify adverse events. A prospective observational cohort

Amaral ACK-B, McDonald A, Coburn NG, Xiong W, Shojania KG, Fowler RA, et al
 BMJ Quality & Safety. 2015 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2014-003833
Notes	<p>Hospital patients experience adverse events (AEs) and various means for detecting (and addressing) such events have been proposed and implemented. This paper discusses the potential role for the hospital medical emergency team (MET) or rapid response team (RRT) in detecting such events. The authors found that reviewing the RRT consults in their study period “identified a high proportion of AEs and preventable AEs. This methodology detected twice as many AEs as the hospital's safety reporting system. RRT clinicians provide a complementary and more sensitive mechanism than traditional safety reporting systems to identify possible AEs in hospitals.”</p>

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	<p>BMJ Quality and Safety has published a number of 'online first' articles, including:</p> <ul style="list-style-type: none">• Failure mode and effects analysis: a comparison of two common risk prioritisation methods (Lisa M McElroy, Rebeca Khorzad, Anna P Nannicelli, Alexandra R Brown, Daniela P Ladner, Jane L Holl)• Integrating empowerment evaluation and quality improvement to achieve healthcare improvement outcomes (Abraham Wandersman, Kassandra Ann Alia, Brittany Cook, Rohit Ramaswamy)• Meta-analysis of the central line bundle for preventing catheter-related infections: a case study in appraising the evidence in quality improvement (Perla J Marang-van de Mheen, Leti van Bodegom-Vos)• Reducing the incidence of oxyhaemoglobin desaturation during rapid sequence intubation in a paediatric emergency department (Benjamin T Kerrey, Matthew R Mittiga, Andrea S Rinderknecht, Kartik R Varadarajan, Jenna R Dyas, G L Geis, J W Luria, M E Frey, T E Jablonski, S B Iyer)

Online resources

[NZ] *Improving Together*

<http://www.improvementmethodology.govt.nz/>

The New Zealand Health Quality & Safety Commission have been part of a group developing Improving Together. Improving Together is a quality improvement methodology toolkit that focuses on identifying work processes that could be improved, and then trialling and testing different changes to reach the best solution. The Improving Together site provides an introduction to quality improvement, including e-learning modules, case studies and other tools and resources that can be used to find simple solutions to everyday work problems.

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