On the Radar

Issue 266
Tuesday 29 March 2016

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On the Radar
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Reports

Patient care: a unified approach. A case study report
London: Royal College of General Practitioners and Royal College of Physicians; 2016. p. 20.

URL	http://www.rcgp.org.uk/news/2016/march/one-size-does-not-fit-all-gps-and-physicians.aspx
Notes	Integrated care and the coordination and continuity of care are all seen as desirable for improving the care patients receive. They all tend to place primary care as the key for achieving these improvements. This report from the UK's Royal College of General Practitioners (RCGP) and Royal College of Physicians (RCP) presents a number of case studies "that exemplify how integration between GPs and physicians can be achieved. The case studies span a wide range of services in England and Wales, and cover a variety of learning points involving different specialties, different population groups and different ways of addressing complex issues. This report has been compiled to share learning from successful examples of integration, and to encourage GPs and physicians to reflect on their own practice. Many of the examples provided are disease specific, owing to the way in which secondary care is organised; however, around the country there are many innovative examples of more holistic treatment".

Saving babies' lives: a care bundle for reducing stillbirth
London: NHS England; 2016. p. 30.

URL	https://www.england.nhs.uk/2016/03/stillbirths/
Notes	NHS England has produced this guidance as part of an effort to halve the rate of stillbirths from 4.7 per thousand to 2.3 per thousand by 2030, potentially avoiding the tragedy of stillbirth for more than 1500 families every year. While the majority of women receive high quality care, there is around a 25 per cent variation in stillbirth rates across England. The guidance seeks to ameliorate this variation by bringing together four key elements of care based on best available evidence and practice in order to help reduce stillbirth rates. The four elements are: 1. Reducing smoking in pregnancy 2. Risk assessment and surveillance for fetal growth restriction 3. Raising awareness of reduced fetal movement 4. Effective fetal monitoring during labour

Patient Safety in Victorian Public Hospitals
Victorian Auditor-General
Melbourne: Victorian Government Printer; 2016 March 2016. 64 p.

URL	http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2015-16/20160323-patient-safety.aspx
Notes	The Victorian Auditor-General's Office has released this report on their most recent audit of patient safety in Victorian hospitals. The audit included assessing how effectively health services manage patient safety and whether they are adequately supported by the Department of Health & Human Services (DHHS), as the health system manager, and the Victorian Managed Insurance Authority (VMIA), which provides insurance and risk management advice to public health services. The audit found that "there have been systemic failures by DHHS, indicating a lack of effective leadership and oversight which collectively pose an unacceptably high risk to patient safety. …These include failing to comply with its patient safety framework, not having an effective statewide incident reporting system and not using patient safety data effectively to identify overall patient safety trends. DHHS is not giving sufficient priority to patient safety. In doing so, it is failing to adequately protect the safety of hospital patients." The report included 13 recommendations: That the Department of Health & Human Services, as a matter of priority: 1. reviews, updates and complies with its 2011 Adverse Events Framework, including incorporating a robust data intelligence strategy 2. implements an effective statewide clinical incident reporting system 3. aggregates, integrates and systematically analyses the clinical incident data it receives from different sources 4. implements a process for health services to report both sentinel events and an absence of sentinel events 5. promptly disseminates lessons learnt from sentinel events to health services 6. includes meaningful indicators in its performance assessment score, such as morbidity and mortality rates 7. shares patient safety data with other government agencies that have a stake in improving patient safety. That health services: 8. ensure timely feedback is provided to those who report incidents on the recommendations from incident investigations and the outcome of actions implemented

	9. evaluate all recommendations from incident investigations for effectiveness to assess whether they are appropriate, are achieving the intended results and are sustainable, as per the Department of Health & Human Services' revised Victorian health incident management policy and guide 10. ensure review of ISR3 and ISR4 patient safety incidents to identify all risk-prevention opportunities to better quantify and understand the prevalence and impact of these incidents 11. ensure that incident investigations comply with the Department of Health & Human Services' policy and guidance. That the Department of Health & Human Services, as a matter of priority: 12. in collaboration with health services, improves training in incident investigations, including comprehensive root cause analysis, in-depth case review training programs and review of lower severity incidents 13. reviews its 2011 Victorian health incident management policy and associated guide, including developing guidance on evaluating the effectiveness of recommended actions from investigations.

Journal articles

The Burns Registry of Australia and New Zealand: progressing the evidence base for burn care
Cleland H, Greenwood JE, Wood FM, Read DJ, She RW, Maitz P, et al.
Medical Journal of Australia. 2016;204(5):195.

DOI	http://dx.doi.org/10.5694/mja15.00989
Notes	Paper describing the outcomes and variation in burns treatment in Australia and New Zealand as revealed in the data gathered in the first four years of the Burns Registry of Australian and New Zealand. The registry was launched in 2009 with the primary aim of improving the quality of burn care in the two countries. Collecting and analysing data from burns units in both countries, the registry has identified "**considerable variation in practice** in areas fundamental to the treatment of burn injury, and also provides evidence of **significant variations in outcomes** that are not explained by simple differences in casemix alone." The authors note that "in response to the findings reported here, ANZBA [Australian and New Zealand Burn Association] launched the Burns Quality Improvement Program (BQIP) in 2013. This program will use data generated by BRANZ to develop **evidence-based standards of care** (few of which are currently available for burn care) and to provide a framework that drives change." In many ways this is a clear exemplar of how a clinical quality registry can be developed to provide a mechanism for better understanding practice and improving treatment and outcomes for patients through high ascertainment and the collection and analysis of data relating to 'real world' patients. The authors observe in their conclusion that these "results demonstrate the feasibility of collecting data, as well as the need for such data, given the evidence of variations in practice and outcomes that we identified. The information provided by BRANZ provides a unique opportunity for significantly improving the quality of care for burns patients in Australia and New Zealand."

For information on the Commission's work on clinical quality registries, including the *Framework for Australian Clinical Quality Registries* and the *Strategic and Operating Principles for Australian Clinical Quality Registries*, see http://www.safetyandquality.gov.au/our-work/information-strategy/clinical-quality-registries/

DOI	http://qualitysafety.bmj.com/content/early/2016/03/18/bmjqs-2015-004839.abstract http://dx.doi.org/10.1136/bmjqs-2015-004839
Notes	The authors of this paper assert that to date patient and public involvement (PPI) in healthcare has tended to be too narrow, patchy and slow, peripheral and "tends to be concentrated at the lowest levels of involvement". They argue that "Patients and the wider public can be involved at most stages of healthcare, and this can have a number of benefits." Arguing that attention to the potential role of patients, families, carers and the public should be broadened they also call for the "adoption of models and frameworks that enable power and decision-making to be shared more equitably with patients and the public in designing, planning and co-producing healthcare." **Figure 1. A multidimensional framework for patient and family engagement in health and healthcare**

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

Re-examining high reliability: actively organising for safety
Sutcliffe KM, Paine L, Pronovost PJ
BMJ Quality & Safety. 2016.

DOI	http://dx.doi.org/10.1136/bmjqs-2015-004698
Notes	This 'Viewpoint' piece summarises the push for hospitals (and other health facilities) to be 'high reliability organisations' (HROs). In this discussion the authors make the observation that for healthcare, resilience may be a more important element in resilience than anticipation (standardisation). They also note that "Highly reliable organisations develop capabilities to detect, contain, cope with and rebound from the inevitable risks and hazards that are part of an indeterminate world, the healthcare world. The hallmark of an HRO is not that it is error free but that errors do not disable it. In a healthcare context, an **HRO would not be error free, it would be harm free**." [my emphasis] The authors go on to discuss a number of important aspects to highly reliable health organisations, including high-performance work practices, trust and respect, heedful inter-relations and the culture and climate of high reliability and safety.

Identifying low-value care: the Royal Australasian College of Physicians' EVOLVE initiative
Soon J, Buchbinder R, Close J, Hill C, Allan S, Turnour C
Medical Journal of Australia. 2016;204(5):180-1.

DOI	http://dx.doi.org/10.5694/mja15.01398
Notes	This early report from the EVOLVE initiative grapples with some key challenges, so far, in efforts by 20 clinical specialities to develop a list of five items of low-value care in their domains of practice. Using a common framework and principles, specialties had some flexibility in how they obtained consensus through the mandated survey-based Delphi process. Challenges identified included: • possible selection bias in the list of low-value practices, and related limited clinical buy-in to the list, if survey participation is not sufficiently representative of the professional body • data deficiencies, making it difficult to determine if particular practices are common, increasing, or inappropriate (e.g. due to a lack of information about indication for use) • the process being specialist-dominated, for which cooperation with Choosing Wisely Australia led by NPS MedicineWise is noted as one remedy. Final thorny challenges relate to • implementation, and the difficulty of translating a list of items into clinician and consumer behaviour change • determining whether treatments and procedures that represent low value in a specific clinical context, are of no value ever, and hence should not be subsidised (in the context of the MBS review).

Effectiveness of the Koorliny Moort out-of-hospital health care program for Aboriginal and Torres Strait Islander children in Western Australia
Cresp R, Clarke K, McAuley KE, McAullay D, Moylan CA, Peter S, et al
Medical Journal of Australia. 2016;204(5):197.

DOI	http://dx.doi.org/10.5694/mja15.00827
Notes	Implementing a culturally appropriate, consumer-centred, coordinated program of care led by Aboriginal Service Providers, significantly improved health care access in the three WA regions in which 70% of all Aboriginal children in WA reside. The Koorliny Moort ("walking with families") program was designed to address disparities in accessing health care for Aboriginal children, who frequently present to hospital later than preferred, and are most often admitted directly from the Emergency Department (ED). Failing to attend appointments or leaving the ED without being seen, are reportedly more frequent in this population. The program analysed results for 942 children in 4 years, with each child acting as their own control pre- and post- referral to Koorliny Moort. Significant changes included a 53% reduced rate of ED presentations, a 30% reduced rate of hospitalisation and reduced mean length of stay. Rates of non-attended appointments also decreased. The authors concluded that it "is possible to positively influence the health-seeking behaviour of families of Aboriginal children by engaging Aboriginal people in their health care, providing effective communication between health service providers, and delivering a coordinated program of care led by Aboriginal service providers."

Preparing for Home: a before-and-after study to investigate the effects of a neonatal discharge package aimed at increasing parental knowledge, understanding and confidence in caring for their preterm infant before and after discharge from hospital
Ingram J, Blair PS, Powell JE, Manns S, Burden H, Pontin D, et al.
Health Services and Delivery Research. 2016 March 2016;4(10).

DOI	http://dx.doi.org/10.3310/hsdr04100
Notes	This item reports on a the implementation of a parent-orientated discharge planning approach (Train-to-Home package) for preterm infants in four neonatal units in south-western England and also looks at the effects on parental self-efficacy scores, infants' length of stay (LOS) and change in costs associated with use of health-care resources in the 8 weeks after discharge, before and after implementation. The report found that the "very early discharge of most babies made further shortening of LOS very difficult to achieve. Despite the lack of change of the parental self-efficacy scores, parents reported that their **understanding and confidence in caring** for their infants were **improved** by the Train-to-Home package, and the **reduction in ED attendance and associated costs** supports this assessment." As with most (all?) HSDR papers, a plan English summary is provided along with the scientific summary, protocol and full report (144 pages).

Pharmacy-led medication reconciliation programmes at hospital transitions: a systematic review and meta-analysis
Mekonnen AB, McLachlan AJ, Brien J
Journal of Clinical Pharmacy and Therapeutics. 2016 [epub].

DOI	http://dx.doi.org/10.1111/jcpt.12364
Notes	Adding to the literature on medication reconciliation is this review and meta-analysis that focused on the impact of pharmacy-led medication reconciliation interventions on medication discrepancies at hospital transitions.

	The review used 19 studies (11 of which were randomised controlled trials) involving a total of 15 525 adult patients. The authors report that "**Pharmacy-led medication reconciliation** interventions were found to be an effective strategy to **reduce medication discrepancies**, and had a greater impact when conducted at either admission or discharge but were less effective during multiple transitions in care."

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

Factors that drive team participation in surgical safety checks: a prospective study
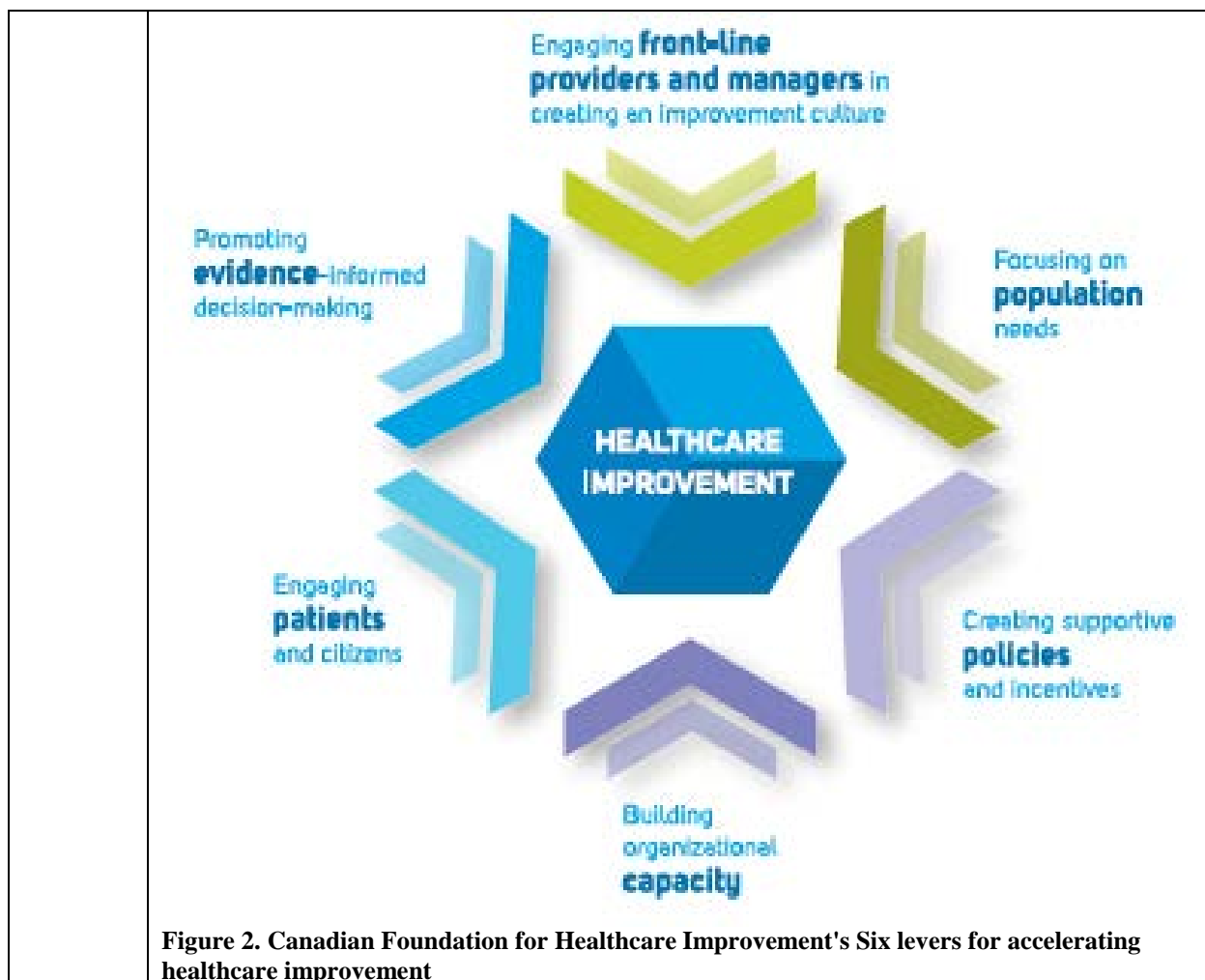Gillespie BM, Withers TK, Lavin J, Gardiner T, Marshall AP
Patient Safety in Surgery. 2016;10(1):1-9.

DOI	http://dx.doi.org/10.1186/s13037-015-0090-5
Notes	This study – based on observations of 10 surgical teams and semi-structured interviews with 70 participants from nursing, surgery and anaesthetics, and the community – sought to identify and describe factors that drive team participation in safety checks in surgery. The conclusions that the authors drew from the observations and their analyses were "**Team participation** in safety checks depends on a convergence of intertwined factors; namely, **team attributes**, **communication strategies** and **checking processes**. A whole-of-team approach to participation in surgical safety checks is far more complex when considering the factors that drive participation. Strategies to increase participation in safety checks need to **target professional communication practices** and **work processes** such as workflow which curtail team members' ability to participate."

HealthcarePapers
Vol. 15 Special Issue 2016

URL	http://www.longwoods.com/publications/healthcarepapers/24405
Notes	A special issue of *HealthcarePapers* has been published with the theme 'A Collaborative Approach to a Chronic Care Problem'. Articles in this special issue of *HealthcarePapers* include: • The **Atlantic Healthcare Collaboration**: Is it Time to Challenge the **West–East Health Gradient** in Canada? (Terrence Sullivan) • A **Collaborative Approach to a Chronic Care Problem** (Jennifer Y Verma, Jean-Louis Denis, Stephen Samis, F Champagne and M O'Neil) • A First Step on the Journey to **High-Quality Chronic Illness Care** (Edward H Wagner) • System-Level Reform in **Healthcare Delivery** for Patients and Populations Living With **Chronic Disease** (Richard Wedge and Hon. Douglas W Currie) • **Collaborative Approach** to a **Chronic Care** Problem: An Academic Mentor's Point of View (Michael Vallis) • Evaluating a **Chronic Disease Management Improvement Collaboration**: Lessons in Design and Implementation Fundamentals (Kaye Phillips, Claudia Amar and Keesa Elicksen-Jensen) • Meeting the **Challenge of Chronic Conditions** in a Sustainable Manner: Building on the AHC Learning (Pedro Delgado) • A Last Word on **Collaborating for Lasting Change** (Jennifer Y Verma, Stephen Samis, Jean-Louis Denis, Maureen O'Neil and F Champagne)

Figure 2. Canadian Foundation for Healthcare Improvement's Six levers for accelerating healthcare improvement

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: • From tokenism to empowerment: progressing **patient and public involvement in healthcare improvement** (Josephine Ocloo, Rachel Matthews) • A cross-sectional observational study of high override rates of **drug allergy alerts** in inpatient and outpatient settings, and opportunities for improvement (Sarah Patricia Slight, Patrick E Beeler, Diane L Seger, Mary G Amato, Qoua L Her, Michael Swerdloff, Olivia Dalleur, Karen C Nanji, InSook Cho, N Maniam, T Eguale, J M Fiskio, P C Dykes, D W Bates) • **Re-examining high reliability**: actively organising for safety (Kathleen M Sutcliffe, Lori Paine, Peter J Pronovost)

International Journal for Quality in Health Care online first articles

URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • SIMulation of **Medication Error** induced by Clinical Trial drug labeling: the SIMME-CT study (Cecile Dollinger, Vérane Schwiertz, Laura Sarfati, Chloé Gourc-Berthod, M-G Guédat, C Alloux, N Vantard, N Gauthier, S He, E Kiouris, A-G Caffin, D Bernard, F Ranchon, and C Rioufol)

| | - Added value of **involving patients** in the first step of multidisciplinary **guideline development**: a qualitative interview study among infertile patients (Elvira M E den Breejen, Rosella P M G Hermens, Wienke H Galama, Wim N P Willemsen, Jan A M Kremer, and W L D M Nelen)
- Influence of **patient-assessed quality of chronic illness care** and patient activation on health-related quality of life (Eindra Aung, Maria Donald, Gail M Williams, Joseph R Coll, and Suhail AR Doi)
- Observations on **quality senior health** business: success patterns and policy implications (Ya-Ting Yang, Yi-Hsin Elsa Hsu, Ya-Mei Chen, Shyi Su, Yao-Mao Chang, Usman Iqbal, Handa Yujiru, and Neng-Pai Lin)
- The **patient satisfaction questionnaire** of EUprimecare project: measurement properties (Marta Cimas, Alba Ayala, Sonia García-Pérez, Antonio Sarria-Santamera, and Maria joão Forjaz)
- Preparing **national health systems** to cope with the impending tsunami of **ageing** and its associated complexities: Towards more sustainable health care (René Amalberti, Wendy Nicklin, and Jeffrey Braithwaite)
- Reporting and use of the **OECD Health Care Quality Indicators** at national and regional level in 15 countries (Alexandru M Rotar, Michael J van den Berg, Dionne S Kringos, and Niek S Klazinga) |

Online resources

Clinical Communiqué
Victorian Institute of Forensic Medicine
Volume 3 Issue 1 March 2016
http://www.vifmcommuniques.org/volume-3-issue-1-march-2016/
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 "three cases where deaths occurred as a result of complications arising from day procedures. None of the cases were urgent and in two cases the procedures were sought by the patients for cosmetic benefits and perceived lifestyle enhancement. Although the cases differed in the type of procedure being performed, common to all three was the failure to recognise rare complications. The seriousness of the evolving symptoms and signs were not fully appreciated by the patients or the clinicians until it was too late. Some of this can be attributed to knowledge gaps on the part of the doctors involved. Much of it can be related to inadequate discharge planning and poor post-operative communication."

[UK] NICE Guidelines and Quality Standards
http://www.nice.org.uk
The UK's National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest updates are:
- Clinical Guideline CG62 *Antenatal care for uncomplicated pregnancies*
  https://www.nice.org.uk/guidance/cg62

[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:

- Nonpharmacologic Interventions for Agitation and Aggression in **Dementia** https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2198
- Treatments for **Fecal Incontinence** https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2201

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