# Australian COmmission on Safety and Quality in Health Care logo with Radar imageOn the Radar

Issue 276

6 June 2016

*On the Radar* is a summary of some of the recent publications in the areas of safety and quality in health care. Inclusion in this document is not an endorsement or recommendation of any publication or provider. Access to particular documents may depend on whether they are Open Access or not, and/or your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

*On the Radar* is available online, via email or as a PDF document from <http://www.safetyandquality.gov.au/publications-resources/on-the-radar/>

If you would like to receive *On the Radar* via email, you can subscribe on our website <http://www.safetyandquality.gov.au/> or by emailing us at H[Umail@safetyandquality.gov.auU](mailto:mail@safetyandquality.gov.au).   
You can also send feedback and comments to H[Umail@safetyandquality.gov.auU](mailto:mail@safetyandquality.gov.au).

For information about the Commission and its programs and publications, please visit <http://www.safetyandquality.gov.au>

You can also follow us on Twitter @ACSQHC.

**On the Radar**

Editor: Dr Niall Johnson [niall.johnson@safetyandquality.gov.au](mailto:niall.johnson@safetyandquality.gov.au)

Contributors: Niall Johnson

**Reports**

*Antibiotic Stewardship in Acute Care: A Practical Playbook*

National Quality Forum, National Quality Partners, Antibiotic Stewardship Action Team

Washington D.C.: National Quality Forum; 2016 May 2016. 38 p.

|  |  |
| --- | --- |
| URL | <http://www.qualityforum.org/Publications/2016/05/Antibiotic_Stewardship_Playbook.aspx> |
| Notes | The USA’s National Quality Forum (NQF), Centers for Disease Control and Prevention (CDC), and the Hospital Corporation of America (HCA) have jointly developed and released a short (38 page) ‘playbook’. The Playbook is designed to help hospitals and health systems strengthen existing antibiotic stewardship initiatives or create antibiotic stewardship programs from the ground up. Based on CDC’s Core Elements of Hospital Antibiotic Stewardship Programs, the Playbook offers practical strategies for implementing antibiotic stewardship programs. |

For information on the Commission’s work on antibiotic stewardship, including *Antimicrobial Stewardship in Australian Hospitals* and the resources around the relevant National Safety and Quality Health Service (NSQHS) Standard see [www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship/](http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship/)

*Eliminating Harm Checklists*

American Hospital Association and Health Research & Educational Trust

Chicago: American Hospital Association; 2016. p. 23.

|  |  |
| --- | --- |
| URL | <http://www.hret-hen.org/topics/ade/2016-eliminating-harm-checklist-hrethen.pdf> |
| Notes | In the past several years checklists (often as part of bundles of interventions) have become common tools in addressing safety (and quality) issues. The American Hospital Association and Health Research & Educational Trust have compiled this short (23-page) collection of evidence-based best practices, improvement strategies and action items along with checklists and resources that have been developed and field tested by participants in their Hospital Engagement Network to prevent various harms. The compilation includes resources for:   * Adverse Drug Events (ADE) * Airway Safety * Central Line-Associated Blood Stream Infections (CLABSI) * *Clostridium Difficile* Infection * Culture of Safety * Early Elective Delivery (EED) * Failure to Rescue (FTR) * Falls with Injury * Hospital Acquired Pressure Ulcers (HAPU) * Iatrogenic Delirium * Obstetrical Harm * Preventable Readmissions * Severe Sepsis and Septic Shock * Surgical Site Infections (SSI) * Undue Radiation Exposure * Venous Thromboembolism (VTE) * Ventilator Associated Events (VAE) |

**Journal articles**

*‘Just culture:’ Improving safety by achieving substantive, procedural and restorative justice*

Dekker SWA, Breakey H

Safety Science. 2016;85:187-93.

|  |  |
| --- | --- |
| DOI | <http://dx.doi.org/10.1016/j.ssci.2016.01.018> |
| Notes | Commentary piece that discusses some of the issues around a ‘just culture’. The authors note that “A ‘just culture’ aims to respond to anxiety about blame-free approaches on the one hand, and a concern about people’s willingness to keep reporting safety-related issues on the other.” The issues identified include:   * substantive justice – which prescribes how regulations, rules and procedures themselves are fair and legitimate * procedural justice – which sets down processes for determining rule-breaches, offers protections for the accused, and governs who should make such determinations * restorative justice – which aims to restore the status of the individual involved and heal relationships and injuries of victims and the wider community in the wake of an ethical breach.   The authors assert that “Just culture approaches need to provide such foundations for a **genuinely just safety culture, to be conducive to reporting, engagement and safety improvement**.” |

*A Program to Prevent Catheter-Associated Urinary Tract Infection in Acute Care*

Saint S, Greene MT, Krein SL, Rogers MAM, Ratz D, Fowler KE, et al

New England Journal of Medicine. 2016;374(22):2111-9.

|  |  |
| --- | --- |
| DOI | <http://dx.doi.org/10.1056/NEJMoa1504906> |
| Notes | Paper reporting on a national US project – the Comprehensive Unit-based Safety Program (CUSP) – that has seen the reduction in catheter-associated urinary tract infections (CAUTIs) in US hospitals. The CUSP is a customisable program in which clinicians use a checklist of clinical best practices and combine it with improvement in safety culture, teamwork, and communications.  The study examined data from 926 hospital units, including intensive care units ICUs across the USA. The researchers found that CAUTI rates decreased by 32 percent in non-ICUs, from 2.28 to 1.54 infections per 1,000 days of catheter use. These units were also able to reduce the overall use of catheters from 20.1 percent to 18.8 percent by avoiding unnecessary or unnecessarily prolonged catheterizations and using alternative urinary collection methods.  In ICUs the authors report finding that catheter use and CAUTI rates were largely unchanged. |

For information on the Commission’s work on healthcare associated infection, see [www.safetyandquality.gov.au/our-work/healthcare-associated-infection/](http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/)

*Bundle interventions used to reduce prescribing and administration errors in hospitalized children: a systematic review*

Bannan DF, Tully MP

Journal of Clinical Pharmacy and Therapeutics. 2016;41(3):246-55.

|  |  |
| --- | --- |
| DOI | <http://dx.doi.org/10.1111/jcpt.12398> |
| Notes | Paper reporting on a systematic review of the literature on bundle interventions to reduce prescribing errors (PEs) and administration errors (AEs) in hospitalised children. The review identified 17 studies but, as the authors report, “while bundle interventions delivering two or more intervention functions have been investigated but that the study quality was too poor to assess impact.” |

*Australian Health Review*

Volume 40 Number 3 2016

|  |  |
| --- | --- |
| URL | <http://www.publish.csiro.au/nid/271/issue/7973.htm> |
| Notes | A new issue of *Australian Health Review* has been published. Articles in this issue of *Australian Health Review* include:   * A system dynamics modelling approach to studying the increasing **prevalence of people with intellectual developmental disorders** in New South Wales (Lynette Lee, Mark Heffernan, Geoffrey McDonnell, Stephanie D Short and Vasi Naganathan) * Evaluation of a **hybrid paper–electronic medication management system** at a residential aged care facility (Rohan A Elliott , Cik Yin Lee and Safeera Y. Hussainy) * **Haematology patients’** desire to access **metropolitan hospital expertise** (Pam McGrath) * **Innovative medical devices and hospital decision making**: a study comparing the views of hospital pharmacists and physicians (Mathilde Billaux, Isabelle Borget, Patrice Prognon, Judith Pineau and N Martelli) * Structured social relationships: a review of **volunteer home visiting programs** for parents of young children (Fiona Byrne, Rebekah Grace, Jaimie Tredoux and Lynn Kemp) * What a great idea! Someone should **evaluate that**... (David D Schmidt) * An **express sexual health service**: in and out in a jiffy (Peta Harrison, Catriona Ooi and Timothy E Schlub) * **National dental waitlists**: what would it take to reset to zero? (Yevgeni Dudko, Estie Kruger and Marc Tennant) * **Medical innovation laws**: an unnecessary innovation (Bernadette Richards) * Learning in the workplace: the **role of Nurse Managers** (Margaret Yen, Franziska Trede and Carmel Patterson) * Hospital employees’ **perceptions of fairness and job satisfaction** at a time of transformational change (Susan Brandis, Ron Fisher, Ruth McPhail, John Rice, Kathy Eljiz, Anneke Fitzgerald, Rod Gapp and Andrea Marshall) * Understanding the perspectives of health service staff on the **Friends and Family Test** (Sandra G Leggat) * Selecting cases for **feedback to pre-hospital clinicians** – a pilot study (Lisa Brichko, Paul Jennings, Christopher Bain, Karen Smith and B Mitra) * Approaches to management of **complaints and notifications about health practitioners** in Australia (Claudette S Satchell, Merrilyn Walton, Patrick J Kelly, E M Chiarella, S M Pierce, M T Nagy , B Bennett and T Carney) * Report on the 4-h rule and **National Emergency Access Target (NEAT)** in Australia: time to review (Andrew Staib, Clair Sullivan, Bronwyn Griffin, Anthony Bell and Ian Scott) * Effects of **frequent PATient moves on patient outcomes** in a large tertiary Hospital (the PATH study): a prospective cohort study (Joan Webster, Karen New, Mary Fenn, Mary Batch, A Eastgate, S Webber and A Nesbit) * Service distribution and models of **rural outreach by specialist doctors** in Australia: a national cross-sectional study (Belinda G O’Sullivan, Matthew R McGrail, Catherine M Joyce and Johannes Stoelwinder) * Picture of the **health status of Aboriginal children** living in an urban setting of Sydney (Suzie Gardner, Susan Woolfenden, Lola Callaghan, Trudy Allende, Jennifer Winters, Grace Wong, Shea Caplice and K Zwi) * New Zealand **patients’ understanding of brand substitution** and opinions on copayment options for choice of medicine brand (Charon Lessing, Toni Ashton and Peter Davis) * Effects of **socioeconomic disadvantage** on **renal failure hospital admissions** in Victoria (Timothy Ore) |

**Online resources**

*New resources help connect care for Tasmanians*

<http://www.primaryhealthtas.com.au/news/new-resources-help-connect-care-tasmanians-0>

The Primary Health Network in Tasmania, Primary Health Tasmania, has launched a range of resources to support more connected care for chronically ill people moving between different health and community services.

According to the Primary Health Tasmania website: “The resources – including guidelines, two online learning platforms for health professionals and the *Passport to Better Health* for consumers – have been developed by Primary Health Tasmania with input from care providers across aged care, community and hospital services, and general practice.”

The resources include adaptable tools, a training guide and an online course that are designed to support implementation of the guidelines.

*Ottawa Rules app*

<https://itunes.apple.com/ca/app/the-ottawa-rules/id1104004722?mt=8> (Apple App store)

<https://play.google.com/store/apps/details?id=ca.ohri.ottawarules> (Google Play for Android devices)

The Ottawa Rules are a set of rules to help health professionals decide when to order x-rays and CT scans. Developed by emergency department physicians at The Ottawa Hospital and the University of Ottawa, the Ottawa Rules are evidence-based decision trees that help physicians determine whether a scan is needed for injured bones, cutting down on unnecessary radiation and wait times. The app includes the Ottawa Knee Rule, the Ottawa Ankle Rules and the Canadian C-spine Rule.

*[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:

* NICE Guideline NG33 ***Tuberculosis*** <https://www.nice.org.uk/guidance/ng33>

*[USA] Patient Safety Primers*

<https://psnet.ahrq.gov/primers/>

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 tow new primers:

* *Adverse Events, Near Misses, and Errors* – The terms adverse events, near misses, and medical errors are used in patient safety to refer to events where patients were harmed (or easily could have been). This Patient Safety Primer defines these terms and related concepts. <https://psnet.ahrq.gov/primers/primer/34>
* *Measurement of Patient Safety* – Measuring patient safety is a complex and evolving field, and achieving accurate and reliable measurement strategies remains a challenge for the safety field. This Patient Safety Primer reviews several of the common measurement strategies used in the safety field. <https://psnet.ahrq.gov/primers/primer/35>

*[UK] National Institute for Health Research*

<https://discover.dc.nihr.ac.uk/portal/home>

The UK’s National Institute for Health Research (NIHR) Dissemination Centre has released the latest ‘Signals’ research summaries. This latest release includes:

* **Donor eggs** may be linked to higher risk of **pregnancy complications** following IVF
* **Coordinating care** for people with **long term conditions and dementia**: room for improvement
* Diclofenac or etoricoxib, but not paracetamol, is effective for treating **osteoarthritis**
* Exercise testing shows potential as a way to identify high-risk patients for **abdominal surgery**
* **Antibiotics** are not necessary for preventing infections following simple **hand surgery**
* **Chemotherapy** for people with **recurrent stomach and oesophageal cancers** can prolong survival by two to three months
* High-flow oxygen therapy may be a useful alternative to other forms of **breathing support for preterm babies**
* **Aldosterone antagonists** reduce deaths, including sudden deaths, in people with **heart failure**
* Chest physiotherapy for **acute bronchiolitis** is ineffective and may be harmful
* **Central lines** coated with antibiotics reduce **bloodstream infections** in children

*[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:

* *Resident* ***Patient Safety Practices in Nursing Home*** *Settings* <https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2224>
* *Disparities Within Serious* ***Mental Illness*** <http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2236>
* *Newer Medications for Lower Urinary Tract Symptoms Attributed to* ***Benign Prostatic Hyperplasia****: A Review* <http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2235>
* *Core Needle and Open Surgical Biopsy for* ***Diagnosis of Breast Lesions****: An Update to the 2009 Report*  
  For Clinicians: *Core-Needle Biopsy for Breast Abnormalities* <https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2233>  
  For Consumers: *Having a Breast Biopsy: A Review of the Research for Women and Their Families* <https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2234>
* *Management and Outcomes of* ***Binge-Eating Disorder***  
  For Clinicians: *Management and Outcomes of Binge-Eating Disorder in Adults: Current State of the Evidence* <https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2212>  
  For Consumers: *Treating Binge-Eating Disorder: A Review of Evidence for Adults* <https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2213>

**Disclaimer**

*On the Radar* is an information resource of the Australian Commission on Safety and Quality in Health Care. The Commission is not responsible for the content of, nor does it endorse, any articles or sites listed. The Commission accepts no liability for the information or advice provided by these external links. Links are provided on the basis that users make their own decisions about the accuracy, currency and reliability of the information contained therein. Any opinions expressed are not necessarily those of the Australian Commission on Safety and Quality in Health Care.