



## On the Radar

Issue 304

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### On the Radar

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### Consultation closing 11 January 2017 – draft Heavy Menstrual Bleeding Clinical Care Standard

[www.safetyandquality.gov.au/ccs/consultation](http://www.safetyandquality.gov.au/ccs/consultation)

The Commission is seeking feedback on the draft *Heavy Menstrual Bleeding Clinical Care Standard*, developed in response to the variation in endometrial ablation and hysterectomy rates observed in the first *Australian Atlas of Healthcare Variation*.

Feedback can be provided easily via the online survey or in writing by 11:59 pm, **11 January 2017**.

Find out about the consultation process and provide your feedback at [www.safetyandquality.gov.au/ccs/consultation](http://www.safetyandquality.gov.au/ccs/consultation)

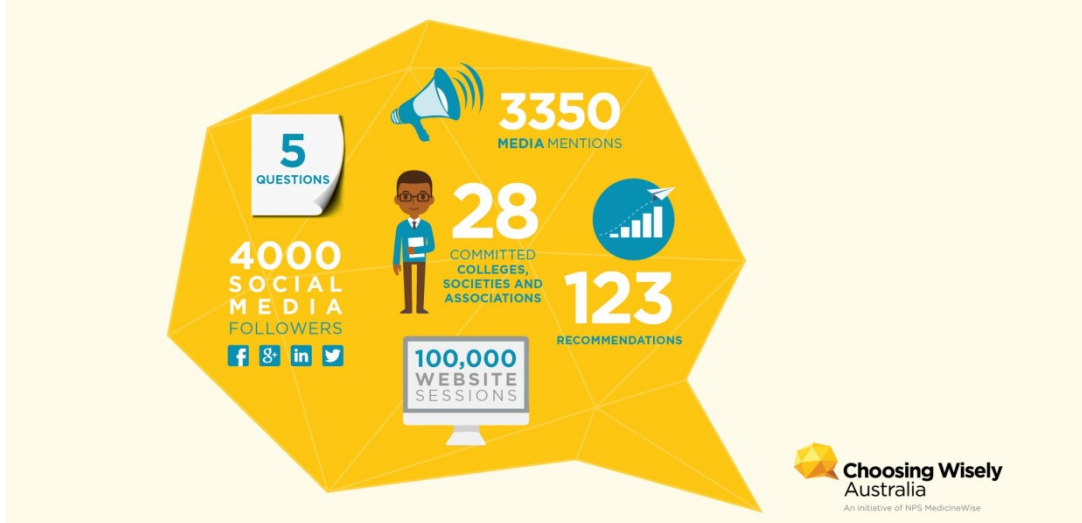
For information about the *Australian Atlas of Healthcare Variation*, see <http://www.safetyandquality.gov.au/atlas>

## Reports

*Choosing Wisely in Australia: 2016 Report*

Choosing Wisely Australia

Sydney: NPS Medicinewise; 2016. p. 17.

URL	<a href="http://www.choosingwisely.org.au/news-and-media/media-centre/choosing-wisely-australia-report">http://www.choosingwisely.org.au/news-and-media/media-centre/choosing-wisely-australia-report</a>
Notes	<p>The Australian arm of the Choosing Wisely initiative (facilitated by NPS Medicinewise) have published this report that provides insights into the drivers of unnecessary healthcare and details the success of the campaign since it launched in Australia last year. Choosing Wisely Australia launched with six member organisations from Australia's specialist medical colleges, societies and associations releasing 26 recommendations. This has grown to 28 (more than 70% of medical colleges) with 123 recommendations published.</p>  <p>The infographic features a yellow speech bubble shape containing several statistics: '5 QUESTIONS' with a document icon, '4000 SOCIAL MEDIA FOLLOWERS' with social media icons (Facebook, Google+, LinkedIn, Twitter), '3350 MEDIA MENTIONS' with a megaphone icon, '28 COMMITTED COLLEGES, SOCIETIES AND ASSOCIATIONS' with a person icon, '123 RECOMMENDATIONS' with a bar chart icon, and '100,000 WEBSITE SESSIONS' with a computer monitor icon. The Choosing Wisely Australia logo is in the bottom right corner.</p>

*Prioritised list of clinical domains for clinical quality registry development. Final report*

Australian Commission on Safety and Quality in Health Care

Sydney: ACSQHC; 2016. 97 p.

URL	<a href="https://www.safetyandquality.gov.au/our-work/information-strategy/clinical-quality-registries/">https://www.safetyandquality.gov.au/our-work/information-strategy/clinical-quality-registries/</a>
Notes	<p>As part of its work on clinical quality registries, the Australian Commission on Safety and Quality in Health Care undertook this project aimed at implementing and documenting a process applying the prioritisation criteria (and other elements) in the framework for Australian clinical quality registries, to create a prioritised list of clinical domains for potential development of national clinical quality registries.</p> <p>The process used, combined the available data with the collective judgement of experts. Key steps included:</p> <ul style="list-style-type: none"> <li>• shortlisting to identify a manageable list of diseases, conditions and interventions based on cost, burden of disease and stakeholder priorities</li> <li>• identifying prioritisation criteria in the Framework that are essential to the successful functioning of a clinical quality registry (threshold criteria)</li> <li>• applying threshold criteria to remove diseases, conditions and interventions that are not suitable for clinical quality registry development</li> <li>• grouping remaining diseases, conditions and interventions into clinical domains</li> <li>• prioritising clinical domains against the remaining prioritisation criteria.</li> </ul>

*Quality at a cost: QualityWatch annual statement 2016*

Fisher E, O'Dowd NC, Dorning H, Keeble E, Kossarova L

London: The Health Foundation and Nuffield Trust; 2016.

URL	<a href="http://www.qualitywatch.org.uk/quality-at-a-cost">http://www.qualitywatch.org.uk/quality-at-a-cost</a>
Notes	The UK's Quality Watch (developed in partnership by the Nuffield Trust and the Health Foundation) have published their annual statement on the British health and social care system. This statement finds the UK system under stress, as is noted on the website "standards in some parts of the health system are being maintained, but it seems that access to services is being forfeited. We observe that the pressure of austerity did not impact on quality measures straight away, but took a few years to be felt. Further 'delayed decline' could occur in other aspects of care quality, given the extent of the challenges faced and ongoing austerity in health and social care spending."

*Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*

Care Quality Commission

Newcastle upon Tyne: Care Quality Commission; 2016. p. 76.

URL	<a href="http://www.cqc.org.uk/content/learning-candour-and-accountability">http://www.cqc.org.uk/content/learning-candour-and-accountability</a>
Notes	<p>Report from the UK's Care quality Commission following a review of how NHS trusts identify, investigate and learn from the deaths of people under their care. The report identified need for improvement in a number of areas.</p> <ul style="list-style-type: none"><li>• Learning from deaths needs much greater priority so as to avoid missing opportunities to improve care.</li><li>• Bereaved relatives and carers must receive an honest and caring response and their right to be meaningfully involved needs to be supported.</li><li>• Healthcare providers should have a consistent approach to identifying and reporting the deaths of people using their services and share this information with other services involved in a patient's care.</li><li>• There needs to be a clear approach to support healthcare professionals' decisions to review and/or investigate a death, informed by timely access to information.</li><li>• Reviews and investigations need to be high quality and focus on system analysis rather than individual errors. Staff should have specialist training and protected time to undertake investigations.</li><li>• Greater clarity is needed to support agencies working together to investigate deaths and to identify improvements needed across services and commissioning.</li><li>• Learning from reviews and investigations needs to be better disseminated, ensuring that appropriate actions are implemented and reviewed.</li><li>• More work is needed to ensure the deaths of people with a mental health or learning disability diagnosis receive the attention they need.</li></ul>

## Journal articles

*Is there a role for patients and their relatives in escalating clinical deterioration in hospital? A systematic review*

Albutt AK, O'Hara JK, Conner MT, Fletcher SJ, Lawton RJ

Health Expectations. 2016[epub].

*A patient feedback reporting tool for OpenNotes: implications for patient-clinician safety and quality partnerships*

Bell SK, Gerard M, Fossa A, Delbanco T, Folcarelli PH, Sands KE, et al

BMJ Quality & Safety. 2016 December 13, 2016.

*PReSaFe: A model of barriers and facilitators to patients providing feedback on experiences of safety*

De Brún A, Heavey E, Waring J, Dawson P, Scott J

Health Expectations. 2016 [epub].

DOI	Albutt et al <a href="http://dx.doi.org/10.1111/hex.12496">http://dx.doi.org/10.1111/hex.12496</a> Bell et al <a href="http://dx.doi.org/10.1136/bmjqs-2016-006020">http://dx.doi.org/10.1136/bmjqs-2016-006020</a> De Brún et al <a href="http://dx.doi.org/10.1111/hex.12516">http://dx.doi.org/10.1111/hex.12516</a>
Notes	<p>A number of items that revolve around the input of patients and their families. The first (Albutt et al) looks at their role in identifying and responding to <b>clinical deterioration</b>. This paper reports on a systematic review of literature on systems involving patients and relatives in the detection of clinical patient deterioration and escalation of patient care. The study found limited studies on the clinical effectiveness of patient and relative-led escalation as studies tended to look at the impact on health-care staff and available resources. The authors report that “Patients and relatives did not overwhelm resources by activating the RRT [rapid response team]. However, they did activate it to address concerns unrelated to patient deterioration.”</p> <p>The second paper (Bell et al) reports on the use of a patient reporting tool alongside the <b>OpenNotes</b> approach. In this study, 6,225 patients were invited to use a patient portal through which they could provide feedback on their clinicians’ notes. 44% of the patients read notes. Of these 1 in 12 patients used the tool, submitting 260 reports. High levels of comprehension, finding the tool valuable, wanting the tool to remain and positive clinician-patient relationships were reported.</p> <p>Potential safety concerns were documented in 23% of reports; 2% did not understand the care plan and 21% reported possible mistakes, including medications, existing health problems, something important missing from the note or current symptoms. The authors note that “Among these, 64% were definite or possible safety concerns on clinician review, and 57% of cases confirmed with patients resulted in a change to the record or care. The feedback tool exceeded the reporting rate of our ambulatory online clinician adverse event reporting system several-fold.” As the authors suggest this “tool may help engage patients as safety partners without apparent negative consequences for clinician workflow or patient-clinician relationships.”</p> <p>The third paper (De Brún et al) describes a study looking at barriers and facilitators to <b>patient reporting of safety</b> experiences. Some of the barriers identified included apparent inability to separate safety from overall satisfaction with care, insufficient understanding of how to report concerns, and a perception that patient feedback would not lead to change.</p>

For information about the Commission’s work on patient and consumer centred care, see [www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/](http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/)

For information about the Commission’s work on recognising and responding to clinical deterioration, see <https://www.safetyandquality.gov.au/our-work/recognising-and-responding-to-clinical-deterioration/>

*Unwanted patients and unwanted diagnostic errors*  
 Redelmeier DA, Etchells EE  
 BMJ Quality & Safety. 2017;26(1):1-3.

DOI	<a href="http://dx.doi.org/10.1136/bmjqs-2015-005150">http://dx.doi.org/10.1136/bmjqs-2015-005150</a>
Notes	Editorial reflecting on studies that looked at the potential for bias and misdiagnosis when dealing with difficult or unpleasant patients. The authors identify a number of means by which clinicians can help ensure that their emotions don't impair their diagnostic skills. Some of these include self-reflection, metacognitive debiasing skills, teamwork and consultation, structured diagnostic checklists or computer-assisted diagnoses and diligent follow-up.

*Development of an Electronic Pediatric All-Cause Harm Measurement Tool Using a Modified Delphi Method*  
 Stockwell DC, Bisarya H, Classen DC, Kirkendall ES, Lachman PI, Matlow AG, et al  
 Journal of Patient Safety. 2016;12(4):180-9.

DOI	<a href="http://dx.doi.org/10.1097/PTS.0000000000000139">http://dx.doi.org/10.1097/PTS.0000000000000139</a>
Notes	Paper reporting on the development of an all-cause pediatric harm measurement tool. After reviewing 108 possible trigger tools and a Delphi process the project devised a list of 51 triggers to be tested. The aim is to produce a tool for identifying harm to pediatric patients in real-time.

*Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout*  
 Shanafelt TD, Noseworthy JH  
 Mayo Clinic proceedings. 2016 [epub].

DOI	<a href="http://dx.doi.org/10.1016/j.mayocp.2016.10.004">http://dx.doi.org/10.1016/j.mayocp.2016.10.004</a>
Notes	Clinician engagement and burnout are seen as important contributors to safety and quality of care. This paper summarises various organisational strategies for promoting engagement and describe how some have been implemented. The authors suggest that their experience “demonstrates that deliberate, sustained, and comprehensive efforts by the organization to reduce burnout and promote engagement can make a difference. Many effective interventions are relatively inexpensive, and small investments can have a large impact. Leadership and sustained attention from the highest level of the organization are the keys to making progress.”

*Identification of priorities for improvement of medication safety in primary care: a PRIORITIZE study*  
 Tudor Car L, Papachristou N, Gallagher J, Samra R, Wazny K, El-Khatib M, et al  
 BMC Family Practice. 2016;17(1):160.

DOI	<a href="https://dx.doi.org/10.1186/s12875-016-0552-6">https://dx.doi.org/10.1186/s12875-016-0552-6</a>
Notes	Paper reporting on a British study that invited 500 primary care clinicians in London to complete an open-ended questionnaire to identify three main problems and solutions relating to medication error in primary care. Analysis of the 113 responses showed top three problems were <b>incomplete reconciliation</b> of medication during patient 'hand-overs', <b>inadequate patient education</b> about their medication use and <b>poor discharge summaries</b> . The survey respondents also identified a range of suggestions for better medication management, quality assurance procedures and patient education.

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

URL	<a href="http://qualitysafety.bmj.com/content/26/1">http://qualitysafety.bmj.com/content/26/1</a>
Notes	<p>A new issue of <i>BMJ Quality and Safety</i> has been published. Many of the papers in this issue have been referred to in previous editions of <i>On the Radar</i> (when they were released online). Articles in this issue of <i>BMJ Quality and Safety</i> include:</p> <ul style="list-style-type: none"> <li>• Editorial: <b>Unwanted patients and unwanted diagnostic errors</b> (Donald A Redelmeier, Edward E Etchells)</li> <li>• Editorial: Turning the page on <b>hospital communications</b> slowly (Robert Wu)</li> <li>• Editorial: <b>Self-care after hospital discharge</b>: knowledge is not enough (Leora I Horwitz)</li> <li>• Editorial: From spotlight reports to time series: equipping <b>boards and leadership teams</b> to drive better decisions (James Mountford, D Wakefield)</li> <li>• Why <b>patients' disruptive behaviours</b> impair <b>diagnostic reasoning</b>: a randomised experiment (Silvia Mamede, Tamara Van Gog, Stephanie C E Schuit, Kees Van den Berge, Paul L A Van Daele, Herman Bueving, Tim Van der Zee, Walter W Van den Broek, Jan L C M Van Saase, H G Schmidt)</li> <li>• Do <b>patients' disruptive behaviours</b> influence the accuracy of a doctor's <b>diagnosis</b>? A randomised experiment (H G Schmidt, Tamara van Gog, Stephanie CE Schuit, Kees Van den Berge, Paul LA Van Daele, Herman Bueving, T Van der Zee, W W Van den Broek, J L C M Van Saase, S Mamede)</li> <li>• <b>Why do we still page each other?</b> Examining the frequency, types and senders of pages in academic medical services (Narath Carlile, Joseph J Rhatigan, David W Bates)</li> <li>• Closing the loop: a process evaluation of <b>inpatient care team communication</b> (Kristy Kummerow Broman, Clark Kensinger, Heather Hart, Jason Mathisen, Sunil Kripalani)</li> <li>• Understanding <b>patient-centred readmission factors</b>: a multi-site, mixed-methods study (S Ryan Greysen, James D Harrison, Sunil Kripalani, Eduard Vasilevskis, Edmondo Robinson, Joshua Metlay, Jeffery L Schnipper, David Meltzer, Neil Sehgal, Gregory W Ruhnke, Mark V Williams, A D Auerbach)</li> <li>• How might health services capture <b>patient-reported safety concerns</b> in a hospital setting? An exploratory pilot study of three mechanisms (Jane Kathryn O'Hara, Gerry Armitage, Caroline Reynolds, Claire Coulson, Liz Thorp, Ikhlaq Din, Ian Watt, John Wright)</li> <li>• Reporting and design elements of <b>audit and feedback</b> interventions: a secondary review (Heather Colquhoun, Susan Michie, Anne Sales, Noah Ivers, J M Grimshaw, Kelly Carroll, Mathieu Chalifoux, Kevin Eva, Jamie Brehaut)</li> <li>• Considering <b>chance in quality and safety performance measures</b>: an analysis of performance reports by boards in English NHS trusts (Kelly Ann Schmidtke, Alan J Poots, Juan Carpio, Ivo Vlaev, Ngianga-Bakwin Kandala, Richard J Lilford)</li> <li>• The role of <b>embedded research in quality improvement</b>: a narrative review (Cecilia Vindrola-Padros, Tom Pape, Martin Utley, Naomi J Fulop)</li> <li>• The problem with red, amber, green: the need to avoid distraction by <b>random variation in organisational performance measures</b> (Jacob Anhøj, Anne-Marie Blok Hellesøe)</li> <li>• A 'busy day' effect on <b>perinatal complications</b> of delivery on <b>weekends</b>: a retrospective cohort study (Jonathan M Snowden, Katy Backes Kozhimannil, Ifeoma Muoto, Aaron B Caughey, K John McConnell)</li> </ul>

URL	<a href="http://www.phrp.com.au/issues/december-2016-volume-26-issue-5/">http://www.phrp.com.au/issues/december-2016-volume-26-issue-5/</a>
Notes	<p>A new issue of <i>Public Health Research &amp; Practice</i> has been published with a focus on emerging infectious diseases and responses to them, including the risk they pose to Australia. Articles in this issue of <i>Public Health Research &amp; Practice</i> include:</p> <ul style="list-style-type: none"> <li>• Editorial: <b>Emerging infectious diseases</b> (Jeremy M McAnulty)</li> <li>• From plague to MERS: coordinating <b>Australia's response to emerging infectious diseases</b> (Jenny Firman, Stephanie A Williams, Chris Baggoley)</li> <li>• Future directions for public health research in <b>emerging infectious diseases</b> (Grant A Hill-Cawthorne, Tania C Sorrell)</li> <li>• <b>Exotic mosquito threats</b> require strategic surveillance and response planning (Cameron E Webb, Stephen L Doggett)</li> <li>• A review of recommendations on the safe and effective use of <b>topical mosquito repellents</b> (Cameron E Webb, Isabel MR Hess)</li> <li>• Describing <b>meningococcal disease</b>: understanding, perceptions and feelings of people in a regional area of NSW, Australia (Julie Kohlhagen, Peter D Massey, Kylie A Taylor, Maggi Osbourn, Myanfwy Maple)</li> <li>• <b>Fall prevention</b> services for older Aboriginal people: investigating availability and acceptability (Caroline Lucaszyk, Julieann Coombes, Lisa Keay, Catherine Sherrington, Anne Tiedemann, Tony Broe, Loraine Lovitt, Rebecca Ivers)</li> <li>• Content analysis of comments posted on Australian online news sites reporting a celebrity admitting <b>smoking while pregnant</b> (Beverly Carroll, Becky Freeman)</li> <li>• Australia's response to <b>Ebola Virus</b> disease in West Africa, 2014–15 (Gwendolyn L Gilbert)</li> <li>• Continuing to lift the burden: using a continuous quality improvement approach to advance <b>Aboriginal tobacco resistance and control</b> (Alvin Lee, Kerri Lucas, Megan A Campbell, Jasmine Sarin)</li> <li>• <b>Zika</b> still a threat for Australia (Anne Messenger)</li> <li>• Senate recommends action on '<b>Lyme-like illness</b>' (Anne Messenger)</li> <li>• Momentum builds for <b>soft-drink tax</b> in Australia (Nyssa Skilton)</li> </ul>

URL	<a href="http://www.longwoods.com/publications/healthcare-policy/24850">http://www.longwoods.com/publications/healthcare-policy/24850</a>
Notes	<p>A new issue of <i>Healthcare Policy</i> has been published. Articles in this issue of <i>Healthcare Policy</i> include:</p> <ul style="list-style-type: none"> <li>• Editorial: <b>Better Science, Better Science Reporting</b> (Jennifer Zelmer)</li> <li>• Doctors, Lawyers and <b>Advance Care Planning</b>: Time for Innovation to Work Together to Meet Client Needs (Nola M Ries, Maureen Douglas, Jessica Simon and Konrad Fassbender)</li> <li>• Stepping Up to the Plate: An Agenda for Research and Policy Action on <b>Electronic Medical Records</b> in Canadian <b>Primary Healthcare</b> (Amanda L Terry, Moira Stewart, Martin Fortin, Sabrina T Wong, Inese Grava-Gubins, Lisa Ashley, Patricia Sullivan-Taylor, Frank Sullivan and Amardeep Thind)</li> <li>• <b>Primary Care Performance Measurement and Reporting</b> at a Regional Level: Could a Matrix Approach Provide Actionable Information for Policy Makers and Clinicians? (Julia M Langton, Sabrina T Wong, Sharon Johnston,</li> </ul>

	<p>Julia Abelson, Mehdi Ammi, Fred Burge, John Campbell, Jeannie Haggerty, William Hogg, Walter P Wodchis and Kimberlyn Mcgrail)</p> <ul style="list-style-type: none"> <li>• <b>What's Measured Is Not Necessarily What Matters:</b> A Cautionary Story from Public Health (Raisa Deber and Robert Schwartz)</li> <li>• How Safe and Innovative Are <b>First-in-Class Drugs</b> Approved by Health Canada: A Cohort Study (Joel Lexchin)</li> <li>• Variation in <b>Emergency Department Transfer Rates</b> from <b>Nursing Homes</b> in Ontario, Canada (Andrea Gruneir, Susan E Bronskill, Alice Newman, Chaim M Bell, Peter Gozdyra, Geoffrey M Anderson and Paula A Rochon)</li> <li>• Designing <b>Integrated Approaches</b> to Support People with <b>Multimorbidity:</b> Key Messages from Systematic Reviews, Health System Leaders and Citizens (Michael G Wilson, John N Lavis and Francois-Pierre Gauvin)</li> <li>• A Review of <b>Discharge Prediction Processes</b> in Acute Care Hospitals (Anna de Groot, Kenneth Blades and Sachin R Pendharkar)</li> </ul>
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*BMJ Quality and Safety* online first articles

URL	<a href="http://qualitysafety.bmj.com/content/early/recent">http://qualitysafety.bmj.com/content/early/recent</a>
Notes	<p><i>BMJ Quality and Safety</i> has published a number of 'online first' articles, including:</p> <ul style="list-style-type: none"> <li>• Our current approach to <b>root cause analysis:</b> is it contributing to our failure to improve patient safety? (Kathryn M Kellogg, Zach Hettinger, Manish Shah, Robert L Wears, Craig R Sellers, Melissa Squires, Rollin J Fairbanks)</li> <li>• Microanalysis of <b>video from the operating room:</b> an underused approach to patient safety research (Jeff Bezemer, Alexandra Cope, Terhi Korkiakangas, Gunther Kress, Ged Murtagh, Sharon-Marie Weldon, Roger Kneebone)</li> <li>• A <b>patient feedback reporting tool for OpenNotes:</b> implications for patient-clinician safety and quality partnerships (Sigall K Bell, Macda Gerard, Alan Fossa, Tom Delbanco, Patricia H Folcarelli, Kenneth E Sands, Barbara Sarnoff Lee, Jan Walker)</li> </ul>

*International Journal for Quality in Health Care* online first articles

URL	<a href="http://intqhc.oxfordjournals.org/content/early/recent?papetoc">http://intqhc.oxfordjournals.org/content/early/recent?papetoc</a>
Notes	<p><i>International Journal for Quality in Health Care</i> has published a number of 'online first' articles, including:</p> <ul style="list-style-type: none"> <li>• Healthcare resource utilization and clinical outcomes associated with <b>acute care and inpatient rehabilitation of stroke patients</b> in Japan (Kyoko Murata, Shiro Hinotsu, Nobutake Sadamasa, Kazumichi Yoshida, Yamagata Sen, Shoji Asari, Susumu Miyamoto, Koji Kawakami)</li> <li>• Developing <b>online accreditation education resources</b> for health care services: An Australian Case Study (Amanda Pereira-Salgado, Leanne Boyd, Matthew Johnson)</li> <li>• <b>Quality management:</b> where is the evidence? Developing an <b>indicator-based approach</b> in Kenya (Helen Prytherch, Maureen Nafula, Charles Kandie, Marc Brodowski, Irmgard Marx, Sandy Kubaj, Irene Omogi, Alexia Zurkuhlen, Claudia Herrler, Katja Goetz, Joachim Szecsenyi, Michael Marx)</li> <li>• Incidence, risk factors and associated mortality of <b>central line-associated bloodstream infections</b> at an intensive care unit in northern India (S.B. Mishra, R. Misra, A. Azim, A.K. Baronia, K.N. Prasad, T.N. Dhole, M. Gurjar, R.K. Singh, B. Poddar)</li> </ul>



## Online resources

[USA] *National Scorecard on Rates of Hospital-Acquired Conditions*

<http://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html>

The US Agency for Healthcare Research and Quality (AHRQ) have published this ‘national scorecard’ showing that an estimated 125,000 fewer patients died and more than \$28 billion in health care costs were saved from 2010 through 2015 due to a 21 percent drop in hospital-acquired conditions (HACs). In total, hospital patients experienced more than 3 million fewer HACs from 2010 through 2015. HACs include adverse drug events, catheter-associated urinary tract infections, central line associated bloodstream infections, pressure ulcers and surgical site infections, among others.

[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 Clinical Guideline CG65 **Hypothermia: prevention and management in adults having surgery**  
<https://www.nice.org.uk/guidance/cg65>
- NICE Quality Standard QS138 **Blood transfusion** <https://www.nice.org.uk/guidance/qs138>
- NICE Quality Standard QS139 **Oral health promotion in the community**  
<https://www.nice.org.uk/guidance/qs139>

[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:

- *Medication-Assisted Treatment Models of Care for **Opioid Use Disorder** in Primary Care Settings*  
<https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2350>

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