AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Books

Global antimicrobial resistance surveillance system (GLASS) report. Early implementation 2016-2017
World Health Organization
Geneva: World Health Organization; 2017. 164 p.

URL	http://who.int/glass/resources/publications/early-implementation-report/en/
Notes	This first report from the WHO's Global Antimicrobial Resistance Surveillance System (GLASS), uses data from 22 countries and more than 500,000 isolates that together indicate that *Escherichia coli*, *Klebsiella pneumoniae*, *Staphylococcus aureus*, *Streptococcus pneumoniae*, and *Salmonella* spp are the most commonly reported resistant bacteria. The report notes that while resistance to the antibiotics used to treat these pathogens varies, **resistance is alarmingly high in some countries**. For example, **resistance to penicillin ranged from zero to 51%**, while **resistance to ciprofloxacin** in urinary tract infections caused by *E coli* ranged from **8% to 65%**. 100% of *E coli* isolates from urine samples collected in Egypt were non-susceptible to ceftriaxone while in Finland the rate of ceftriaxone resistant isolates was less than 5%. In Germany only 15% of *Klebsiella pneumoniae* isolates from blood samples were non-susceptible to ciprofloxacin, while the resistance rate in Latvia was around 60%.

For information on the Commission's work on antimicrobial use and resistance in Australia, see https://www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/

Reports

Against the odds: Successfully scaling innovation in the NHS
Albury D, Beresford T, Dew S, Horton T, Illingworth J, Langford K
Innovation Unit and the Health Foundation; 2018.

URL	http://www.innovationunit.org/projects/against-the-odds/
Notes	Generalisation, transferability or scaling up are often challenging transformations – taking an intervention that has been successful in one setting and making it work it work in another setting or at scale requires understanding of context and nuance and brings new challenges. This report from the UK's Innovation Unit and Health Foundation highlights the need to create the right conditions to spread health care innovations. The authors identified 10 innovations that have successfully spread across the UK's NHS in recent years and then drew insights into how scale might be more effectively pursued and supported in the future. The report's key findings focus on creating the right environment for scaling innovations. Ways to do this include the following. • Giving 'adopters' of innovation greater **recognition and support**. The current system primarily rewards innovators, but those taking up innovations often need time, space and resources to implement and adapt an innovation. • Making it easier for innovators to set up **dedicated organisations or groups** to drive innovation at scale. • Taking more **holistic and sophisticated approaches** to scaling. This can include explicitly defining national and local health care priorities in ways that create strategic opportunities for innovators.

Journal articles

Measuring, Reporting, and Rewarding Quality of Care in 5 Nations: 5 Policy Levers to Enhance Hospital Quality Accountability
Pross C, Geissler A, Busse R
The Milbank Quarterly. 2017;95(1):136-83.

URL	https://dx.doi.org/10.1111/1468-0009.12248 https://www.milbank.org/quarterly/articles/measuring-reporting-rewarding-quality-care-5-nations-5-policy-levers-enhance-hospital-quality-accountability/
Notes	Paper looking at hospital quality accountability in England, Germany, the Netherlands, Sweden, and the United States using interviews and literature review. The authors found across these countries that 'Measuring strategies are more similar across countries, while quality reporting and financial rewards are more dissimilar.' From their analyses, the authors identified five policy levers for enhancing quality transparency: 1) the government should take a central role in establishing **standards and incentives** for quality transparency and health IT system integration; 2) system centralization and decentralization need to be balanced to ensure both **national comparability and local innovation**; 3) health systems need to focus more on **outcome transparency** and less on process measures; 4) health systems need to engage **providers as proponents of quality transparency**; and 5) **reporting** should focus on hospital and condition levels to ensure **comparability** and enable meaningful patient choice.

Postsurgical prescriptions for opioid naive patients and association with overdose and misuse: retrospective cohort study
Brat GA, Agniel D, Beam A, Yorkgitis B, Bicket M, Homer M, et al
BMJ. 2018;360:j5790.

Primary care models for treating opioid use disorders: What actually works? A systematic review
Lagisetty P, Klasa K, Bush C, Heisler M, Chopra V, Bohnert A
PLoS ONE. 2017;12(10):e0186315.

DOI	Brat et al https://dx.doi.org/10.1136/bmj.j5790 Lagisetty et al https://dx.doi.org/10.1371/journal.pone.0186315
Notes	The rise is opioid usage in recent years has led to the 'opioid epidemics' now being reported in various countries, perhaps most particularly in the United States. These two papers look at opioid practice in two domains – the impact of post-surgical prescribing in generating issues and primary care approaches for treating some of the issues. Brat et al report on their retrospective cohort study that looked at the impact of post-operative opioid prescribing in (more than a million) patients who had never received opioids before. They report finding **increased opioid misuse** among those patients who received **larger quantities** of opioid medications compared to those who received fewer opioid medications. Also, the **longer duration opioid prescription** showed greater likelihood opioid misuse being diagnosed in the future. Appropriate prescribing after surgery may need to focus on keeping the number and duration of opioids as low as possible. Lagisetty et al report on their review that sought to systematically analyse evidence-based, primary care Opioid Use Disorder (OUD) Medication-Assisted Treatment (MAT) interventions so as to structures and processes associated with improved patient outcomes. Based on a review of 35 interventions ((10 RCTs and 25 quasi-experimental interventions) that tested MAT, buprenorphine or methadone, in primary care settings across 8 countries, they report 'that **multidisciplinary** and **coordinated care delivery models** are an effective strategy to implement OUD treatment and increase MAT access in primary care'

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

Strategies to reduce patient harm from infusion-associated medication errors: a scoping review
Wolf ZR
Journal of Infusion Nursing. 2018;41(1):58-65.

DOI	https://doi.org/10.1097/NAN.0000000000000263
Notes	Medication errors are one of the most common forms of error in health care. Different medication delivery methods have their own particular risks. This review article – based on review of 20 articles – looked at infusion with a focus on ways of improving infusion safety such as staff education and supervision, standardisation (equipment, protocols, etc.), smart pump systems, and cognitive aids. The review also describes the particular risks of infusion, such as clinician knowledge and patient complexity.

Safety culture, patient safety, and quality of care outcomes: a literature review.
Seung Eun L, Linda DS, Dahinten VS, Catherine V, Karen Dunn L, Chang Gi P
Western Journal of Nursing Research. 2017 [epub].

DOI	https://doi.org/10.1177/0193945917747416
Notes	Culture and its relationship with the safety and quality of care has been something of a recurring theme of late. However, this literature review found that the relationship between safety culture and patient safety outcomes (in hospital settings) was rather inconsistent across the 17 studies examined. Some of this stems from definitional issues along with 'semantic inconsistencies, infrequent use of a theory or theoretical framework, limited discussions of validity of instruments used, and significant methodological variations'. The authors suggest a theoretical framework and validated safety culture instruments could help better examine the relationship between safety culture and patient harm.

Promising practices for improving hospital patient safety culture
Campione J, Famolaro T
Joint Commission Journal on Quality and Patient Safety. 2018;44(1):23-32.

DOI	https://doi.org/10.1016/j.jcjq.2017.09.001
Notes	Also on the topic of culture is this paper describing a project that used the (US) Agency for Healthcare Research and Quality Survey on Patient Safety Culture data to identify a number of US hospitals that had shown significant improvement over time in the Survey. The project reviewed data submitted by 536 hospitals from 2007 through 2014 and identified 6 large (> 400 beds) hospitals. The project team then interviewed quality leaders at those 6 hospitals. Qualitative analysis revealed common best practices across those hospitals, including **goal setting**, **systematic safety culture measurement**, **communication and feedback** of results, **leadership and clinician engagement** in improvement efforts, and the implementation of **patient safety initiatives**.

Primary care providers' perspectives on errors of omission
Poghosyan L, Norful AA, Fleck E, Bruzzese J-M, Talsma A, Nannini A
The Journal of the American Board of Family Medicine. 2017;30(6):733-42.

DOI	http://dx.doi.org/10.3122/jabfm.2017.06.170161
Notes	Paper describing a qualitative study based on interviews with 26 primary care providers in New York state that sought to identify types of errors of omission that can occur in primary care. The main categories of **errors of omission** that the providers identified were omitting **patient teaching**, **patient follow-up**, **emotional support**, and **addressing mental health** needs. The providers perceived that time constraints, unplanned patient visits and emergencies, and administrative burden led to these gaps in care. They also stressed that organisational support and infrastructure, effective teamwork and communication, and preparation for the patient encounter were important safeguards to prevent errors of omission within their practices.

Patient Safety in Complementary Medicine through the Application of Clinical Risk Management in the Public Health System
Rossi E, Bellandi T, Picchi M, Baccetti S, Monechi M, Vuono C, et al
Medicines. 2017;4(4):93.

DOI	http://dx.doi.org/10.3390/medicines4040093
Notes	Much of the safety and quality literature is focused on mainstream medicine. This paper discusses the use of failure mode and effect analysis in order to characterise the patient safety issues that may exist with complementary medicine, including acupuncture and homeopathy. For some the lack of an evidence base for the efficacy of these approaches is itself a major concern; let alone the actual practice behaviours. The authors sought to develop a systematic approach to detect and prevent clinical risks in complementary medicine and increase patient safety through the analysis of activities in homeopathy and acupuncture centres. They suggest that an approach using a combination of significant event audit (SEA) and failure modes and effects analysis (FMEA) can reveal potential risks for patients and suggest actions for safer and more reliable services in CM

BMJ Quality & Safety
February 2018 – Volume 27 – 2

URL	https://qualitysafety.bmj.com/content/27/2
Notes	A new issue of *BMJ Quality and Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality and Safety* include: • Editorial: Lending a hand: could **machine learning** help hospital staff make better use of **patient feedback**? (Chris Gibbons, Felix Greaves) • Editorial: **Raising up** the voices of the closest observers of care (Naomi S Bardach) • Editorial: **Intraoperative non-technical skills**: a critical target for improving surgical outcomes (Kara Vande Walle, Caprice Greenberg) • The use of **patient feedback** by **hospital boards** of directors: a qualitative study of two NHS hospitals in England (Robert Lee, Juan I Baeza, N J Fulop) • Wisdom of patients: predicting the quality of care using **aggregated patient feedback** (Alex Griffiths, Meghan P Leaver) • Are **Facebook user ratings** associated with hospital cost, quality and patient satisfaction? A cross-sectional analysis of hospitals in New York State (Lauren Campbell, Yue Li) • **Nursing home Facebook reviews**: who has them, and how do they relate to other measures of quality and experience? (Jennifer Gaudet Hefele, Yue Li, Lauren Campbell, Adrita Barooah, Joyce Wang) • Impact of two-step **urine culture ordering** in the emergency department: a time series analysis (Amanda Stagg, Haydon Lutz, Sakshi Kirpalaney, John Justin Matelski, Adam Kaufman, Jerome Leis, Janine McCready, Jeff Powis) • Anticipation, teamwork and cognitive load: chasing efficiency during **robot-assisted surgery** (Kevin Sexton, Amanda Johnson, Amanda Gotsch, Ahmed A Hussein, Lora Cavuoto, Khurshid A Guru) • Simple example of a practical solution to make **patient feedback** more useful (L Marjon Dijkema, Lisa W Dümmer, Jasmijn D Generaal, Merel B Klunder, Anna Bouwknegt, Frederik Keus, Iwan C C van der Horst) • **Night-time communication** at Stanford University Hospital: perceptions, reality and solutions (Andrew Jordan Sun, Libo Wang, Minjoung Go, Zac

	Eggers, Raymond Deng, Paul Maggio, Lisa Shieh) • Advancing **infection prevention and antimicrobial stewardship** through improvement science (Jerome A Leis) • Are the **NHS national outcomes frameworks** past their sell-by date? (Veena S Raleigh, Julia Cream, Richard Murray)

Australian Health Review
Volume 42 Number 1

URL	http://www.publish.csiro.au/ah/issue/8879
Notes	A new issue of the *Australian Health Review* has been published. Articles in this issue of *Australian Health Review* include: • A two-way street: reciprocal teaching and learning in **refugee health** (Timothy James Martin, Coen Butters and Linny Phuong) • Improving **health literacy** about **dementia** among older Chinese and Vietnamese Australians (Betty Haralambous, Paulene Mackell, Xiaoping Lin, Marcia Fearn and Briony Dow) • Health professionals' views on **health literacy** issues for culturally and linguistically diverse women in **maternity care**: barriers, enablers and the need for an integrated approach (Jo-anne Hughson, Fiona Marshall, Justin Oliver Daly, Robyn Woodward-Kron, John Hajek and David Story) • What's in a name? An overview of organisational **health literacy terminology** (Elizabeth Meggetto, Bernadette Ward and Anton Isaccs) • Building **health literacy responsiveness** in Melbourne's west: a systems approach (Mindy L Allott, Tanya Sofra, Gail O'Donnell, Jeremy L Hearne and Lucio Naccarella) • Key lessons for designing **health literacy professional development** courses (Lucio Naccarella and Bernice Murphy) • Effect of **health insurance on direct hospitalisation costs** for in-patients with ischaemic stroke in China (Ma Yong, Xiong Xianjun, Li Jinghu and Fang Yunyun) • **Faecal occult blood testing (FOBT)-based colorectal cancer screening** trends and predictors of non-use: findings from the South Australian setting and implications for increasing FOBT uptake (Kamelia Todorov, Carlene Wilson, Greg Sharplin and Nadia Corsini) • 'Why didn't you write a **not-for-cardiopulmonary resuscitation order**?' Unexpected death or failure of process? (Michele Levinson, Amber Mills, Jonathan Barrett, Gaya Sritharan and Anthea Gellie) • **Electronic health records** and online medical records: an asset or a liability under current conditions? (Judith Allen-Graham, Lauren Mitchell, Natalie Heriot, Roksana Armani, David Langton, Michele Levinson, Alan Young, Julian A Smith, Tom Kotsimbos and John W Wilson) • Hunter and New England **HealthPathways**: a 4-year journey of **integrated care** (Jane S Gray, Judith R Swan, Margaret A Lynch, Tracey M Tay, Marika-Jane Mackenzie, John H Wiggers, Karen A Harrison, Robert C McDonald, Ian P O'Dea, Louise M Harrigan, Sandra M Fitzgerald and on behalf of the Hunter and New England HealthPathways Steering Committee) • Legislation, policies and guidelines related to **breastfeeding** and the **Baby Friendly Health Initiative** in Australia: a document analysis (Anahita Esbati, Margaret Barnes, Amanda Henderson and Jane Taylor)

	• Challenges in implementing **individual placement and support** in the Australian **mental health service** and policy context (Yolande Stirling, Kate Higgins and Melissa Petrakis) • **Advance care directive documentation**: issues for clinicians in New South Wales (Mark I Friedewald and Peter A Cleasby) • Are **wait lists** inevitable in subacute ambulatory and community health services? A qualitative analysis (Katherine E Harding, Nicole Robertson, David A Snowdon, Jennifer J Watts, Leila Karimi, Mary O'Reilly, Michelle Kotis and Nicholas F Taylor) • **Assistive technology pricing** in Australia: is it efficient and equitable? (Michael P Summers and George Verikios) • **Rural health services** and the task of **community participation** at the local community level: a case study (Elena Wilson, A Kenny and V Dickson-Swift) • Funding **therapies for rare diseases**: an ethical dilemma with a potential solution (Colman Taylor, Stephen Jan and Kelly Thompson)

BMJ Quality and Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Editorial: Advancing the science of **patient decision aids** through reporting guidelines (Robert J Volk, Angela Coulter) • Impact of **order set design** on **urine culturing** practices at an academic medical centre emergency department (Satish Munigala, Ronald R Jackups, Jr, Robert F Poirier, Stephen Y Liang, H Wood, S R Jafarzadeh, D K Warren) • **Task errors by emergency physicians** are associated with interruptions, multitasking, fatigue and working memory capacity: a prospective, direct observation study (Johanna I Westbrook, Magdalena Z Raban, Scott R Walter, Heather Douglas) • **Patient experience** of **general practice** and **use of emergency hospital** services in England: regression analysis of national cross-sectional time series data (Thomas E Cowling, Azeem Majeed, Matthew J Harris) • **Symptom-Disease Pair Analysis of Diagnostic Error** (SPADE): a conceptual framework and methodological approach for unearthing misdiagnosis-related harms using big data (Ava L Liberman, David E Newman-Toker) • Implementation of a **colour-coded universal protocol safety initiative** in Guatemala (Brad M Taicher, Shannon Tew, Ligia Figueroa, Fausto Hernandez, Sherry S Ross, Henry E Rice)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-access?papetoc
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • The spectrum of **ethical issues in a Learning Health Care System**: a systematic qualitative review (Stuart McLennan; Hannes Kahrass; Susanne Wieschowski; Daniel Strech; Holger Langhof) • Using **statistical process control** methods to trace small changes in perinatal mortality after a training program in a low-resource setting (Estomih R Mduma; Hege Ersdal; Jan Terje Kvaloy; Erling Svensen; Paschal Mdoe; Jeffrey Perlman; Hussein Lessio Kidanto; Eldar Soreide)

	• Assessing **functional status after intensive care unit stay**: the Barthel Index and the Katz Index (Leda Tomiko Yamada da Silveira; Janete Maria da Silva; Júlia Maria Pavan Soler; Carolina Yea Ling Sun; Clarice Tanaka; Carolina Fu) • The development of **quality indicators for home care** in China (Xianping Tang; Xuemei Chen; Yajuan Pang; Lanshu Zhou) • A comparison of outcomes between Canada and the United States in **patients recovering from hip fracture repair**: secondary analysis of the FOCUS trial (Lauren A Beaupre; Eugene K Wai; Donald R Hoover; Helaine Noveck; Darren M Roffey; Donald R Cook; Jay S Magaziner; Jeffrey L Carson) • Cross-sectional study of characteristics of **clinical registries** in Australia: a resource for clinicians and policy makers (Dewan Md. Emdadul Hoque; Rasa Ruseckaite; Paula Lorgelly; John J McNeil; Sue M Evans) • De-freezing **frozen patient management** (Ayala Kobo-Greenhut; Amin Shnfi; Eran tal-or; Racheli Magnazi; Amos Notea; Meir Ruach; Erez Onn; Ayala Cohen; Etti Doveh; Izhar Ben Shlomo; Yonatan Hasin) • Contractual **health services performance agreements** for responsive health systems: from conception to implementation in the case of Qatar (Huda Al-Katheeri; Fadi El-Jardali; Nour Ataya; Noura Abdulla Salem; Nader Abbas Badr; Diana Jamal) • Short- and long-term effects of **clinical pathway** on the quality of **surgical non-small cell lung cancer care** in China: an interrupted time series study (Xinyu Wang; Shaofei Su; Hao Jiang; Jiaying Wang; Xi Li; Meina Liu)

Online resources

[UK] Making sense of accountable care
https://www.kingsfund.org.uk/publications/making-sense-accountable-care
The King's Fund in the UK has posted this 'long read' on accountable care. The piece describes the term, what it has come to mean (a synonym for integrated care) and how it is being implemented in the UK.

[UK] NICE Guidelines and Quality Standards
https://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 reviews or updates are:

- NICE Guideline NG82 *Age-related* ***macular degeneration***
  https://www.nice.org.uk/guidance/ng82
- NICE Guideline NG83 ***Oesophago-gastric cancer****: assessment and management in adults*
  https://www.nice.org.uk/guidance/ng83
- NICE Guideline NG84 ***Sore throat*** *(acute):* ***antimicrobial prescribing***
  https://www.nice.org.uk/guidance/ng84

[UK] National Institute for Health Research
https://discover.dc.nihr.ac.uk/portal/search/signals
The UK's National Institute for Health Research (NIHR) Dissemination Centre has released the latest 'Signals' research summaries. This latest release includes:

- Stopping biological drugs for **rheumatoid arthritis** can lead to twice the relapse rate
- New screening pathway could help to identify a rare, single-gene form of **diabetes**
- A primary care intervention helps **older people with depression**
- Biological therapies for **psoriasis** do not increase serious infection risk
- A surgical procedure for **shoulder pain** is less effective than previously thought
- Single urine samples are just as good as 24-hour collections for diagnosing **pre-eclampsia**
- Staying on antidepressants may prevent a relapse of **anxiety**
- **National tobacco control policies** linked to improvements in children's health
- Blood test reduces mortality and shortens antibiotic use among adults with **chest infection**
- Two common operations to fix a **broken tibia** have similar outcomes

[USA] Effective Health Care Program reports
https://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:

- ***Attention Deficit Hyperactivity Disorder:*** *Diagnosis and Treatment in Children and Adolescents*
  https://effectivehealthcare.ahrq.gov/opics/adhd-update/systematic-review-2018
