AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Reports

Mapping primary care in Australia
Swerissen H, Duckett S, Moran G
Melbourne: Grattan Institute; 2018.

URL	https://grattan.edu.au/report/mapping-primary-care-in-australia/
Notes	This latest report from the Grattan Institute's health program, argues that primary care in Australia needs reform, particularly to ensure better access and equity. There is also a need for better co-ordination and integration of care for people with complex and chronic conditions. The authors believe that "Australia needs a comprehensive national primary care framework to improve patient care and prevention; formal agreements between the Commonwealth, the states and Primary Health Networks to improve system management; and new funding, payment and organisational arrangements to help keep populations healthy and to provide better long-term care for the increasing number of older Australians who live with complex and chronic conditions." For those of a cartographic bent, the title refers to a metaphorical mapping, not a literal one. There are no maps in the report.

For information on the Commission's work on primary health care, see https://www.safetyandquality.gov.au/our-work/primary-health-care/

IHI Innovation System
IHI White Paper
Martin LA, Mate K
Boston: Institute for Healthcare Improvement; 2018. p. 29.

URL	http://www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Innovation-System.aspx
Notes	The (US) Institute for Healthcare Improvement has released this 'white paper' that seeks to describes how a health care organization might create its own internal innovation system, based on the needs of the organization, that focuses on improving health care delivery. The paper provides a description of the IHI innovation system and includes guidance on: • Determining the innovation system architecture: goals, priorities, and dedicated resources for innovation • Creating a disciplined innovation process • Establishing ongoing management of the innovation system by identifying innovation drivers, developing processes, and integrating operations and innovation

Journal articles

National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Australian clinical guidelines for the diagnosis and management of atrial fibrillation 2018
Brieger D, Amerena J, Attia JR, Bajorek B, Chan KH, Connell C, et al
Medical Journal of Australia. 2018 [epub].

National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Australian clinical guidelines for the management of heart failure 2018
Atherton JJ, Sindone A, De Pasquale CG, Driscoll A, MacDonald PS, Hopper I, et al
Medical Journal of Australia. 2018 [epub].

DOI	Brieger et al https://doi.org/10.5694/mja18.00646 Atherton et al https://doi.org/10.5694/mja18.00647
Notes	The National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand have developed these two clinical guidelines for to assist clinicians in caring for adult patients with atrial fibrillation and heart failure. The full clinical guidelines are available in the journal Heart, Lung and Circulation at https://doi.org/10.1016/j.hlc.2018.06.1043 and https://doi.org/10.1016/j.hlc.2018.06.1042 respectively.

NSW Clinical Guidelines: Treatment of Opioid Dependence 2018
NSW Ministry of Health
Sydney: NSW Health; 2018. p. 136.

URL	http://www.health.nsw.gov.au/aod/Pages/nsw-clinical-guidelines-opioid.aspx
Notes	NSW Health has developed these guidelines that seek to provide clinical guidance and policy direction for opioid treatment in NSW. The guidelines aim to: • improve access to opioid treatment by: • personalise patient care by introducing a system that differentiates between those who have low/moderate treatment needs and can be treated in community settings and those with complex/high treatment needs and should be referred to and treated in the specialist treatment sector • support more effective coordination of care across health services.

	These guidelines are intended for use in generalist health settings (for example primary care, hospital, clinic or community settings) as well as specialised drug and alcohol / opioid treatment clinics.

Antimicrobial prescribing for children in primary care
Yan J, Hawes L, Turner L, Mazza D, Pearce C, Buttery J
Journal of Paediatrics and Child Health. 2018.

DOI	https://doi.org/10.1111/jpc.14105
Notes	This Australian study used data extracted from 39 general practices in eastern metropolitan Melbourne over a 5-year period, 2010–2014 in order to examine the patterns of antimicrobial in children. The first *Australian Atlas of Healthcare Variation* demonstrated both high levels and variation of antimicrobial use in Australia. This study found that • On average, **one in five** individual children was **prescribed an antibiotic each year**. • Most commonly prescribed antibiotics were cephalexin, amoxycillin/clavulanate, cefaclor, phenoxymethylpenicillin and roxithromycin. • Less than 3% of all prescriptions were for amoxycillin. • **Peaks** in prescribing were noted over **winter months** • **Reason for prescription** was **not recorded** for **82%** of prescriptions. • Frequency of **antibiotic prescription per consultation varied substantially** (2.1–19.7%) between general practitioner clinics • Overall, antibiotic prescribing decreased by 2.3% over the 5-year period.

For information about and access to the *Australian Atlas of Healthcare Variation* series, see https://www.safetyandquality.gov.au/atlas/

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

Association of Opioid-Related Adverse Drug Events With Clinical and Cost Outcomes Among Surgical Patients in a Large Integrated Health Care Delivery System
Shafi S, Collinsworth AW, Copeland LA, Ogola GO, Qiu T, Kouznetsove M, et al
JAMA Surgery. 2018 [epub].

DOI	https://doi.org/10.1001/jamasurg.2018.1039
Notes	Study that used clinical and administrative data covering 135, 379 patients in order to determine the incidence and consequences of opioid-related adverse drug events in patients undergoing hospital-based surgical and endoscopic procedures in a US health care system with 21 hospitals. Of the 135,379 patients, 14 386 (**10.6%**) experienced **opioid-related adverse drug events**. The authors report that these events were associated with significantly **worse patient outcomes**, including **increased inpatient mortality**, greater likelihood of **discharge to another care facility**, **prolonged length of stay**, **high cost** of hospitalization, and **higher rate of 30-day readmission**.

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

For information on the Commission's work on safety in e-health, including electronic medication management (EMM) systems, see https://www.safetyandquality.gov.au/our-work/safety-in-e-health/

Transition to a new electronic health record and pediatric medication safety: lessons learned in pediatrics within a large academic health system
Whalen K, Lynch E, Moawad I, John T, Lozowski D, Cummings BM
Journal of the American Medical Informatics Association. 2018;25(7):848-54.

DOI	https://doi.org/10.1093/jamia/ocy034
Notes	Paper describing the experience of roll-out of a new electronic health record (EHR) in a mixed neonatal, paediatric and adult hospital with staggered implementation. The paper examined the medication safety and implementation challenges and solutions in the paediatric population. This is another example of how changes in technology that are aimed at improving safety and quality can introduce new challenges, but some of these are temporary and many can be anticipated. The authors report that on implementation, there was a 5-fold increase in the overall number of medication safety reports but after three months rate of reported medication errors had returned to baseline. The majority of reports were near misses. Three major safety themes were identified: 1. enterprise logic in rounding of doses and dosing volumes; 2. ordering clinician seeing a concentration and product when ordering medications 3. the need for standardised dosing units through age contexts created issues with continuous infusions and pump library safeguards.

Impact of an antiretroviral stewardship strategy on medication error rates
Shea KM, Hobbs AL, Shumake JD, Templet DJ, Padilla-Tolentino E, Mondy KE
American Journal of Health-System Pharmacy. 2018;75(12):876-85.

DOI	http://doi.org/10.2146/ajhp170420
Notes	This study of the implementation of an antiretroviral stewardship strategy (including prospective audit by staff pharmacists through use of an antiretroviral medication therapy checklist at the time of order verification) in a single centre reported significant **reduction** in the **overall error rate** and in various error types, including **incorrect/incomplete medication** regimen, **incorrect dosing** regimen, **incorrect renal dose** adjustment, **incorrect administration**, and the presence of a major **drug–drug interaction**. This is further evidence on the utility of stewardship programs.

Targeting the 'right' patients for integrated care: stakeholder perspectives from a qualitative study
Stokes J, Riste L, Cheraghi-Sohi S
Journal of Health Services Research & Policy. 2018 [epub].

DOI	https://doi.org/10.1177/1355819618788100
Notes	Better integrated and co-ordinated care is seen as a possible panacea for improving the care of patients with complex and chronic conditions. This qualitative study problematizes this view somewhat. The study is based on analysis of qualitative interviews with relevant stakeholders (including programme managers, programme initiators, a representative of the payers, medical and social care professionals and allied health services staff) from two integrated care sites in England. The two sites focused on individualized management of 'high-risk' patients through multidisciplinary team case management. However, the data-driven approach to targeting patients did not align with stakeholders' experience of selecting patients in practice. The 'right' patients were at lower risk than those recommended by policy, and their complexities were identified as comprising mostly social rather than medical issues. The authors suggest that this may help explain why management of high-risk patients has not been found to be effective, undermining the assumption that this approach will lead to cost savings. They suggest that "There is a need to expand beyond an individually targeted approach to incorporate prevention and to address social issues."

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

10,000 good catches: increasing safety event reporting in a pediatric health care system
Crandall KM, Almuhanna A, Cady R, Fahey L, Floyd TT, Freiburg D, et al
Pediatric Quality & Safety. 2018;3(2):e072.

DOI	https://doi.org/10.1097/pq9.0000000000000072
Notes	Paper describing how a US paediatric 'health care system' devised and implemented a safety reporting system that sought to encourage reporting as a means of improving reliability and the safety culture.

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: • The problem with **pay-for-performance** schemes (Suhas Gondi, Derek Soled, Ashish Jha) • Public reporting of **antipsychotic prescribing in nursing homes**: population-based interrupted time series analyses (Noah M Ivers, Monica Taljaard, Vasily Giannakeas, Catherine Reis, Evelyn Williams, Susan Bronskill)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-access
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Translating evidence in complex systems: a comparative review of **implementation and improvement frameworks** (Julie E Reed; Stuart Green; Cathy Howe) • Obesity in total laparoscopic hysterectomy for **early stage endometrial cancer**: health gain and inpatient resource use (N R Armfield; M Janda; A Obermair) • Goal attainment and renal outcomes in patients enrolled in the **chronic kidney disease care** program in Taiwan: a 3-year observational study (Yi Wang; Yueh-Ting Lee; Wen-Chin Lee; Hwee-Yeong Ng; Chien-Hsing Wu; Chien-Te Lee)

Online resources

[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 NG102 ***Community pharmacies****: promoting health and wellbeing*
  https://www.nice.org.uk/guidance/ng102

[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:

- **Outpatient video consultations** are feasible but challenging for the NHS
- Ultrasound shows potential for confirming the diagnosis of **pneumonia in children**
- School-based self-regulation interventions can improve **child academic, health and behavioural outcomes**
- A reminder that **too much oxygen** increases mortality in acutely ill adults
- Structured training improves skills of **wheelchair users**
- Varicose vein injections help new **venous leg ulcers** heal
- Enhanced recovery programmes after **stomach cancer surgery** reduce hospital stay without increasing complications
- Lamotrigine is not effective for the treatment of **borderline personality disorder**
- **Gallbladder surgery** through a single-incision is more risky than a multiple incision technique
- Testing oxygen levels of **newborn babies** helps find **serious heart defects**.

European Centre for Disease Prevention and Control Public Health Training
https://eva.ecdc.europa.eu/course/index.php?categoryid=34
The European Centre for Disease Prevention and Control Public Health Training Section has developed training materials for

- Development, Implementation and Evaluation of Prudent Antibiotics use Campaigns
- Legionnaires' Disease
- Multi-Drug Resistant Micro-organisms in Health Care Settings
- Point Prevalence Surveys
- Epidemiological aspects of Vaccine Preventable Diseases.

[USA] Governance Quality Engagement Diagnostic
http://trustees.aha.org/checklists/TI_0718_Conway-quality-tool.pdf
The American Hospital Association has made available the *Governance Quality Engagement Diagnostic* tool. The tool is described as "a self-assessment tool that can help health care boards and leaders highlight barriers and challenges to effective board engagement in quality oversight".
