



On the Radar

Issue 406

18 February 2019

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On the Radar

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Measuring patient safety culture

<https://www.surveymonkey.com/r/ACSQHCsafetyculture>

The Australian Commission on Safety and Quality in Health Care invites hospital staff to assist with its project on measuring patient safety culture through an [online survey](#).

The survey forms part of a consultation to identify the elements of patient safety culture that are seen as important for measurement. The survey will be complemented with interviews from hospital executives and engagement of hospital staff through an expert advisory group. These consultations will be used to identify which of the available validated surveys is best suited to the Australian context.

The survey is open to hospital staff including clinical, auxiliary and support staff until **27 February 2019** and takes approximately 10 minutes to complete. Additional information is included on the first page of the survey.

For questions, contact our Indicator Development team on 02 9126 3600 or email indicators@safetyandquality.gov.au.

Reports

Spinal Services. GIRFT programme national speciality report. January 2019

Hutton M

London: NHS Improvement; 2019. p. 101.

URL	https://gettingitrightfirsttime.co.uk/spinal-surgery-report/
Notes	<p>The UK's Getting it Right First Time (GIRFT) has released this report on spinal treatment that reports variation in the management of lower back and radicular (sciatica) pain in England. Some of this treatment is also in contradiction to existing guidance. For example, in '2015 to 2018 an average of 5.7% of patients with back pain received three or more facet joint injections in a year despite evidence and guidance advising against them', with the annual cost of repeat injections estimated to be £10.5m. The report recommends that patients receiving these injections should receive longer-term physical and psychological rehabilitation programmes, ideally to home.</p> <p>The report contains 22 recommendations that offer opportunities to improve the patient experience through earlier discharge from hospital, reducing cancelled operations and ensuring trusts are equipped to deliver the best care in the most-timely manner. It is estimated that the recommendations could deliver cost efficiencies of up to £27m. The recommendations focus on better and more patient-centric care, for example:</p> <ul style="list-style-type: none"> • For patients with suspected cauda equina syndrome, referral without delay to 24 hour magnetic resonance imaging (MRI) scanning in hospitals. If not treated quickly this condition can lead to a range of disabilities including permanent limb paralysis and permanent loss of bowel and bladder function. • All major trauma centres should have 24/7 ability to stabilise and decompress the spine in patients with a fractured or dislocated spine. The median time from injury to surgery is one day, but a third of patients wait two days or more. • Changes to the referral pathway for patients with paediatric spinal deformity surgery to reduce waiting times and risk of cancellation.

Journal articles

Exercise for preventing falls in older people living in the community

Sherrington C, Fairhall NJ, Wallbank GK, Tiedemann A, A MZ, Howard K, et al

Cochrane Database of Systematic Reviews 2019.

DOI	https://doi.org/10.1002/14651858.CD012424.pub2
Notes	<p>This Cochrane review sought to assess the effects (benefits and harms) of exercise interventions for preventing falls in older people living in the community. Based on 108 randomised controlled trials (RCTs) with 23,407 participants the authors report 'Exercise programmes reduce the rate of falls and the number of people experiencing falls in older people living in the community (high-certainty evidence).' They went on to observe that 'The exercise programmes that reduce falls primarily involve balance and functional exercises, while programmes that probably reduce falls include multiple exercise categories (typically balance and functional exercises plus resistance exercises). Tai Chi may also prevent falls but we are uncertain of the effect of resistance exercise (without balance and functional exercises), dance, or walking on the rate of falls.'</p>

For information on the Commission’s work on falls prevention, see <https://www.safetyandquality.gov.au/our-work/falls-prevention/>

New guidelines from the Thrombosis and Haemostasis Society of Australia and New Zealand for the diagnosis and management of venous thromboembolism

Tran HA, Gibbs H, Merriman E, Curnow JL, Young L, Bennett A, et al. Medical Journal of Australia 2019.

DOI	https://doi.org/10.5694/mja2.50004
Notes	<p>As the abstract for this paper notes, venous thromboembolism (VTE), including deep vein thrombosis (DVT) and pulmonary embolism (PE), is the third most common cardiovascular disease and, globally, more than an estimated 10 million people have it yearly. It is a chronic and recurrent disease. VTE is also a common hospital-acquired complication (HAC). A HAC is a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.</p> <p>This paper in the <i>Medical Journal of Australia</i> reports on the recent development of guidelines for the diagnosis and management of DVT and PE on behalf of the Thrombosis and Haemostasis Society of Australia and New Zealand. The main recommendations include:</p> <ul style="list-style-type: none"> • Diagnosis of VTE should be established with imaging; it may be excluded by the use of clinical prediction rules combined with D-dimer testing. • Proximal DVT or PE caused by a major surgery or trauma that is no longer present should be treated with anticoagulant therapy for 3 months. • Proximal DVT or PE that is unprovoked or associated with a transient risk factor (non-surgical) should be treated with anticoagulant therapy for 3–6 months. • Proximal DVT or PE that is recurrent (two or more) and provoked by active cancer or antiphospholipid syndrome should receive extended anticoagulation. • Distal DVT caused by a major provoking factor that is no longer present should be treated with anticoagulant therapy for 6 weeks. • For patients continuing with extended anticoagulant therapy, either therapeutic or low dose direct oral anticoagulants can be prescribed and is preferred over warfarin in the absence of contraindications. • Routine thrombophilia testing is not indicated. • Thrombolysis or a suitable alternative is indicated for massive (haemodynamically unstable) PE. <p>The major change in management as a result of the guideline is that most patients with acute VTE should be treated with a factor Xa inhibitor and be assessed for extended anticoagulation.</p>

For information about the Commission’s work, including the 2018 *Venous Thromboembolism Prevention Clinical Care Standard*, see <https://www.safetyandquality.gov.au/our-work/clinical-care-standards/venous-thromboembolism-prevention-clinical-care-standard/>

2018 Update on Medical Overuse

Morgan DJ, Dhruva SS, Coon ER, Wright SM, Korenstein D

JAMA Internal Medicine. 2019;179(2):240-6.

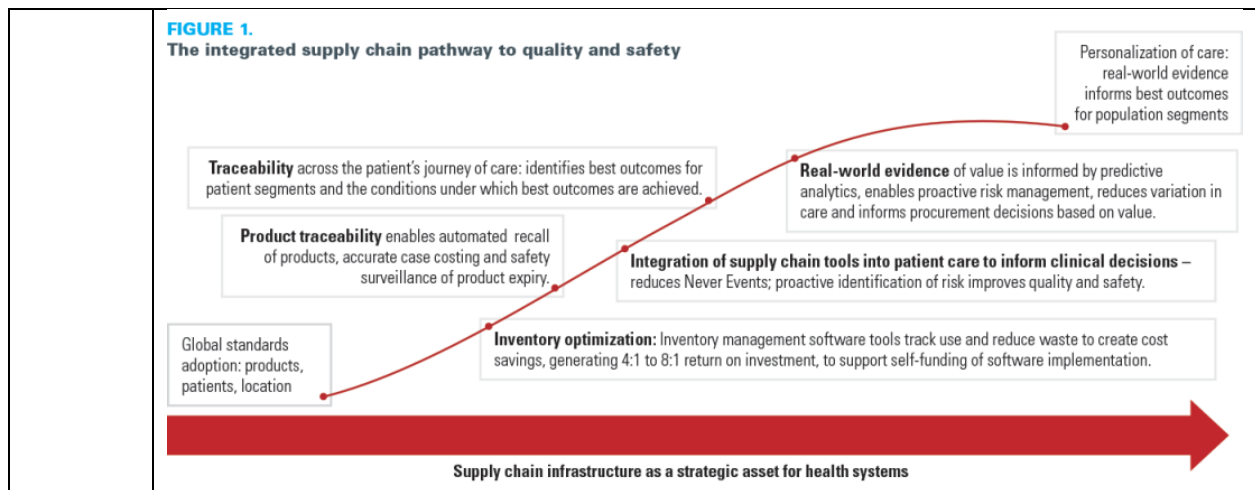
DOI	https://doi.org/10.1001/jamainternmed.2018.5748
Notes	<p>With the emergence of the issue of ‘overuse’ these authors have for a number of years now provided an update on the key literature in the field. In this, their update for 2018, the authors identified 1446 articles, of which 910 addressed medical overuse. From those, 111 were deemed relevant with 10 being selected as the most influential on the consensus of the authors. The selected articles included findings that:</p> <ul style="list-style-type: none"> • unnecessary electrocardiograms are common (performed in 22% of patients at low risk) and can lead to a cascade of services • lipid monitoring rarely affects care • patients who were overdiagnosed with cancer experienced anxiety and criticism about not seeking treatment • calcium and vitamin D supplementation does not reduce hip fracture • pregabalin does not improve symptoms of sciatica but frequently has adverse effects (40% of patients experienced dizziness) • antipsychotic medications increased the severity of delirium in patients receiving hospice care and were associated with an increased risk of death • robotic-assisted radical nephrectomy was without benefits by being slower and more costly than laparoscopic surgery • high-sensitivity troponin testing often yielded false-positive results, as 16% of patients with positive troponin results in a US hospital had a myocardial infarction • one-third of patients who received a diagnosis of asthma had no evidence of asthma • restructuring the electronic health record was able to reduce unnecessary testing (from 31.3 to 13.9 low-value tests performed per 100 patient visits).

Clinically Integrated Supply Chain Infrastructure in Health Systems: The Opportunity to Improve Quality and Safety

Snowdon AW

Healthcare Quarterly. 2018;21(3):20-3.

DOI	https://doi.org/10.12927/hcq.2018.25706
Notes	<p>Item suggesting that suggests that improving supply chain infrastructure in clinical settings could act as ‘system-level strategy to advance quality, reduce cost and strengthen patient safety in health systems’. The belief is that transformations to efficiency and quality in other economic sectors could have similar (or even greater) benefits in health care. The authors suggest that implementing supply chain technologies and processes could improve health system performance and strengthen patient safety by ‘proactively identifying potential sources of error to enable clinicians to intervene to prevent adverse events’. Some readers may consider that this is a rather optimistic view of the efficacy and utility of such solutions. Others may look to specific issues and limitations (such as how barcoding tends to be at the product level rather than the more granular level of an individual item, device, dosage, patient, etc. There are examples of closed loop systems that have implemented such granular systems and the issue of the journal in which this paper appears has three accompanying papers describing examples of supply chain infrastructure in a number of health systems in different countries.</p>



The prevalence of perceptions of mismatch between treatment intensity and achievable goals of care in the intensive care unit: a cross-sectional study

Anstey MH, Litton E, Trevenen ML, Thompson K, Webb S, Seppelt I, et al
Intensive Care Medicine. 2019 [epub].

DOI	https://doi.org/10.1007/s00134-019-05543-y
Notes	This paper reports on a cross-sectional, observational study conducted in 21 Intensive Care Units (ICUs) in Australia and New Zealand that examined patient prevalence data along with a survey of ICU staff. The study sought to examine the existence of mismatches between the level or intensity of care patients received. In the sample of 307 patients, 62 (20.2%) were reported to be receiving a mismatch in treatment intensity by at least one ICU healthcare professional. Patients were more likely to receive mismatched treatments if they were more severely unwell , if they were an emergency admission or if they had an advance care directive .

Integrating Care in Scotland

Fooks C, Goldhar J, Wodchis WP, Baker GR, Coutts J
Healthcare Quarterly. 2018;21(3):37-41.

DOI	https://doi.org/10.12927/hcq.2018.25702
Notes	Better integration and coordination of care has been seen a laudable goal for the better care of patients, especially those with multiple chronic conditions. This piece summarises a discussion with the Director for Health and Social Care Integration in Scotland that examined the Scottish experience following the legislation of integrated health and social care. A particular feature is the issues of local needs and variations.

Patient Experience Journal

Volume 5, Issue 3 (2018)

URL	http://pxjournal.org/journal/vol5/iss3/
Notes	A new issue of the <i>Patient Experience Journal</i> (PXJ) has been published with the theme ' Patient & Family Experience in Children's Hospitals and Pediatric Care '. Articles in this issue of <i>Patient Experience Journal</i> include: <ul style="list-style-type: none"> • Editorial: Elevating the discourse on experience in healthcare's uncertain times (Jason A Wolf) • Patient partner compensation in research and health care: the patient perspective on why and how (Dawn P Richards, Isabel Jordan, Kimberly Strain, and Zal Press) • First, do no harm: The patient's experience of avoidable suffering as harm (Ashley Bauer)

	<ul style="list-style-type: none"> • Standardising the collection of patient-reported experience measures to facilitate benchmarking and drive service improvement (Kathleen L Withers, Sarah Puntoni, Susan O'Connell, Robert I Palmer, and Grace Carolan-Rees) • Developing the first pan-Canadian acute care patient experiences survey (Salima Hadibhai, Jeanie Lacroix, and Kira Leeb) • Can specific feedback improve patients' satisfaction with hospitalist physicians? A feasibility study using a validated tool to assess inpatient satisfaction (Sarah E Richards, Rachel Thompson, Steven Paulmeyer, Ashvita Garg, Sarah Malik, Kristy Carlson, Elizabeth Lyden, and Jason Shiffermiller) • Transforming care through bedside leader rounding: Use of handheld technology leads to improvement in perceived patient satisfaction (Alison Tothy, Sunitha K Sastry, Mary K Springman, Heather M Limper, John Fahrenbach, and Susan M Murphy) • Improving the patient experience through patient portals: Insights from experienced portal users (Cynthia J Sieck, J L Hefner, and A S McAlearney) • Barriers and enablers of patient and family centred care in an Australian acute care hospital: Perspectives of health managers (Bradley Lloyd, Mark Elkins, and Lesley Innes) • Racial/ethnic and geographic differences in access to a usual source of care that follows the patient-centered medical home model: Analyses from the Medical Expenditure Panel Survey data (Zo Ramamonjiarivelo, Delawnia Comer-HaGans, Shamly Austin, Karriem Watson, and Alicia Kaye Matthews) • What older adults want from their health care providers (Hazel Williams-Roberts, Sylvia Abonyi, and Julie Kryzanowski) • Patients educating health care providers on Lynch syndrome (Kelsey Hennig, Barry DeCoster, Rebecca Chu, Wendy Parker, Lisa Campo-Engelstein, and Allison M. Burton-Chase) • The perioperative patient experience of hand and wrist surgical patients: An exploratory study using patient journey mapping (Else F de Ridder, Tessa Dekkers, Jarry T Porsius, Gerald Kraan, and Marijke Melles) • Rules of engagement: Strategies used to enlist and retain underserved mothers in a mental health intervention (Maureen J Baker; Beth Perry Black; and Linda S Beeber) • How younger adults with psychosocial problems experienced person-centered health consultations (Line Soot, Kirsten S Freund, Jørgen Lous, Mikkel Vass, and Lotte Hvas) • A photo-elicitation study of homeless and marginally housed Veterans' experiences with patient-centered care (Samuel F Sestito, Keri L Rodriguez, Kristina L Hruska, J W Conley, M A Mitchell, and A J Gordon) • Perceptions of patient-centered care among veterans with gastroesophageal reflux disease on proton pump inhibitor therapy (Salva N Balbale; Andrew Gawron; and Sherri L LaVela) • Effectiveness of the communication model, C.O.N.N.E.C.T., on patient experience and employee engagement: A prospective study (Agnes Barden and Nicole Giammarinaro) • Tell Me More: Promoting compassionate patient care through conversations with medical students (Danielle Qing, Anjali Narayan, Kristin Reese, Sarah Hartman, Taranjeet Ahuja, and Alice Fornari)
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BMJ *Quality and Safety* online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	<p>BMJ <i>Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • A qualitative positive deviance study to explore exceptionally safe care on medical wards for older people (Ruth Baxter, Natalie Taylor, Ian Kellar, Rebecca Lawton) • MRI for patients with cardiac implantable electronic devices: simplifying complexity with a ‘one-stop’ service model (Anish N Bhuva, Patricia Feuchter, Angela Hawkins, Lizette Cash, Redha Boubertakh, Jane Evanson, Richard Schilling, Martin Lowe, James C Moon, Charlotte H Manisty)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-access
Notes	<p>International Journal for Quality in Health Care has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • The Danish unique personal identifier and the Danish Civil Registration System as a tool for research and quality improvement (Jan Mainz; Mikkel Hagen Hess; Søren Paaske Johnsen) • Patient safety culture in Polish Primary Healthcare Centers (Dorota Raczkiwicz; Jakub Owoc; Jan Krakowiak; Cezary Rzemek; Alfred Owoc; Iwona Bojar) • Developing medical record-based, healthcare quality indicators for psychiatric hospitals in China: a modified Delphi-Analytic Hierarchy Process study (Feng Jiang; Tingfang Liu; Huixuan Zhou; Jeffrey J Rakofsky; Huanzhong Liu; Yuanli Liu; Yi-Lang Tang) • Editorial: Healthcare quality-improvement and measurement strategies and its challenges ahead (Usman Iqbal; Ayesha Humayun; Yu-Chuan (Jack) Li)

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:

- Clinical Guideline CG62 **Antenatal care for uncomplicated pregnancies**
<https://www.nice.org.uk/guidance/cg62>
- Quality Standard QS179 **Child abuse and neglect** <https://www.nice.org.uk/guidance/qs179>
- Quality Standard QS180 **Serious eye disorders** <https://www.nice.org.uk/guidance/qs180>

[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:

- *Addressing **Social Isolation** To Improve the Health of **Older Adults**: A Rapid Review*
<https://effectivehealthcare.ahrq.gov/topics/social-isolation/rapid-product>

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