AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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This week's content

Reports

Patients' Preferences Matter: Stop the silent misdiagnosis
Mulley A, Trimble C, Elwyn G
London: The King's Fund, 2012.

Notes	From the King's Fund webpage: 'Many doctors aspire to excellence in diagnosing disease. Far fewer, unfortunately, aspire to the same standards of excellence in diagnosing patients' preferences for their care. Because doctors are rarely made aware of an erroneous preference diagnosis, it could be called 'the silent misdiagnosis'. Misdiagnosing patients' preferences may be less obvious than misdiagnosing disease, but the consequences for the patient can be just as severe. *Patients' preferences matter: stop the silent misdiagnosis* outlines the scale of the problem, showing that:' • when they are well informed, **patients may make different choices** about treatment • **what patients want often differs from what doctors think they want** • there may be significant **variations in care across geographic regions**.
URL	http://www.kingsfund.org.uk/blog/silent_misdiagnosis.html
TRIM	64267

Time to Intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardiorespiratory arrest. A report by the National Confidential Enquiry into Patient Outcome and Death
Findlay GP, Shotton H, Kelly K, Mason M.
National Confidential Enquiry into Patient Outcome and Death, 2012.

Notes	The (UK) National Confidential Enquiry into Patient Outcome & Death (NCEPOD) has published its latest report on patients who underwent cardiopulmonary resuscitation (CPR) as a result of in-hospital cardiorespiratory arrest. A multidisciplinary advisory group of clinicians from emergency medicine, critical care, anaesthesia, cardiology/general medicine and resuscitation officers reviewed over 500 cases that occurred in UK hospitals over a 14-day period. Data sources included case notes, clinical questionnaires and resuscitation forms. An alarming number of cases were found where care was sub-optimal, with particular failures in assessment on admission and the formulation of appropriate care plans. In **38% of patients** it was thought that **cardiac arrest could have been prevented** if the patient had been managed appropriately, with particular problems identified with the lack of timely consultant input after admission. Further issues were identified with poor decision-making and documentation of whether or not CPR should be attempted, with only 10% of patients having a documented decision about CPR status on admission. The advisory group thought that 'do not attempt CPR' should have been documented in a further 20% of cases. Principal recommendations from the study include: • **Early, explicit decision-making** about the appropriateness of CPR for all patients acutely admitted to hospital, ideally during the initial admission process and definitely at the initial consultant review. When CPR is considered inappropriate at admission, consultant involvement must occur at that time. Decisions should be clearly documented. • Where patients deteriorate after non-consultant review then **care should be escalated** to a more senior doctor. If this is not done then the reasons for non-escalation must be clearly documented in the case notes. • Health care professionals as a whole must understand that patients can remain for active treatment but that in the event of a cardiac arrest CPR attempts may be futile. Providing active treatment is not a reason not to **consider and document** what should happen in the event of a cardiac arrest. • Each hospital should agree a plan for **airway management** during cardiac arrest. • Each hospital should **audit** all CPR attempts and assess what proportion of patients should have had a 'do not attempt CPR' decision in place and should not have undergone CPR.
URL	http://www.ncepod.org.uk/2012cap.htm

Alive and clicking: Information that benefits all
An uneasy consensus: Patients, citizens and the NHS
May 2012 Paper 3
NHS Confederation

Notes	This paper explores the potential for using and sharing information in the NHS. It looks at the costs and benefits of informing and communicating with patients through web and social media platforms against the costs of not doing so effectively.
URL	http://www.nhsconfed.org/Publications/discussion-paper/Pages/Alive-clicking.aspx

Primary Care: Today and Tomorrow
Improving general practice by working differently
Deloitte Centre for Health Solutions, 2012.

Notes	This report from Deloitte Centre for Health Solutions discusses the capacity and capability of [UK] general practice, both currently and in the future, with a focus on GPs and general practice nurses. The authors have highlighted the need for general practice to work differently to cope effectively with increasing demands. Rising life expectancy, accompanied by increasingly complex long-term health conditions, a stretched primary care workforce and unprecedented financial and healthcare reform are amongst the challenges facing primary care in the UK.
URL	http://www.deloitte.com/view/en_GB/uk/research-and-intelligence/deloitte-research-uk/deloitte-uk-centre-for-health-solutions/bb6e38f609817310VgnVCM3000001c56f00aRCRD.htm

Journal articles

The resistance war
Randall J
MJA InSight, Issue 22 – 12 June 2012

Notes	Opinion piece by Janette Randall on the latest campaign against antimicrobial resistance launched this year by the NPS. Randall emphasises the importance of spending time to educate patients about the appropriate prescribing and use of antibiotics, and urges GPs to "lead the fight" against antibiotic resistant bacteria and the overuse of antibiotics in Australia.
URL	http://www.mjainsight.com.au/view?post=Janette+Randall%3A+The+resistance+war&post_id=9520&cat=comment

For information on the Commission's work on antimicrobial stewardship, see http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship/

US model for hospital care at home reduces costs and increases patient satisfaction
Roehr B
BMJ 2012;344:e3997

Notes	Report on a 'hospital at home' acute care program run through Presbyterian Healthcare Services in Albuquerque, New Mexico. The program combines daily home visits by doctors and nurses with telemedicine technology. This report looks at the challenges and benefits of delivering care in this manner, including the conclusion that the "'hospital at home' acute care program has reduced costs by 19% with similar or better clinical outcomes and increased patient satisfaction."
DOI	http://dx.doi.org/10.1136/bmj.e3997

The Journey Across the Health Care (Dis)Continuum for Vulnerable Patients: Policies, Pitfalls, and Possibilities
Jenq G, Tinetti ME
JAMA: The Journal of the American Medical Association 2012;307(20):2157-2158.

Notes	This short piece notes how vulnerable patients can be at particular risk.
DOI	http://dx.doi.org/10.1001/jama.2012.5566

Technological approaches to improving care
Oxtoby K
BMJ 2012;344:e2936

Notes	Health has rather mixed approach to technology, being simultaneously an 'early adopter' and something of a laggard. This brief piece in the *BMJ* describes the shortlisted entries for the Transforming Patient Care using Technology award in the BMJ Group's Improving Health Awards 2012. The shortlisted entries are: • UK Met Office Healthy Outlook alert service – a service that sends alerts to people with chronic obstructive pulmonary disease when weather conditions may pose greater risks. • Oxford University Hospitals electronic laboratory medicine communication system – a communications system for laboratory medicine orders which allows staff to identify patients by barcode scanning their wristbands and to print specimen labels from the bedside that is helping to reduce the number of mislabelled tests and has improved accuracy of data, enhanced patient safety, and speeded up the results process. • Nottingham wireless working system for out of hours care – a wireless communication system that works across ward desktop computer, a tablet computer held by the hospital at night coordinator, and mobile phones held by the junior doctors and has led to reduced costs and improved staff satisfaction and efficiency, including a reduction in average length of stay and emergency calls. • Barts and The London NHS Trust Cardiac Recovery from Operation Quality Assessment System (C-ROQAS) – a database designed to predict the normal progress of a patient's recovery after cardiac surgery and flag up when individuals are not recovering as expected so that staff can quickly respond to their needs.
DOI	http://dx.doi.org/10.1136/bmj.e2936

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • **The Australian Primary Care Collaboratives Program: improving diabetes care** (Andrew W Knight, Dale Ford, Ralph Audehm, S Colagiuri, J Best) • **Avoiding handover fumbles**: a controlled trial of a structured handover tool versus traditional handover methods (Christina E Payne, Jason M Stein, Traci Leong, Daniel D Dressler) • Impact of online education on intern behaviour around joint commission national patient safety goals: a randomised trial (Tim J Shaw, Luise I Pernar, Sarah E Peyre, John F Helfrick, Kaitlin R Vogelgesang, E Graydon-Baker, Y Chretien, E J Brown, J C Nicholson, J J Heit, J PT Co, T Gandhi) • Anaesthetic drug administration as a potential contributor to healthcare-associated infections: a prospective simulation-based evaluation of aseptic techniques in the administration of anaesthetic drugs (Derryn A Gargiulo, Janie Sheridan, Craig S Webster, Simon Swift, Jane Torrie, Jennifer Weller, Kaylene Henderson, Jacqueline Hannam, Alan F Merry)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Building China's municipal healthcare performance evaluation system: a Tuscan perspective (Hao Li, Sara Barsanti, and Anna Bonini) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs032v1?papetoc • Investigating **patient safety culture across a health system**: multilevel modelling of differences associated with service types and staff demographics (B Gallego, M T Westbrook, A G Dunn, and J Braithwaite) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs028v1?papetoc • **User-experience surveys** with maternity services: a randomized comparison of two data collection models (O A Bjertnaes and H H Iversen) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs031v1?papetoc

Online resources

[USA]Five Effective Ways to Prevent Harm
http://www.infectioncontroltoday.com/articles/2012/06/five-effective-ways-to-prevent-harm.aspx
This item on *Infection Control Today* discusses the importance of having an effective harm prevention program that is underpinned by a culture of safety focused on improvement rather than judgment, and in which it is as easy as possible for staff to do the right thing, every time. The authors describe strategies for preventing harm: **making doing the right thing the standard**, **implementing care bundles**, **using hand hygiene** visual cues and reminders, **encouraging everyone to speak up**, **getting leaders involved**, and **measuring the harm** rate over time.

[UK] The Fifteen Steps Challenge: Quality from a patient's perspective
http://www.institute.nhs.uk/productives/15stepschallenge/15stepschallenge.html
The 15 Steps Challenge is a toolkit that was co-produced with patients, relatives, volunteers, staff, governors and senior leaders, to look at hospital care through the eyes of patients and relatives, helping to hear and see what good looks like.
The toolkit provides a series of questions and prompts to guide patients, carers and staff through their first impressions of a ward. The Challenge will help to gain an understanding of how patients feel about the care provided and how high levels of confidence can be built.
The purpose of the 15 Steps Challenge is:

- to help staff, patients and others to work together to identify improvements that can enhance the patient experience
- to provide a way of understanding patients' first impressions more clearly
- to develop a method for creating positive improvements in the quality of care.

[Scotland] Safety Improvement in Primary Care
http://www.health.org.uk/news-and-events/newsletter/safety-improvement-in-primary-care
The Safety Improvement in Primary Care project is a remarkable success story. Promoting patient safety in general practice, it formed part of the Health Foundation's Closing the Gap through Clinical Communities programme, bridging best practice and delivery of care.
The project involved 50 primary care teams from four health boards in Scotland, and has shown such positive results that it has gone on to form the basis of a national programme.
Clinical lead, Dr Neil Houston, explains the project and the results that have been achieved.

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