On the Radar

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On the Radar
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Reports

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
February 2013
London: The Stationery Office

Notes	The final report of the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust was published this week. Media reports had suggested that a recommendation of a statutory 'duty of candour' would be among the recommendations. The report has 3 volumes and a separate 125-page Executive Summary. There is also a 9-page press statement form the inquiry chairman. In his covering letter the inquiry chairman has stated: "The report has identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. That they did not has a number of causes, among them: - A culture focused on doing the system's business – not that of the patients; - An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern; - Standards and methods of measuring compliance which did not focus on the effect of a service on patients; - Too great a degree of tolerance of poor standards and of risk to patients;

	• A failure of communication between the many agencies to share their knowledge of concerns; • Assumptions that monitoring, performance management or intervention was the responsibility of someone else; • A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession; • A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation. I have made a great many recommendations, no single one of which is on its own the solution to the many concerns identified. The essential aims of what I have suggested are to: • Foster a common **culture** shared by all in the service of putting the patient first; • Develop a set of fundamental **standards**, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated; • Provide professionally endorsed and evidence-based means of **compliance** with these fundamental standards which can be understood and adopted by the staff who have to provide the service; • Ensure **openness, transparency and candour** throughout the system about matters of concern; • Ensure that the relentless focus of the healthcare regulator is on policing **compliance** with these standards; • Make all those who provide care for patients – individuals and organisations – properly **accountable** for what they do and to ensure that the **public is protected** from those not fit to provide such a service; • Provide for a proper degree of **accountability** for senior managers and leaders to place all with **responsibility for protecting the interests of patients** on a level playing field; • **Enhance the recruitment, education, training and support** of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to **integrate the essential shared values of the common culture** into everything they do; • Develop and share ever **improving means of measuring and understanding the performance** of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system."
URL	http://www.midstaffspublicinquiry.com/report
TRIM	Executive Summary 74887

Journal articles

A paradox in healthcare service development: Professionalization of service users
El Enany N, Currie G, Lockett A
Social Science & Medicine 2013;80(0):24-30.

Notes	Involving consumers, including into the development and design of healthcare services, has become more common over the past decade. However, the emergence of a distinct class of 'professional' consumers has also been observed, with suggestions that such individuals become organisational insiders, limiting their capacity to act as authentic representatives of 'genuine' health service consumers. This study examines the processes that may give rise to 'unrepresentative' consumer involvement observed within a UK mental health service by drawing on in-depth interviews with providers, managers and consumer representatives. Results indicate that unrepresentative consumer involvement occurs through a combination of: (a) self-selection by more ambitious and outspoken consumers (seeing themselves as "high fliers of the service user community"), and (b) providers actively selecting, educating and socialising certain consumers to suit their professional agendas. Some providers felt that volunteers or 'normal' consumers "often held meetings back because they were unable to think in the same way as professionals". Somewhat similar to the paper by Hor et al reviewed in *On the Radar* Issue 113 (Finding the patient in patient safety), the findings of this study may have implications in how health services more generally recruit and involve consumers. With consumer involvement increasing it may be worth considering the stratification of consumer representatives more closely.
DOI	http://dx.doi.org/10.1016/j.socscimed.2013.01.004

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

A Multidisciplinary Approach to Reduce Central Line Associated Bloodstream Infections
McMullan C, Propper G, Schuhmacher C, Sokoloff L, Harris D, Murphy P, et al
Joint Commission Journal on Quality and Patient Safety 2013;39(2).

Notes	For a number of healthcare acquired infections there are interventions that are known to be effective – and transferable and replicable. This paper reports on one US hospital's (Stony Brook University Hospital) implementation of a series of interventions across various groups within the hospital that sought to reduce Central Line Associated Bloodstream Infections (**CLABSI**). One of the interesting aspects here is the discussion of how the interventions had to be 'tweaked' to suit the specifics of the setting before the best results were achieved. These tweaks are identified by evaluating the interventions and further refining them. The hospital's overall **CLABSI rate decreased** by **59%** in a **five-year** period and by **more than 80% in the most recent 12 months.**
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2013/00000039/00000002/art00002

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

Reducing Hospital Errors: Interventions that Build Safety Culture
Singer SJ, Vogus TJ
Annual Review of Public Health 2013;34(1) [epub].

Notes	This review takes the view that "isolated interventions are unlikely to reduce the underlying causes of hospital errors" and that a safety culture has to be developed as sustained and effective error reduction requires "systemic interventions". The model of safety culture described involves "enabling, enacting and elaborating" processes. The "enabling activities help shape perceptions…which promotes enactment of safety culture. Using this model the authors discuss (and classify) various "interventions as enabling, enacting or elaborating a culture of safety." Changing culture can be seen as too big and too difficult a task; but it can also be a matter of understanding scale and context – and then determining what 'enabling', 'enacting' or 'elaborating' activities can influence that culture in the given setting.
DOI	http://dx.doi.org/10.1146/annurev-publhealth-031912-114439

Speaking Up — When Doctors Navigate Medical Hierarchy
Srivastava R
New England Journal of Medicine 2013; 368:302-305

Notes	This perspective piece offers a candid description of an episode of care in a Melbourne hospital, from the point of view of the medical oncologist. It raises questions of communication, hierarchy, collaboration, courage, and a more holistic approach to the provision of health care, and considers the fatal consequences of a failure to speak up.
DOI	http://dx.doi.org/10.1056/NEJMp1212410

The Quality and Outcomes Framework—where next?
Gillam S, Steel N
BMJ 2013;346:f659

Notes	Since 2004, the UK Quality and Outcomes Framework (QOF), a system of financial incentives and information technology (computerised prompts and decision support) intended to achieve evidence based quality targets, has operated as "the most comprehensive national primary care pay for performance scheme in the world". This article considers the QOF and proposed changes to it, looking at evidence of its success, the experience of doctors working under the scheme, and future QOF policy direction.
DOI	http://dx.doi.org/10.1136/bmj.f659

Effect of Daily Chlorhexidine Bathing on Hospital-Acquired Infection
Climo MW, Yokoe DS, Warren DK, Perl TM, Bolon M, Herwaldt LA, Weinstein RA, Sepkowitz KA, Jernigan JA, Sanogo K, Wong ES
New England Journal of Medicine 2013;368(6):533-542

Notes	A cluster-randomized, nonblinded crossover trial to evaluate the effect of **daily bathing with chlorhexidine-impregnated washcloths** on the acquisition of multidrug resistant organisms (MDROs) and the incidence of hospital-acquired bloodstream infections, conducted across nine ICUs or bone marrow transplantation units from different geographic regions in the United States. The trial found that **the rate of hospital-acquired bloodstream infections was 28% lower during the intervention period** than during the control period (4.78 vs. 6.60 cases per 1000 patient-days, P=0.007).
DOI	http://dx.doi.org/10.1056/NEJMoa1113849

Notes	The latest issue of *Health Affairs* has the theme of a *New Era of Patient Engagement*. Articles in this issue include: • Rx For The '**Blockbuster Drug' Of Patient Engagement** (Susan Dentzer) • **Engaging Patients** And Their Loved Ones In The **Ultimate Conversation** (Maureen Bisognano and Ellen Goodman) • What The Evidence Shows About Patient Activation: **Better Health Outcomes And Care Experiences**; Fewer Data On Costs (Judith H. Hibbard and Jessica Greene) • Patients With **Lower Activation** Associated With **Higher Costs**; Delivery Systems Should Know Their Patients' 'Scores' (Judith H. Hibbard, Jessica Greene, and Valerie Overton) • **Patient And Family Engagement**: A **Framework** For Understanding The Elements And Developing Interventions And Policies (Kristin L. Carman, Pam Dardess, M Maurer, S Sofaer, K Adams, C Bechtel, and J Sweeney) • **Early Lessons** From Four 'Aligning Forces For Quality' Communities **Bolster The Case** For Patient-Centered Care (Deborah Roseman, Jessica Osborne-Stafsnes, Christine Helwig Amy, S Boslaugh, and K Slate-Miller) • Choice Architecture Is A Better Strategy Than Engaging Patients To Spur Behavior Change (Robert F. Nease, S G Frazee, L Zarin, and S B Miller) • Pioneering New Ways To **Engage The Disabled** (Stephen J. Langel) • Patients, Providers, And Systems Need To Acquire A Specific Set Of **Competencies** To Achieve Truly Patient-Centered Care (Elizabeth Bernabeo and Eric S. Holmboe) • Patients With **Mental Health Needs** Are Engaged In Asking Questions, But Physicians' Responses Vary (Ming Tai-Seale, P K Foo, and C D Stults) • A Demonstration Of **Shared Decision Making In Primary Care** Highlights Barriers To Adoption And Potential Remedies (Mark W. Friedberg, K Van Busum, R Wexler, M Bowen, and Eric C. Schneider) • **Shared Decision Making**: Examining Key **Elements And Barriers** To Adoption Into Routine Clinical Practice (France Légaré and Holly O. Witteman) • Enhanced Support For **Shared Decision Making Reduced Costs Of Care** For Patients With Preference-Sensitive Conditions (David Veroff, Amy Marr, and David E. Wennberg) • Group Health's Participation In A Shared Decision-Making Demonstration Yielded Lessons, Such As **Role Of Culture Change** (Jaime King and Benjamin Moulton) • **Decision Aids**: When 'Nudging' Patients To Make A Particular Choice Is More Ethical Than Balanced, Nondirective Content (J S Blumenthal-Barby, Scott B Cantor, Heidi Voelker Russell, Aanand D Naik, and Robert J Volk) • An Effort To Spread **Decision Aids** In Five California **Primary Care** Practices Yielded Low Distribution, Highlighting Hurdles (Grace A Lin, M Halley, K A S Rendle, C Tietbohl, S G May, L Trujillo, and D L. Frosch) • Ten **Strategies To Lower Costs, Improve Quality, And Engage Patients**: The View From Leading Health System CEOs (Delos M Cosgrove, Michael Fisher, Patricia Gabow, Gary Gottlieb, George C Halvorson, Brent C James,

	• Engaged Patients Will **Need Comparative Physician-Level Quality Data** And Information About Their Out-Of-Pocket Costs (Jill Mathews Yegian, Pam Dardess, Maribeth Shannon, and Kristin L. Carman) • Focus Groups Highlight That Many Patients Object To **Clinicians' Focusing On Costs** (Roseanna Sommers, Susan Dorr Goold, Elizabeth A McGlynn, Steven D Pearson, and Marion Danis) • A Proposed **'Health Literate Care Model'** Would Constitute A Systems Approach To Improving Patients' Engagement In Care (Howard K. Koh, Cindy Brach, Linda M. Harris, and Michael L. Parchman) • A **National Action Plan** To Support Consumer **Engagement Via E-Health** (Lygeia Ricciardi, F Mostashari, J Murphy, J G Daniel, and E P Siminerio) • HealthPartners' **Online Clinic** For Simple Conditions **Delivers Savings** Of $88 Per Episode and High Patient Approval (Patrick T. Courneya, Kevin J. Palattao, and Jason M. Gallagher) • How The **Patient-Centered Outcomes Research Institute** Is Engaging Patients And Others In Shaping Its Research Agenda (Rachael Fleurence, J V Selby, K Odom-Walker, G Hunt, D Meltzer, J R Slutsky, and C Yancy) • Providers, Payers, The Community, And Patients Are All Obliged To **Get** Patient Activation And **Engagement Ethically Right** (Marion Danis and Mildred Solomon) • Default Options In **Advance Directives** Influence How Patients Set Goals For **End-Of-Life Care** (Scott D Halpern, George Loewenstein, Kevin G Volpp, Elizabeth Cooney, Kelly Vranas, Caroline M Quill, M S McKenzie, M O Harhay, N B Gabler, T Silva, R Arnold, D C Angus, and C Bryce)
URL	http://content.healthaffairs.org/content/current

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BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Treatment **quality indicators predict short-term outcomes** in patients with diabetes: a prospective cohort study using the GIANTT database (Grigory Sidorenkov, Jaco Voorham, Dick de Zeeuw, Flora M Haaijer-Ruskamp, Petra Denig) • Do you have to re-examine to **reconsider your diagnosis**? Checklists and cardiac exam (Matthew Sibbald, Anique B H de Bruin, Rodrigo B Cavalcanti, Jeroen J G van Merrienboer) • Building **collaborative teams** in neonatal intensive care (Dara Brodsky, Munish Gupta, Mary Quinn, Jane Smallcomb, Wenyang Mao, Nina Koyama, Virginia May, Karen Waldo, Susan Young, DeWayne M Pursley) • Contextual information influences **diagnosis accuracy** and decision making in simulated emergency medicine emergencies (Allistair Paul McRobert, Joe Causer, John Vassiliadis, Leonie Watterson, J Kwan, M A Williams) • Usability of a computerised drug monitoring programme to detect **adverse drug events** and non-compliance in outpatient ambulatory care (Claudine Auger, Alan J Forster, Natalie Oake, Robyn Tamblyn)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[UK] Good practice in prescribing and managing medicines and devices
http://www.gmc-uk.org/Prescribing_Guidance__2013__50955425.pdf
The (UK) General Medical Council has published this short (11 page) guidance for clinicians on best prescribing and management practice. It is an extension of their 2006 Good Medical Practice and is intended to provide "more detailed advice on how to comply with these principles when prescribing and managing medicines and medical devices, including appliances".

Cancer Australia Consumer Learning and Consumer Involvement Toolkit
http://www.consumerlearning.canceraustralia.gov.au
http://www.consumerinvolvement.canceraustralia.gov.au
Cancer Australia has launched a pair of websites (or "multimedia resources") intended to increase the involvement of people affected by cancer in cancer control efforts. The resources are:
- the **Consumer Learning** website which is designed to enhance consumer knowledge and confidence to participate in cancer research and clinical trials. The website contains short online learning modules and video presentations to guide consumers who are seeking to participate in clinical trials and research
- the **Consumer Involvement Toolkit** will support CEOs, managers, health professionals, researchers and policy makers to effectively involve consumers in their organisation's work. By providing practical, easy-to-navigate and user friendly tools including case studies, templates and other time saving aids such as checklists, these organisations and individuals will find it easier to engage and involve people affected by cancer.