AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar is a summary of some of the recent publications in the areas of safety and quality in health care. Inclusion in this document is not an endorsement or recommendation of any publication or provider.

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On the Radar
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Reports

Closing the Quality Gap Series
Agency for Healthcare Research and Quality
Rockville MD

Notes	In 2004 , the US Agency for Healthcare Research and Quality produced a series of evidence reports, *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*, to "bring data to bear on quality improvement opportunities". These reports described the evidence on quality improvement strategies related to chronic conditions, practice areas, and cross-cutting priorities. A new series, *Closing the Quality Gap: Revisiting the State of the Science* has just been released. This series broadens the scope of settings, interventions, and clinical conditions, while continuing the focus on improving the quality of health care through critical assessment of relevant evidence. Along with a summary report and a methods report, *Through the Quality Kaleidoscope: Reflections on the Science and Practice of Improving Health Care Quality*, the reports in this series include: • *Bundled Payment: Effects on Health Care Spending and Quality* • *The Patient-Centered Medical Home* • *Quality Improvement Interventions To Address Health Disparities*

	• *Medication Adherence Interventions: Comparative Effectiveness* • *Public Reporting as a Quality Improvement Strategy* • *Prevention of Healthcare-Associated Infections* • *Quality Improvement Measurement of Outcomes for People With Disabilities* • *Improving Health Care and Palliative Care for Advanced and Serious Illness*
URL	http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1375&pageaction=displayproduct

Journal articles

Performance data on all surgeons in England will be published within two years
Iacobucci G
BMJ 2012;345.

Notes	Brief report noting that within two years 'league tables' showing the **results of individual surgeons working in the NHS in England are to be published**. It is argued that these would aid in driving improvements in standards by forcing surgeons to deal with performance problems in an open and transparent manner.
DOI	http://dx.doi.org/10.1136/bmj.e8377

Wisdom through adversity: Learning and growing in the wake of an error
Plews-Ogan M, Owens JE, May NB
Patient Education and Counseling [epub].

Notes	Addition to the literature on the '**second victim**' in which the authors aimed to examine how clinicians coped with having made a serious mistake. Based on in-depth interviews with 61 clinicians who had made a serious medical error the authors identify common elements in how clinicians coped positively with these circumstances, and the ways in which they learned and changed. The authors identified five major elements in the process of coping positively with the experience of a serious medical error. These elements included **acceptance**, **stepping in**, **integration**, **new narrative** and **wisdom**. The ARHQ PSNet summary noted: "Physicians experienced fundamental changes in both personal and professional relationships, describing themselves as having increased compassion, humility, and tolerance for uncertainty as a result of being involved in an error. Interestingly, few reported utilizing institutional resources to help with the recovery process, instead relying on informal support from colleagues."
DOI	http://dx.doi.org/10.1016/j.pec.2012.12.006

Canadian Journal of Anesthesia/Journal canadien d'anesthésie
Volume 60, Issue 2, February 2013
Special Issue: Innovation in Perioperative Patient Safety / Numéro spécial : Innovations en sécurité périopératoire des patients

Notes	The current issue of the *Canadian Journal of Anesthesia/Journal canadien d'anesthésie* is a special issue on the theme of *Innovation in Perioperative Patient Safety* that includes articles:

	• **Opportunities** to enhance perioperative patient safety: 2013 and beyond (Donald R Miller) • Editorial: An **overview** of quality and safety in health care (Alan F Merry) • Review article: Practical **current issues in perioperative patient safety** (John H Eichhorn) • The evolving role of **information technology** in perioperative patient safety (Michael Stabile, Lebron Cooper) • **Improving drug safety** for patients undergoing anesthesia and surgery (Beverley A Orser) • Perioperative **checklist methodologies** (T G Weiser, W R Berry) • The role of **practice guidelines** and evidence-based medicine in perioperative patient safety (Edward Crosby) • Safety aspects of anesthesia in **under-resourced locations** (Angela Enright) • The role of **hypotension** in perioperative stroke (Jilles B Bijker) • Risks of anemia and related management strategies: can perioperative **blood management** improve patient safety? (Gregory M T Hare, John Freedman) • The anesthesiologist's role in the prevention of **surgical site infections** (Shawn S Forbes, Richard F McLean) • **Simulation**: a means to address and improve patient safety (Viren N. Naik, Susan E. Brien) • **Innovations** in Perioperative Quality and Patient Safety (Donald R. Miller)
URL	http://link.springer.com/journal/12630/60/2/page/1

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Estimated nursing workload for the implementation of **ventilator bundles** (Westyn Branch-Elliman, Sharon B Wright, Jean M Gillis, M D Howell) • A theory-driven, longitudinal evaluation of the impact of **team training** on **safety culture** in 24 hospitals (Katherine J Jones, Anne M Skinner, Robin High, Roni Reiter-Palmon) • Developing a **patient measure of safety** (PMOS) (Sally J Giles, Rebecca J Lawton, Ikhlaq Din, Rosemary R C McEachan) • Assessment of the **global trigger tool** to measure, monitor and evaluate patient safety in cancer patients: reliability concerns are raised (Thea Otto Mattsson, Janne Lehmann Knudsen, Jens Lauritsen, K Brixen, J Herrstedt) • **Patient experience** in the accident and emergency department (Thomas Steven Chance, Vinod Patil)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[US] Choosing Wisely®
http://www.choosingwisely.org/doctor-patient-lists/
This US initiative has extended its list of tests and procedures that may be unnecessary, possibly harmful. Since the campaign was launched in 2012, more than 130 tests and procedures have been called into question by 25 US medical specialty societies.

[USA] What works?
http://www.rwjf.org/en/about-rwjf/program-areas/quality-equality/promising-practices.html
The Robert Wood Johnson Foundation has developed a collection of 'success stories' from the front lines of US health care. The library includes short summaries of interventions that tackle major issues that affect health care quality and equality, including:

- Patient safety
- Staff satisfaction and retention
- Emergency Department operations
- Reducing readmissions and improving care transitions
- Addressing disparities
- Patient satisfaction and engagement

[USA] 4 awesome infection-prevention videos
http://www.fiercehealthcare.com/special-reports/4-awesome-infection-prevention-videos
The editors at US site *FierceHealthcare* compiled this short list of "four healthcare provider videos that go above and (way) beyond to inspire their employees to join the fight against infections. From flash mobs to musical dream sequences, these videos make this very serious issue fun--and, more importantly, memorable." The videos are:

- I'm a believer ... in clean hands
- Just say 'HEY HAC NO'
- I wanna wash my hands
- A lunch break for hand hygiene

[USA] Transitions of Care (TOC) Portal
http://www.jointcommission.org/toc.aspx
The US Joint Commission has established this site with resources for clinicians and patients to help achieve safe care transitions.

For information about the Commission's work on clinical communications, including clinical handover, see http://www.safetyandquality.gov.au/our-work/clinical-communications/
