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On the Radar

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On the Radar
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Reports

Exploring patient participation in reducing health-care-related safety risks
World Health Organization Regional Office for Europe
Copenhagen: World Health Organization Regional Office for Europe, 2013.

Notes	A 190-page report from the WHO European office providing an overview of the legal influences on patient safety and explores the relationship between patients' rights, patient participation and patient safety. The report offers a synthesis of studies of patient involvement, with detailed examples from Bulgaria, France, the Netherlands, Poland and Portugal. The report highlights the need to strengthen a continuum of information between various levels of care, including patient experiences, health literacy and engagement. It offers recommendations at various levels of health service delivery. By contributing to the wider process of evidence collation, it is hoped that it may aid in identifying efficient ways to build realistic and informed expectations of health care, while encouraging patients to be vigilant and knowledgeable, thus ensuring maximum safety standards.
URL	http://www.euro.who.int/en/what-we-publish/abstracts/exploring-patient-participation-in-reducing-health-care-related-safety-risks
TRIM	77139

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

Making integrated care happen at scale and pace: Lessons from experience
Ham C, Walsh N
London. The King's Fund, 2013:8.

Notes	Brief (8-page) paper from the (UK) King's Fund based on the premise that better integrated care can improve the patient experience and the outcomes and efficiency of care, particularly with those with chronic heath conditions. The paper summarises 16 steps to be taken to make integrated care a reality. The authors have drawn on work by The King's Fund and others to provide examples of good practice. The authors accept that there are no universal solutions or approaches to integrated care that will work everywhere and there is also no 'best way' of integrating care, and thereby the importance of local context and discovery and of sharing examples of good practice when developing policy and practice. The 16 steps include: 1. Find common cause with partners and be prepared to share 2. Develop a shared narrative to explain why integrated care matters 3. Develop a persuasive vision to describe what integrated care will achieve 4. Establish shared leadership 5. Create time and space to develop understanding and new ways of working 6. Identify services and user groups where the potential benefits are greatest 7. Build integrated care from the bottom up as well as the top down 8. Pool resources 9. Innovate 10. Recognise that there is no 'best way' of integrating care 11. Support and empower users 12. Share information 13. Use the workforce effectively and innovatively 14. Set specific objectives and measure and evaluate progress 15. Be realistic about the costs 16. Act on together as part of a coherent strategy
URL	http://www.kingsfund.org.uk/publications/making-integrated-care-happen-scale-and-pace

Rating providers for quality: a policy worth pursuing?
Nuffield Trust
London: Nuffield Trust, 2013.

Notes	This report was commissioned by the UK Secretary of State for Health to examine whether ratings of provider performance should be used in health and social care. The report concludes that the costs and benefits in implementing a ratings system may be favourable for providers of social care and for general practices, but the benefits are less certain for hospitals.
URL	http://www.nuffieldtrust.org.uk/publications/rating-providers-quality

Journal articles

Indication-based prescribing prevents wrong-patient medication errors in computerized provider order entry (CPOE)
Galanter W, Falck S, Burns M, Laragh M, Lambert BL
Journal of the American Medical Informatics Association 2013 [epub].

Notes	This study suggests that requiring a clinician to link medication orders to patient health problems can prevent wrong patient orders and keeps problem lists up to date. In this work the authors implemented a computerised provider order entry (CPOE) system that required the clinician placing the order to link the medicine to an indication in the patient's 'problem list'. This was to help ensure that orders were being placed for the correct patient by cross-referencing the main reasons that a medication is normally prescribed with the patient's identified health problems. If no matching problem was found in the medical record, the prescriber was alerted and was prompted to enter the condition. The authors report that over a six-year period, there was an interception rate of 1 intercepted wrong-patient order per 4,000 electronic alerts. In 59% of the intercepted errors, the prescriber had more than one chart open when they started the medication order.
DOI	http://dx.doi.org/10.1136/amiajnl-2012-001555

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

Description and Evaluation of Adaptations to the Global Trigger Tool to Enhance Value to Adverse Event Reduction Efforts
Kennerly DA, Saldana M, Kudyakov R, da Graca B, Nicewander D, Compton J
Journal of Patient Safety 2013 [epub].

Notes	This paper describes how one US health system adapted the Global Trigger Tool (GTT) to better suit their needs and context. The project sought to adapt the GTT as a sustainable monitoring tool able to characterize adverse events (AEs) for organizational learning. The health system, Baylor Health Care System (BHCS) expanded the AE data collected to include judgments of preventability, presence on admission, relation to care provided or not provided, and narrative descriptions. To reduce costs, they focused on patients with length of stay (LOS) of 3 days or more, suspecting greater likelihood they had experienced an AE; adapted the sample size and frequency of review; and used a single nurse reviewer followed by quality assurance review within the Office of Patient Safety. They report that in 2008, 91% of identified AEs were in patients with LOS of 3 days or greater; there were 6.4 AEs per 100 discharges with LOS of less than 3 days versus 27.1 AEs per 100 discharges with LOS of 3 days or greater. Most AEs were identified via the "surgical" (36.3%) and "patient care" (36.0%) trigger modules. The authors believe that the GTT can be adapted to health-care organizations' goals and resource limitations and argue that "This flexibility was essential in crossing our organization's "value threshold."""
DOI	http://dx.doi.org/10.1097/PTS.0b013e31827cdc3b

International Journal for Quality in Health Care
Vol. 25, No. 2
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Notes	A new issue of *International Journal for Quality in Health Care* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of the *International Journal for Quality in Health Care* include: • Editorial: **If quality is the answer … what is the question?** (Roshan Perera and Helen Moriarty) • Editor's choice: Associations of **patient safety outcomes** with models of **nursing care organization** at unit level in hospitals (Carl-Ardy Dubois, Danielle D'amour, Eric Tchouaket, Sean Clarke, M Rivard, and R Blais) • Continuous innovation: developing and using a clinical database with new technology for patient-centred care—the case of the **Swedish quality register for arthritis** (John Ovretveit, Christina Keller, Helena Hvitfeldt Forsberg, Anna Essén, Staffan Lindblad, and Mats Brommels) • A measurement instrument for **spread of quality improvement** in healthcare (S.S. Slaghuis, M.M.H. Strating, R.A. Bal, and A.P. Nieboer) • Validating the Danish adaptation of the World Health Organization's **International Classification for Patient Safety** classification of patient safety incident types (Kim Lyngby Mikkelsen, Jacob Thommesen, and Henning Boje Andersen) • Can **incident reporting** improve safety? Healthcare practitioners' views of the effectiveness of incident reporting (Janet E. Anderson, Naonori Kodate, Rhiannon Walters, and Anneliese Dodds) • **Adverse event reporting** in Czech long-term care facilities (Zdeňrk Hěib, Pavel Vychytil, and David Marx) • Validity and reliability on three European language versions of the **Safety Organizing Scale** (Dietmar Ausserhofer, Maria Schubert, Mary Blegen, Sabina De Geest, and René Schwendimann) • Assessment of **patient safety culture** in Palestinian public hospitals (Motasem Hamdan and Abed Alra'oof Saleem) • The effect of a checklist on the quality of **post-anaesthesia patient handover**: a randomized controlled trial (Cornelie Salzwedel, Hans-Jürgen Bartz, Ina Kühnelt, Daniel Appel, O Haupt, S Maisch, and G N Schmidt) • Compliance with the **WHO Surgical Safety Checklist**: deviations and possible improvements (Christofer Rydenfält, Gerd Johansson, Per Odenrick, Kristina Åkerman, and Per Anders Larsson) • The use of a standard design medication room to promote **medication safety**: organizational implications (H. Rozenbaum, L. Gordon, M. Brezis, and N. Porat) • **Timeliness of cancer care** from diagnosis to treatment: a comparison between patients with breast, colon, rectal or lung cancer (Xue Li, Andrew Scarfe, Karen King, David Fenton, Charles Butts, and Marcy Winget) • Wait watchers: the application of a **waiting list active management** program in ambulatory care (Antonio Giulio De Belvis, M Marino, M Avolio, F Pelone, D Basso, G A Dei Tos, S Cinquetti, and W Ricciardi)
URL	http://intqhc.oxfordjournals.org/content/25/2?etoc

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • TeamGAINS: a tool for structured debriefings for simulation-based team trainings (Michaela Kolbe, Mona Weiss, Gudela Grote, Axel Knauth, Micha Dambach, Donat R Spahn, Bastian Grande) •
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[USA] Re-Engineered Discharge (RED) Toolkit.
http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html
The US Agency for Healthcare Research and Quality (ARHQ) has provide this toolkit to help hospitals implement Project RED. Researchers at the Boston University Medical Center (BUMC) developed and tested the Re-Engineered Discharge (RED). Research showed that the RED was effective at reducing readmissions and post-hospital emergency department visits. The Agency for Healthcare Research and Quality contracted with BUMC to develop this toolkit to assist hospitals, particularly those that serve diverse populations, to replicate the RED.

[USA] 10 Tips to Help Promote Patient Safety
http://www.ashrm.org/ashrm/education/programs/patient_safety/files/NPSAW-tip-sheet.pdf
The American Society for Healthcare Risk Management has produced this 4-page fact sheet listing 10 patient safety concerns and offers tips to address them.