On the Radar

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On the Radar
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Reports

Patient-centred leadership: Rediscovering our purpose
King's Fund
London: The King's Fund, 2013.

Notes	This report from the UK charity The King's Fund discussed the failings of care at Mid Staffordshire in relation to NHS leadership and culture. It sets out what needs to be done to avoid similar failures in future, focusing on the role of three key 'lines of defence' against poor-quality care: frontline clinical teams, the boards leading NHS organisations, and national organisations responsible for overseeing the commissioning, regulation and provision of care. The key findings are: • The leadership of the NHS at a national level needs to create conditions in which local organisations have the freedom to deliver consistently high standards of care and where the needs of patients come first. • The quality of care provided by NHS organisations should, first and foremost, be a corporate responsibility under the leadership of boards, who must lead by example by focusing on the quality and safety of care. • Leaders need to value and support frontline staff and ensure the main focus is on patients and their care.

	• Leadership development should give priority to supporting leaders at all levels to be patient-centred and to ensure that staff have the time and resources required to deliver high-quality care. • Patient leaders should work alongside NHS leaders to support the transformation called for in the Francis Inquiry report.
URL	http://www.kingsfund.org.uk/publications/patient-centred-leadership

Measuring Patient Experiences in Primary Health Care: A review and classification of items and scales used in publicly-available questionnaires
Wong ST, Haggerty J
Vancouver. Centre for Health Services and Policy Research, University of British Columbia, 2013.

Notes	The purpose of this review was to identify items and scales to inform the composition of a core Patient Experience Survey for use across Canada. This scoping review provides an up-to-date review of the publicly available instruments that purport to measure patients' experiences in PHC. The Patient Experience Survey measures six dimensions (15 sub-dimensions) of PHC that are best measured based on patient reports: 1) **Access**, 2) Interpersonal **Communication**, 3) **Continuity and Coordination**, 4) **Health Promotion** within Technical Quality of Care, 5) **Trust**, and 6) **Patient-Reported Impacts of Care**.
URL	http://www.chspr.ubc.ca/pubs/report/measuring-patient-experiences-primary-health-care-review-and-classification

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/

Journal articles

Practices to prevent venous thromboembolism: a brief review
Lau BD, Haut ER
BMJ Quality & Safety 2013 [epub].

Notes	This review article covers 16 articles that described practices to prevent venous thromboembolism (VTE). Two studies employed education only, four implemented paper-based tools, four used computerised tools, two evaluated audit and feedback strategies, and four studies used combinations of intervention types. The authors conclude that "**Many intervention types have proven effective** to different degrees in improving VTE prevention. Provider education is likely a required additional component and should be combined with other intervention types. Active mandatory tools are likely more effective than passive ones. Information technology tools that are well integrated into provider workflow, such as alerts and computerised clinical decision support, can improve best practice prophylaxis use and prevent patient harm resulting from VTE."
DOI	http://dx.doi.org/10.1136/bmjqs-2012-001782

For more information on the prevention of venous thromboembolism (VTE), see
http://www.safetyandquality.gov.au/our-work/medication-safety/vte-prevention-resource-centre/

Clinical supervisors: are they the key to making care safer?
Walton M, Barraclough B
BMJ Quality & Safety 2013 [epub].

Notes	The importance of leadership and supervision for the safety and quality of care, particularly clinical leadership and supervision, is often commented upon. In this editorial Merrilyn Walton and Bruce Barraclough ponder whether clinical supervisors are themselves familiar enough with the safety and quality knowledge base and demonstrate sufficient expertise. Thus, **do clinical supervisors themselves first need to demonstrate patient safety competencies** before being responsible for supervising trainees?
DOI	http://dx.doi.org/10.1136/bmjqs-2012-001637

The pursuit of better diagnostic performance: a human factors perspective
Henriksen K, Brady J
BMJ Quality & Safety 2013.

Notes	Adding to the recent interest/literature in diagnosis is the paper taking a human factors approach to (mis)diagnosis. From the abstract, the authors discuss "questions that focus on who owns the problem, treating cognitive and system shortcomings as separate issues, why knowledge in the head is not enough, and what we are learning from health information technology (IT) and the use of checklists. To encourage empirical testing of interventions that aim to improve diagnostic performance, a systems engineering approach making use of rapid-cycle prototyping and simulation is proposed. To gain a fuller understanding of the complexity of the sociotechnical space where diagnostic work is performed, a final note calls for the formation of substantive partnerships with those in disciplines beyond the clinical domain." Recently the HARC Forum (Hospital Alliance for Research Collaboration) in Sydney heard Mark Graber speak on *Reducing diagnostic error in medicine: What can I do?* The presentation is available at https://www.saxinstitute.org.au/events/upcoming-9th-harc-forum/
DOI	http://dx,.doi.org/10.1136/bmjqs-2013-001827

Do team processes really have an effect on clinical performance? A systematic literature review
Schmutz J, Manser T
British Journal of Anaesthesia 2013;110(4):529-544.

Notes	Teamwork is a ubiquitous aspect to contemporary healthcare. This piece in the *British Journal of Anaesthesia* offers a systematic literature review of the impact of team process behaviours on clinical performance. Based on 28 English-language studies published in 2001–2012 the authors report that all the selected studies reported at least one significant relationship between team processes or an intervention and performance, with some non-significant effects also reported. Most of the reported effect sizes were large or medium while the study quality ranged from medium to high. While the studies are diverse in team process behaviours investigated and the methods used they do "suggest that **team process behaviours do influence clinical performance and that training results in increased performance**".
DOI	http://dx.doi.org/10.1093/bja/aes513

Leadership and Patient Safety: A Review of the Literature
Ring L, Fairchild RM
Journal of Nursing Regulation 2013;4(1):52-56.

Notes	This review of the literature on leadership and patient safety reported that "the **competency of health care leaders to create positive work environments and manage constant change is essential to the success of teams and organizations"** and that **"**the **creation of learning cultures to promote patient safety**" are key.
URL	http://www.journalofnursingregulation.com/content/E3106214327862X6

"Apologies" for Pathologists: Why, When, and How to Say "Sorry" After Committing a Medical Error
Dewar R, Parkash V, Forrow L, Truog R
International Journal of Surgical Pathology 2013.

Notes	The need to be transparent about errors is now widely accepted. This paper discuss how one group of clinicians – for whom the clinician-patient relationship is often indirect – can participate in such processes. In this piece the authors use two examples to show how other colleagues routinely play an intermediary role in their day-to-day transactions and in the communication of a pathologist error to the patient. The authors describe the concept of a "dual-hybrid" mind-set in the intermediary and its role in representing the pathologists' viewpoint. With this dual-hybrid mind-set, "the intermediary physician can align with the patients' philosophy and like the patient, consider the smallest deviation from norm to be an error. Alternatively, they might embrace the traditional physician philosophy and communicate only those errors that resulted in a clinically inappropriate outcome. Neither may effectively reflect the pathologists' interests." The authors suggest that that pathologists should develop strategies to communicate errors that include considerations of meeting with the patients directly.
DOI	http://dx.doi.org/10.1177/1066896913487986

For more information on the Commission's work on open disclosure, including the *Australian Open Disclosure Framework,* see http://www.safetyandquality.gov.au/our-work/open-disclosure/

Cancer risk in 680,000 people exposed to computed tomography scans in childhood or adolescence: data linkage study of 11 million Australians
Mathews JD, Forsythe AV, Brady Z, Butler MW, Goergen SK, Byrnes GB, et al.
BMJ 2013;346.

Notes	The safety or otherwise of various diagnostic processes may be an important aspect of the safety of care, particularly as they are such common processes. This widely reported population-based, cohort, data linkage study using 10.9 million Australia Medicare records of patients aged 0–19 suggested that there was an elevated incidence of cancers associated with this population that had undergone diagnostic computed tomography (CT) scans. The authors suggest that **CT scans** "**should be limited to situations where there is a definite clinical indication**, with every scan optimised to provide a diagnostic CT image at the lowest possible radiation dose."
DOI	http://dx.doi.org/10.1136/bmj.f2360

Targeted versus Universal Decolonization to Prevent ICU Infection
Huang SS, Septimus E, Kleinman K, Moody J, Hickok J, Avery TR, et al.
New England Journal of Medicine [epub]

Notes	Methicillin-resistant *Staphylococcus aureus* (MRSA) has been targeted by infection prevention and control efforts due to its virulence and disease spectrum, and increasing prevalence in health care settings. In intensive care unit (ICU) settings, patients are commonly screened for nasal carriage of MRSA. One strategy to reduce transmission and prevent disease in *S. aureus* carriers is decolonisation, usually with a multiday regimen of intranasal mupirocin and chlorhexidine bathing. This study used a three-group, cluster-randomized trial to **compare strategies for preventing MRSA clinical isolates and infections in adult ICUs** in 160 hospitals in the US. The three groups were: • Usual care – screening on admission, and contact precautions for those with a positive test • Targeted decolonisation – screening and contact precautions similar to the first group. Patients known to have MRSA colonisation or infection underwent a decolonisation regimen of intranasal mupirocin and daily bathing with chlorhexidine-impregnated cloths • Universal decolonisation – no screening on admission to ICU, all patients received intranasal mupirocin and chlorhexidine bathing. The study found that **universal decolonisation of patients in the ICU was the most effective strategy**, significantly reducing MRSA-positive clinical cultures by 37% and bloodstream infections from any pathogen by 44%.
DOI	http://dx.doi.org/10.1056/NEJMoa1207290

Attributable mortality of ventilator-associated pneumonia: a meta-analysis of individual patient data from randomised prevention studies
Melsen WG, Rovers MM, Groenwold RHH, Bergmans DCJJ, Camus C, Bauer TT, et al.
The Lancet Infectious Diseases 2013 [epub].

Notes	Ventilator-associated pneumonia (VAP) is an adverse event that is considered preventable or avoidable. This paper provides an estimate of mortality attributable to VAP by conducting a meta-analysis using patient data of 6284 patients from 24 trials. The author's assert that "**The overall attributable mortality of ventilator-associated pneumonia is 13**%, with higher rates for surgical patients and patients with a mid-range severity score at admission. Attributable mortality is mainly caused by prolonged exposure to the risk of dying due to increased length of ICU stay."
DOI	http://dx.doi.org/10.1016/S1473-3099(13)70081-1

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Restructuring of the Diabetes Day Centre: a pilot **lean project in a tertiary referral centre** in the West of Ireland (A M McDermott, P Kidd, M Gately, R Casey, H Burke, P O'Donnell, F Kirrane, S F Dinneen, T O'Brien) • **Patient safety in** healthcare preregistration **educational curricula**: multiple case study-based investigations of eight medicine, nursing, pharmacy and physiotherapy university courses (Kathrin Cresswell, Amanda Howe, Alison Steven, Pam Smith, Darren Ashcroft, Karen Fairhurst, Fay Bradley, Carin Magnusson, Maggie McArthur, Pauline Pearson, Aziz Sheikh, on

	behalf of the Patient Safety Education Research Group) • The contribution of **prescription chart design** and familiarity to prescribing error: a prospective, randomised, cross-over study (Victoria R Tallentire, Rebecca L Hale, Neil G Dewhurst, Simon R J Maxwell) • Editorial: **Patient bedside observations**: what could be simpler? (Michael Buist, Stella Stevens)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

A quality improvement tool for primary health care
www.youtu.be/MGOY2lMk0WQ
Introduction to the APHCRI Centre of Research Excellence in Primary Health Care Microsystems Practice Improvement Tool (PC-PIT): The PC-PIT is an online tool that includes a range of elements which are relevant to high practice function and patient-centred care. Dr Lisa Crossland hosted a webinar to provide an overview of the PC-PIT and a national trial of the tool.

[UK] Patient safety resource centre: Helping you make the right change
http://patientsafety.health.org.uk/
The (UK) charity the Health Foundation has produced this website to provide fast, reliable access to accurate, up-to-date patient safety information for managers and healthcare professionals. Among the materials are key research papers, national standards, implementation guidelines and specific patient safety case studies.