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On the Radar

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On the Radar
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Reports

Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report
Keogh B
London. National Health Service, 2013:61.

Notes	Professor Sir Bruce Keogh, NHS Medical Director for England, was tasked to review the quality of care and treatment provided by those NHS trusts or foundation trusts that were persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review. Although the 14 hospital trusts covered by the review were selected using national mortality measures as a 'warning sign' or for potential quality problems, the investigation looked more broadly at the quality of care and treatment provided within these organisations. The review considered the performance of the hospitals across six key areas: • mortality • patient experience • safety • workforce • clinical and operational effectiveness • leadership and governance.

	The report identified patterns across many of the 14 hospitals including: • professional and geographic isolation • failure to act on data or information that showed cause for concern • the absence of a culture of openness • a lack of willingness to learn from mistakes • ineffectual governance and assurance processes. Sir Bruce has also set out a vision for where the NHS can get to within two years. This includes: • Making demonstrable progress to reducing avoidable deaths in hospitals • Patients and clinicians will have confidence in the quality of assessments made by the Care Quality Commission, not least because they will have been active participants in inspections • No hospital will be an island – professional, academic and managerial isolation will be a thing of the past • Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by Trust boards • Patients will not just feel like they have been listened to but will be able to see how their feedback is impacting on their own care and the care of others.
URL	http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx
TRIM	83540

2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care
U.S. Department of Health and Human Services
Washington D.C.

Notes	The US Department of Health and Human Services has released the *2013 Annual Progress Report to Congress on the National Strategy for Quality Improvement in Health Care*. The report provides details on implementation activities by the private and public sectors, efforts to align quality measures, and successes in six priority areas, including patient safety, community health, and affordability. This year's report highlights: • Effective performance measurement, Quality improvement in the six priority areas that include patient safety, community health, and affordability. • Progress against the three strategic opportunities, including the development of organizational infrastructure at the community level. The US *National Quality Strategy* has 3 aims and 6 priorities: ***Aims:*** 1. Better Care 2. Healthy People/Health Communities 3. Affordable Care ***Priorities:*** 1. Making care safer by reducing harm caused in the delivery of care. 2. Ensuring that each person and family is engaged as partners in their care. 3. Promoting effective communication and coordination of care. 4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.

	5. Working with communities to promote wide use of best practices to enable healthy living. 6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.
URL	http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm

Journal articles

Hospital Strategies Associated With 30-Day Readmission Rates for Patients With Heart Failure
Bradley EH, Curry L, Horwitz LI, Sipsma H, Wang Y, Walsh MN, et al
Circulation: Cardiovascular Quality and Outcomes 2013;6(4):444-450.

Notes	The desire to reduce re-admissions of hospital patients is widespread, for a range of motivations. This paper reports on a number of strategies that hospitals may be able to use to reduce 30-day readmissions of particular patients, in this instance, patients with heart failure. As a Commonwealth Fund commentary on this piece noted: "The need to readmit a patient to the hospital soon after discharge can be an indicator of poor care coordination. Hospital readmissions are also extremely costly to the health system overall." The **six strategies** that were associated with **significantly lower risk-standardised 30-day readmission rates** are: • partnering with community physicians or physician groups; • partnering with other local hospitals; • having nurses take responsibility for medication reconciliation; • arranging follow-up appointments prior to discharge; • having a process in place to send all discharge papers or electronic summaries directly to the patient's primary physician; and • assigning staff to follow up on test results that return after the patient is discharged. Clearly these are primarily aimed at improving **clinical communications** and **co-ordination and continuity of care**.
DOI	http://dx.doi.org/10.1161/circoutcomes.111.000101 Commonwealth Fund commentary: http://www.commonwealthfund.org/Publications/In-the-Literature/2013/Jul/Hospital-Strategies-Associated-with-30-Day-Readmission-Rates.aspx

Reducing Cardiopulmonary Arrest Rates in a Three-Year Regional Rapid Response System Collaborative
Rosen MJ, Hoberman AJ, Ruiz RE, Sumer Z, Jalon HS
Joint Commission Journal on Quality and Patient Safety 2013;39(7):328-336.

Notes	The utility of rapid response teams, METs or similar has not always been apparent. This 3-year study of a **rapid response system** found it was associated with **decreases in non–intensive care unit code rates and overall hospital mortality**.
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2013/00000039/00000007/art00008

The Patient-Reported Incident in Hospital Instrument (PRIH-I): assessments of data quality, test–retest reliability and hospital-level reliability
Bjertnaes O, Skudal KE, Iversen HH, Lindahl AK
BMJ Quality & Safety 2013 [epub].

Notes	Paper examining the Patient-Reported Incident in Hospital Instrument (PRIH-I) and evaluating its performance in Norway in 2011. The PRIH-I comprises 13 questions about patient-perceived incidents in hospitals, and apparently can be easily and cost-effectively included in national patient-experience surveys. The authors note that while the missing-item rate and test–retest reliability were poor for several items, the "hospital-level reliability was satisfactory for most of the items. The incident items contribute to a patient-reported incident index, with excellent data quality and hospital-level reliability."
DOI	http://dx.doi.org/10.1136/bmjqs-2012-001756

Documenting Quality Improvement and Patient Safety Efforts: The Quality Portfolio. A Statement from the Academic Hospitalist Taskforce
Taylor B, Parekh V, Estrada C, Schleyer A, Sharpe B
Journal of General Internal Medicine 2013:1-5.

Notes	From the patient perspective, to the clinicians and a tool for recording and monitoring one's performance in patient safety and improvement activities. The (US) Society of General Internal Medicine Academic Hospitalist Task Force sought to develop a practical tool, the quality portfolio, to systematically document quality and safety achievements. The portfolio has eight categories including: (1) a faculty narrative (2) leadership and administrative activities (3) project activities (4) education and curricula (5) research and scholarship (6) honours, awards, and recognition (7) training and certification, and (8) an appendix. The authors offer this comprehensive, yet practical tool as a method to document quality and safety activities.
DOI	http://dx.doi.org/10.1007/s11606-013-2532-z

National trends in hospital-acquired preventable adverse events after major cancer surgery in the USA
Sukumar S, Roghmann F, Trinh VQ, Sammon JD, Gervais M-K, Tan H-J, et al.
BMJ Open 2013;3(6) [epub]

Notes	Paper reporting on a retrospective, cross-sectional analysis of a weighted-national estimate of 2,508,917 patients from the US Nationwide Inpatient Sample (NIS) undergoing major oncological procedures (colectomy, cystectomy, oesophagectomy, gastrectomy, hysterectomy, lung resection, pancreatectomy and prostatectomy). The study used the Agency for Healthcare Research and Quality Patient Safety Indicators (PSIs) to identify trends in hospital-acquired adverse events. Of the 2,508,917 patients in the sample 324,852 **experienced at least 1 PSI event** (**12.9%**). Patients with at least 1 PSI experienced **higher rates of in-hospital mortality**, **prolonged length of stay** and excessive hospital-charges

	Patients treated at **lower volume hospitals experienced both higher PSI events and failure-to-rescue rates**. The authors conclude that "there has been a substantial increase in the [US] national frequency of potentially avoidable adverse events after major cancer surgery, with a detrimental effect on numerous outcome-level measures. However, there was a concomitant reduction in failure-to-rescue rates and overall mortality rates. Policy changes to improve the increasing burden of specific adverse events, such as **postoperative sepsis**, **pressure ulcers** and **respiratory failure**, are required."
DOI	http://dx.doi.org/10.1136/bmjopen-2013-002843

A Handoff Protocol from the Cardiovascular Operating Room to Cardiac ICU Is Associated with Improvements in Care Beyond the Immediate Postoperative Period
Kaufman J, Twite M, Barrett C, Peyton C, Koehler J, Rannie M, et al.
Joint Commission Journal on Quality and Patient Safety 2013;39(7):306-311.

Notes	Transitions, handovers or hand-offs are regarded as potentially risky and various protocols and checklists have been developed to aid clinicians in ensuring the risks are minimised. This paper reports on one such protocol – in cardiac care – and documents how it has improved care in a university-affiliated children's hospital.. When examining such interventions, particularly with a view to implementing them elsewhere, it is important to consider the context and what adjustments may be appropriate. The authors report that the implementation of this handoff protocol from the cardiovascular operating room to the cardiac intensive care unit was associated with **sustained decrease in unplanned extubations and in mean ventilator times**.
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2013/00000039/00000007/art00004

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Use of health information technology to reduce **diagnostic errors** (Robert El-Kareh, Omar Hasan, Gordon D Schiff) • Value of a modified early **obstetric warning system** (MEOWS) in managing **maternal complications** in the peripartum period: an ethnographic study (Nicola Mackintosh, Kylie Watson, S Rance, J Sandall) • A structured judgement method to enhance **mortality case note review**: development and evaluation (Allen Hutchinson, Joanne E Coster, Katy L Cooper, Michael Pearson, Aileen McIntosh, Peter A Bath) • Reducing **cardiac arrests in the acute admissions unit**: a quality improvement journey (Daniel J Beckett, Monica Inglis, Sharon Oswald, Elaine Thomson, Wilma Harley, Jennifer Wilson, R C Lloyd, K D Rooney) • Experience of general hospital care in older patients with cognitive impairment: are we measuring the **most vulnerable patients' experience**? (Sarah E Goldberg, Rowan H Harwood) • Electronic health record-based triggers to detect potential **delays in cancer diagnosis** (Daniel R Murphy, Archana Laxmisan, Brian A Reis, Eric J Thomas, Adol Esquivel, S N Forjuoh, R Parikh, M M Khan, H Singh)

	• The role of technology in **clinician-to-clinician communication** (Lisa M McElroy, Daniela P Ladner, Jane L Holl)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[USA] Patient Safety Primer: Diagnostic Errors
http://psnet.ahrq.gov/primer.aspx?primerID=12
The US Agency for Healthcare Research and Quality (AHRQ) produces a series of 'primers' on various topics. A new primer available on AHRQ's Patient Safety Network identifies the cognitive biases and health system problems leading to diagnostic errors and steps to prevent both.