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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Free public lecture – Shared Decision Making
Shared Decision Making: Building on research to help it happen in practice
Wednesday 16 October 2013-09-12

The Australian Commission on Safety and Quality in Health Care invites you to a public lecture by Professor France Légaré – an international expert in the field of shared decision making in health care.
Shared decision making involves clinicians and patients making decisions together using the best available evidence. In partnership with their clinician, patients are encouraged to consider available screening, treatment, or management options and the likely benefits and harms of each, to communicate their preferences, and help select the course of action that best fits these.

Join us for Professor Légaré's discussion on shared decision making and how public interest in this area is leading to changes in practice.
Time: 5:00pm to 6:45pm
Venue: Mercure Hotel, 818-820 George Street, Haymarket, Sydney

For further information see http://www.safetyandquality.gov.au/our-work/shared-decision-making/

Journal articles

Improving The Quality Of Health Care: What's Taking So Long?
Chassin MR
Health Affairs 2013;32(10):1761-1765.

The Long Wait For Medical Excellence
Millenson ML
Health Affairs 2013;32(10):1757-1760.

High-Reliability Health Care: Getting There from Here
Chassin MR, Loeb JM
Milbank Quarterly 2013;91(3):459-490.

Notes	A pair of recent articles involving Mark Chassin, one a short Viewpoint piece in *Health Affairs*, the other a much lengthier item in *Milbank Quarterly*. The two are both advocating for and describing ways to continue to improve the quality of health care. In his Viewpoint item, Chassin laments the apparently slow progress in reducing the levels of harm occurring to patients. This is also echoed in another Viewpoint piece, by Michael Millenson, that reflects on the 1997 book, *Demanding Medical Excellence: Doctors and Accountability in the Information Age*, and suggests that the necessary 'paradigm shift' is, at best, still happening. Chassin concludes his Viewpoint piece with the prescription of "**addressing overuse** problems as vigorously as preventable complications, embracing much more effective **process-improvement strategies** and tools, and changing the **culture** within our health care organizations to one that supports **high reliability**." This clearly points the way to his longer article in Milbank Quarterly in which he delves into much more detail on the possibilities and opportunities for and of high reliability health care. The paper examines what health care can take form high reliability industries, how hospitals currently rate on high reliability principles, adapting high reliability thinking to health, and a "practical framework for improvement" with examples and attention to the importance of context. Key aspects or domains are **leadership**, **culture** and **robust process improvement** approaches. The framework contains 14 components in the 3 domains and describes 4 "evolutionary stages of maturity on the road to high reliability" for each component. Possibly the key here is that "**Hospitals *can* make substantial progress toward high reliability** …"
DOIs	Chassin, Health Affairs http://dx.doi.org/10.1377/hlthaff.2013.0809 Millenson http://dx.doi.org/10.1377/hlthaff.2013.0567 Chassin and Loeb, Milbank Quarterly http://dx.doi.org/10.1111/1468-0009.12023
TRIM	Chassin and Loeb, Milbank Quarterly 88591

The challenge of doing less
Dyer O
BMJ 2013;347 [epub]

Notes	Over the last two years, the Choosing Wisely campaign, led by the ABIM Foundation in the US, has recruited more than 50 specialty societies to each produce a list of five procedures that are overused in their field. The message of these lists is not to stop certain procedures occurring, but rather to encourage clinicians, and consumers, to think carefully before proceeding.

	This article examines some of the criticisms and compliments given to the campaign as it enters the final stage.
DOI	http://dx.doi.org/10.1136/bmj.f5904

Engaging patients in medication reconciliation via a patient portal following hospital discharge
Heyworth L, Paquin AM, Clark J, Kamenker V, Stewart M, Martin T, et al
Journal of the American Medical Informatics Association 2013 [epub].

Effect of Barcode-assisted Medication Administration on Emergency Department Medication Errors
Bonkowski J, Carnes C, Melucci J, Mirtallo J, Prier B, Reichert E, et al.
Academic Emergency Medicine 2013;20(8):801-806.

Detection of medication-related problems in hospital practice: a review
Manias E
British Journal of Clinical Pharmacology 2013;76(1):7-20.

Notes	A number of papers on various aspect of **medication safety**. Heyworth et al. describe how a secure email service ('**Secure Messaging for Medication Reconciliation Tool**' (SMMRT)) from a pharmacist asking discharged patients to confirm their discharge medication list, indicate whether they had discontinued any prescribed medications, and prompted for questions was positively received and that in the pilot study pharmacists detected 108 medication discrepancies and 23 potential adverse drug events in the 51 medication lists sent. In another paper on spreading the use of technology, Bonkowski et al, report how the introduction of **barcode-assisted medication administration** was associated with an **80% reduction in medication administration errors** in a US academic medical centre's emergency department. Taking a broader view on hospital medication errors, Manias undertook this review of the detection of "medication-related problems" in hospitals. The review sought to examine the effectiveness of detection methods in terms of their ability to identify and accurately determine medication-related problems in hospitals. Manias reports that detection methods that were better able to identify medication-related problems included **chart review**, **computer monitoring**, **direct care observation** and **prospective data collection**. Manias recognises a number of limitations of the available literature and suggests that "Greater attention should be placed on combining methods, such as chart review and computer monitoring in examining trends. More research is needed on the use of claims data, direct care observation, interviews and prospective data collection as detection methods."
DOIs	Heyworth et al http://dx.doi.org/10.1136/amiajnl-2013-001995 Bonkowski et al http://dx.doi.org/10.1111/acem.12189 Manias http://dx.doi.org/10.1111/bcp.12049

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

"That Was a Close Call": Endorsing a Broad Definition of Near Misses in Health Care
Marks CM, Kasda E, Paine L, Wu AW
Joint Commission Journal on Quality and Patient Safety 2013;39(10):475-479.

Improving patient safety in the ICU by prospective identification of missing safety barriers using the bow-tie prospective risk analysis model
Kerckhoffs MC, van der Sluijs AF, Binnekade JM, Dongelmans DA
Journal of Patient Safety 2013;9(3):154-159.

Miscount Incidents: A Novel Approach to Exploring Risk Factors for Unintentionally Retained Surgical Items
Judson TJ, Howell MD, Guglielmi C, Canacari E, Sands K
Joint Commission Journal on Quality and Patient Safety 2013;39(10):468-474.

Notes	This grouping of papers look at issues of identifying errors, risks and opportunities. Marks et al. suggest that by paying more attention to **close calls** and near misses we may learn more than by just focussing on adverse events. Close calls/near misses are "unplanned events caused by errors that do not result in patient injury but have the potential to do so". However, the authors suggest this definition: "an event or situation that did not produce patient harm because it did not reach the patient, either due to chance or to capture before reading; or if it did reach the patient, due to robustness of the patient or to timely intervention(for example, an antidote was administered)." The authors argue that the "Use of a broad definition of close calls, which embraces not only those incidents that never reach the patient but those that do so without causing actual harm, can be useful to uncover a broader range of patient safety incidents. These incidents can then be subjected to classification, investigation, and efforts to generate corrective action at an organizational level, as demonstrated by the experience at The Johns Hopkins Hospital." Kerckhoffs et al recommend the use of a particular method of detecting risk. In this case they used the 'Bow-Tie' prospective risk analysis model to identify latent **safety hazards in intensive care**. In the paper the authors report on their Bow Tie analysis conducted by multidisciplinary teams of doctors and nurses on a Dutch 28-bed ICU. The analysis was performed on intrahospital transportation, unplanned extubation, and communication. In each of the three areas the analyses revealed missing but implementable barriers and practical recommendations. Thus this form of analysis was found to be beneficial in identify and enhancing patient safety. It could be argued that this is just one of a range of techniques or approaches that could be adopted and it may that the real object is to be a critical, reflexive and learning individual/unit/organisation that is willing to learn and improve. Judson et al also examined risk, in this case risk factors for **retained surgical items** (RSIs). The authors report on their cohort study of all consecutive operative cases over a 12-month period at a large US academic medical centre that included 23,955 operations. The study looked for miscount incidents so as to examine the risk factors. Some 84 miscount incidents (0.35%) were identified in the 23,955 operations. From their analyses the authors report that "**length of the case** and the **number of providers** involved in the case were independent risk factors for miscount incidents may offer insight into risk-targeted strategies to prevent RSIs, such as postoperative imaging, bar-coded surgical items, and radiofrequency technology."

	It could be said that all of these papers examine aspects of cognition and focus. In similar vein, the Society to Improve Diagnosis in Medicine has produced a **Clinical Reasoning Toolkit**. The toolkit offers resources to aid clinicians improve their understanding of cognitive errors and diagnostic reasoning.
URL / DOI	Marks et al http://www.ingentaconnect.com/content/jcaho/jcjqs/2013/00000039/00000010/art00005 Kerckhoffs et al http://dx.doi.org/10.1097/PTS.0b013e318288a476 Judson et al http://www.ingentaconnect.com/content/jcaho/jcjqs/2013/00000039/00000010/art00004 Clinical Reasoning Toolkit http://www.improvediagnosis.org/ClinicalReasoning

Massachusetts General Physicians Organization's Quality Incentive Program Produces Encouraging Results
Torchiana DF, Colton DG, Rao SK, Lenz SK, Meyer GS, Ferris TG
Health Affairs 2013;32(10):1748-1756.

Notes	Paper reporting on how one major US hospital instituted incentive payments for salaried physicians in 2006 and how over thirteen six-month terms, the program has used 130 different quality measures. The authors note that "Although quality-of-care improvements and cost reductions were difficult to calculate, anecdotal evidence points to multiple successes. … The program also facilitated the adoption of an electronic health record, improved hand hygiene compliance, increased efficiency in radiology and the cancer center, and decreased emergency department use. The program demonstrated that **even small incentives** tied to carefully structured metrics, priority setting, and clear communication **can help change** salaried physicians' behavior in ways that **improve the quality and safety** of health care and ease the physicians' sense of administrative burden."
DOI	http://dx.doi.org/10.1377/hlthaff.2013.0377

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • **Identification of poor performance** in a national medical workforce over 11 years: an observational study (Liam J Donaldson, Sukhmeet S Panesar, Pauline A McAvoy, Diana M Scarrott) • From physician intent to the pharmacy label: prevalence and description of discrepancies from a cross-sectional **evaluation of electronic prescriptions** (Gary L Cochran, Donald G Klepser, Marsha Morien, Daniel Lomelin, Rebecca Schainost, Lina Lander) • Safely and effectively **reducing inpatient length of stay**: a controlled study of the General Internal Medicine Care Transformation Initiative (Finlay A McAlister, Jeffrey A Bakal, Sumit R Majumdar, Stafford Dean, Rajdeep S Padwal, Narmin Kassam, Maria Bacchus, Ann Colbourne) • 'Not another safety culture survey': using the **Canadian patient safety climate survey** (Can-PSCS) to measure provider perceptions of PSC across health settings (Liane R Ginsburg, Deborah Tregunno, Peter G Norton, Jonathan I Mitchell, Heather Howley)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

Notes	The *International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • **Patient satisfaction** with service quality in an **oncology** setting: implications for prognosis in non-small cell lung cancer (Digant Gupta, Mark Rodeghier, and Christopher G Lis) • High-quality chronic care delivery improves **experiences of chronically ill** patients receiving care (Jane Murray Cramm and Anna Petra Nieboer) • Trust in the health-care **provider–patient relationship**: a systematic mapping review of the evidence base (Nicola Brennan, Rebecca Barnes, Mike Calnan, Oonagh Corrigan, Paul Dieppe, and Vikki Entwistle)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

[UK] Transforming Participation in Health and Care, Guidance for Commissioners
http://www.england.nhs.uk/2013/09/25/trans-part/
NHS England has produced this guidance to aid clinical commissioning groups and commissioners in NHS England to enable:

- patients and carers to participate in planning, managing and making decisions about their care and treatment through the services they commission;
- the effective participation of the public in the commissioning process itself, so that services reflect the needs of local people.

The purpose is to support commissioners to improve individual and public participation and to better understand and respond to the needs of the communities they serve.

[USA] It's all about the culture
http://www.hpoe.org/resources/case-studies/1449
From the Hospitals in Pursuit of Excellence ((HPOE) is this new case study. This study describes how a US health care system, Mountain States Health Alliance (MHSA) adopted Lean management and found that the transformation meant improved patient care, employee satisfaction and reduced costs as MSHA shifted its organisational culture.