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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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Journal articles

Patient-Reported Missed Nursing Care Correlated With Adverse Events
Kalisch BJ, Xie B, Dabney BW
American Journal of Medical Quality 2013 [epub].

Notes	The role patients can play in monitoring and improving care delivery is at times contested. This US study surveyed 729 inpatients in 2 acute care hospitals in an attempt to determine the extent and type of missed nursing care and possible association with patient-reported adverse outcomes. The authors report that the patients reported more missed nursing care in the domain of basic care than in communication and in time to respond. The five most frequently reported elements of **missed nursing care** were the following: **mouth care** (50.3%), **ambulation** (41.3%), **getting out of bed** into a chair (38.8%), providing **information** about tests/procedures (27%), and **bathing** (26.4%). They also report that the "patients who reported skin breakdown/**pressure ulcers**, **medication errors**, new **infections**, **IVs** running dry, IVs infiltrating, and other problems during the current hospitalization reported significantly more overall missed nursing care."
DOI	http://dx.doi.org/10.1177/1062860613501715

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

Do variations in hospital mortality patterns after weekend admission reflect reduced quality of care or different patient cohorts? A population-based study
Concha OP, Gallego B, Hillman K, Delaney GP, Coiera E
BMJ Quality & Safety 2013 [epub].

Notes	Widely reported paper from UNSW academics that examined the 'weekend effect'. The study examined emergency department admissions to all 501 hospitals in New South Wales between 2000 and 2007 – a total of 3 381 962 admissions for 539 122 patients and 64 789 deaths at 1 week after admission. The researchers computed excess mortality risk curves for weekend over weekday admissions, adjusting for age, sex, co-morbidity and diagnostic group. They found that weekends accounted for 27% of all admissions and 28% of deaths and that 16 of 430 diagnosis groups had a significantly increased risk of death following weekend admission. These accounted for 40% of all deaths, and demonstrated "different temporal excess mortality risk patterns: early care effect (cardiac arrest); care effect washout (e.g., pulmonary embolism); patient effect (e.g., cancer admissions) and mixed (e.g., stroke)." The authors conclude that "excess mortality patterns of the weekend effect vary widely for different diagnostic groups. Recognising these different patterns should help identify at-risk diagnoses where quality of care can be improved in order to minimise the excess mortality associated with weekend admission."
DOI	http://dx.doi.org/10.1136/bmjqs-2013-002218

Using "Near Misses" Analysis to Prevent Wrong-Site Surgery
Yoon RS, Alaia MJ, Hutzler LH, Bosco JA
Journal for Healthcare Quality 2013 [epub].

Notes	Another recent addition to the literature on near misses or close calls, this article looks at applying learnings from such (non)events to improve surgery, particularly to prevent wrong-site surgery. The intervention sought to reduce the number of near-miss events pertaining to wrong-site surgery, including incorrectly sided surgical bookings and incorrectly performed preoperative time-out procedures. Pre- and post-intervention, incorrectly booked cases, and improperly performed pre-surgical time-out procedures were recorded. Surgeons and their staff were educated regarding the importance of and proper way to perform these tasks. Examination of the 12,215 cases (6,126 the "pre-education" cohort, 6,089 cases "post-education" cohort) revealed that in the first four months of the study, the monthly rate of incorrectly booked cases was 0.75%. Since the intervention, the rate decreased to 0.41%. The percentage of improperly performed time-out procedures decreased from 18.7% to 5.9% after the educational interventions were performed. By reducing the incidence of near misses, logically this reduces the likelihood of actually wrong site surgery.
DOI	http://dx.doi.org/10.1111/jhq.12037

When Is a Medical Treatment Unnecessary?
Rosenbaum L
The New Yorker. New York, 2013.

Notes	Somewhat provocative piece suggesting that examination of practice variation and the use of guidelines and the like may be depriving patients of care they need. This piece revolves around the anecdotal story of a single patient. The author is right to point out that the populations used in randomised clinical trials are not 'real world' and that 'real' patients can have much more complex medical histories and conditions. As has been discussed elsewhere, variation in medical practice can be good, bad inexplicable or even unwarranted. Good medicine is not formulaic, but is also appropriately varied. This piece could have been extended so as to make the connection between appropriate clinical variation, evidence, patient-centred care, and shared decision-making. A genuinely patient-centred approach would examine the context, needs and values of the patient in coming to a shared decision while using nuanced evidence, possibly using some sort of decision aid that's based on evidence from a range of sources, including RCTs, clinical registries, etc.
URL	http://www.newyorker.com/online/blogs/elements/2013/10/the-most-slandered-treatment-in-medicine.html

Ill communication
Hitchcock K
The Monthly. Melbourne. The Monthly Pty Ltd, 2013.

Notes	An interesting and, at times humorous, short piece by Dr Karen Hitchcock published in *The Monthly*. It's essentially about the importance of human interaction and communication in medicine, and the challenge of reconciling these 'softer' skills with the technical and intellectual demands of medical practice and training. Food for thought.
URL	http://www.themonthly.com.au/issue/2013/october/1380549600/karen-hitchcock/ill-communication

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: • Limitations of using same-**hospital readmission metrics** (Sheryl M Davies, Olga Saynina, Kathryn M McDonald, and Laurence C Baker) • **ICD-11 for quality and safety**: overview of the WHO quality and safety topic advisory group (William A Ghali, Harold A Pincus, Danielle A Southern, Susan E Brien, Patrick S Romano, Bernard Burnand, Saskia E Drösler, Vijaya Sundararajan, Lori Moskal, Alan J Forster, Yana Gurevich, Hude Quan, Cyrille Colin, William B Munier, James Harrison, Brigitta Spaeth-Rublee, Nenad Kostanjsek, and T. Bedirhan Üstün) • Performance measurements in **diabetes care**: the complex task of selecting quality indicators (Hiske Calsbeek, Nicole A B M Ketelaar, Marjan J Faber, Michel Wensing, and Jozé Braspenning)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

[UK] Hospital Intelligent Monitoring
http://www.cqc.org.uk/public/hospital-intelligent-monitoring
The UK Care Quality Commission has developed this model of 'intelligent monitoring' of more than 150 different indicators. This webpage provides information about the intelligent modelling approach, including FAQs and the indicators and methodology.

Recommended readings – Shared decision making
As an occasional feature *Recommended readings* will identify a number of key or influential works on a specific subject. For the first of these we are looking at the topic of shared decision making.
Making Shared Decision-making a Reality: No decision about me, without me
Coulter A, Collins A
London: The King's Fund, 2011.
http://www.kingsfund.org.uk/publications/making-shared-decision-making-reality

Shared Decision Making: Examining Key Elements And Barriers To Adoption Into Routine Clinical Practice
Légaré F, Witteman HO
Health Affairs 2013;32(2):276-284
http://dx.doi.org/10.1377/hlthaff.2012.1078

Shared decision making: Really putting patients at the centre of healthcare
Stiggelbout AM, Weijden TVd, Wit MPTD, Frosch D, Légaré F, Montori VM, et al.
BMJ 2012;344.
http://dx.doi.org/10.1136/bmj.e256

Implementing shared decision making in the NHS
Elwyn G, Laitner S, Coulter A, Walker E, Watson P, Thomson R
BMJ 2010;341.
http://dx.doi.org/10.1136/bmj.c5146

Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial
Shepherd HL, Barratt A, Trevena LJ, McGeechan K, Carey K, Epstein RM, et al.
Patient Education and Counseling 2011;84(3):379-385.
http://dx.doi.org/10.1016/j.pec.2011.07.022

Implementing patient question-prompt lists into routine cancer care
Dimoska A, Butow PN, Lynch J, Hovey E, Agar M, Beale P, et al.
Patient Education and Counseling 2012;86(2):252-258.
http://dx.doi.org/10.1016/j.pec.2011.04.020
