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On the Radar

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On the Radar
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Books

Shared Health Information: Toward better, safer care
Ministry of Health (New Zealand)
Wellington: Ministry of Health, 2013.

Notes	Short booklet from the New Zealand Ministry of Health showcasing examples of information technology innovation and use within the health and disability sector. The book describes the increasing use of connected electronic systems which provide clinicians and consumers with relevant information when it is needed at the point of care and how that can contribute to the safety and quality of care.
URL	http://www.health.govt.nz/publication/sharing-health-information-toward-better-safer-care

Reports

NHS Services, Seven Days a Week

Notes	This report of NHS Services, Seven Days a Week Forum, convened by Professor Sir Bruce Keogh, National Medical Director, points to significant variation in outcomes for patients admitted to hospitals at the weekend across the NHS in England – a problem affecting most healthcare systems around the world. In the report are set out **ten new clinical standards** that describe the standard of urgent and emergency care all patients should expect seven days a week, each supported by clinical evidence and developed in partnership with the Academy of Medical Royal Colleges. The clinical standards cover: **1. Patient Experience** **2. Time to first consultant review** **3. Multi-disciplinary Team (MDT) review** **4. Shift handovers** **5. Diagnostics** **6. Intervention / key services** **7. Mental health** **8. On-going review** **9. Transfer to community, primary and social care** **10. Quality improvement.**
URL	http://www.england.nhs.uk/2013/12/15/sir-bruce-keogh-7ds/

Using clinical communities to improve quality: Ten lessons for getting the clinical community approach to work in practice
The Health Foundation
London. The Health Foundation, 2013:20.

Notes	This short report from the (UK) Health Foundation introduces an approach – the **clinical community** – that was used by the Foundation's Closing the Gap through Clinical Communities programme to support and secure improvements in health systems across multiple sites. The report outlines **ten key lessons** for getting the approach to work in practice and avoiding potential pitfalls: **1. Choose the right challenge for a clinical community approach** **2. Build a strong core team** **3. Recruit a community** **4. Resource the community properly** **5. Start with a clear 'theory of change', but review and adapt in light of learning and experience** **6. Foster a sense of community and belonging** **7. Recognise and deal with conflict and marginalisation** **8. Find a balance between 'hard' and 'soft' tactics** **9. Use data wisely** **10. Recognise the contextual influences on improvement and the need for customisation.**
URL	http://www.health.org.uk/publications/using-clinical-communities-to-improve-quality/

High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. IHI White Paper
Swensen S, Pugh M, McMullan C, Kabcenell A.
Cambridge, Massachusetts. Institute for Healthcare Improvement, 2013.

Notes	The US Institute for Healthcare Improvement (IHI) has published this 34-page white paper based on is the findings of an IHI 90-Day Innovation Project on leadership. In the white paper the authors discuss three interdependent dimensions of leadership that they consider define high-impact leadership in health care. • **New Mental Models**: Proposing a set of ideas that constitute new mental models for leaders as they re-design care delivery systems to compete on value, rather than on volume. • **High-Impact Leadership Behaviours**: Five leadership behaviours to accelerate cultural change and support efforts to achieve results. • **IHI High-Impact Leadership Framework**: Building on IHI's legacy leadership models and thinking, the IHI High-Impact Leadership Framework presents an updated, simpler leadership framework that serves as a guide for where leaders need to focus efforts and resources in order to drive improvement and innovation. This updated framework adds three essential areas of leadership efforts: driven by persons and community; shape desired organizational culture; and engage across traditional boundaries of health care systems.
URL	http://www.ihi.org/knowledge/Pages/IHIWhitePapers/HighImpactLeadership.aspx
TRIM	93393

Journal articles

Implementing a national program to reduce catheter-associated urinary tract infection: a quality improvement collaboration of state hospital associations, academic medical centers, professional societies, and governmental agencies
Fakih MG, George C, Edson BS, Goeschel CA, Saint S
Infection Control and Hospital Epidemiology 2013;34(10):1048-1054.

Notes	Paper describing how the USA is scaling up the successes of the Michigan catheter-associated urinary tract infection (CAUTI) collaborative. The US Department of Health and Human Services issued a plan for a 25% reduction of CAUTI by 2013. The papers note that the key components of the project are: (1) centralised coordination of the effort and dissemination of information to state hospital associations and hospitals (2) data collection based on established definitions and approaches (3) focused guidance on the technical practices that will prevent CAUTI (4) emphasis on understanding the socio-adaptive aspects (both the general, unit-wide issues and CAUTI-specific challenges), and (5) partnering with specialty organizations and governmental agencies who have expertise in the relevant subject area. The authors also suggest that this "work may serve in the future as a model for other large improvement efforts to address other hospital-acquired conditions, such as venous thromboembolism and falls."
DOI	http://dx.doi.org/10.1086/673149

For information about the Commission's work on healthcare associated infection, including hand hygiene, see http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Interventions to reduce colonisation and transmission of antimicrobial-resistant bacteria in intensive care units: an interrupted time series study and cluster randomised trial
Derde LPG, Cooper BS, Goossens H, Malhotra-Kumar S, Willems RJL, Gniadkowski M, et al.
The Lancet Infectious Diseases 2014;14(1):31-39.

Notes	This European study of interventions to reduce colonisation and transmission of antimicrobial-resistant bacteria in Intensive Care Units (ICUs) involved 3 phases in 13 European ICUs (a 6 month baseline period (phase 1), an interrupted time series study of universal chlorhexidine body-washing combined with hand hygiene improvement for 6 months (phase 2), followed by a 12–15 month cluster randomised trial (phase 3). Simply put, "**Improved hand hygiene** plus unit-wide **chlorhexidine body-washing reduced acquisition of antimicrobial-resistant bacteria**, particularly MRSA."
DOI	http://dx.doi.org/10.1016/S1473-3099(13)70295-0

Determinants of surgical decision making: a national survey
Wilson NP, Wilson FP, Neuman M, Epstein A, Bell R, Armstrong K, et al
American Journal of Surgery 2013;206(6):970-978.

Notes	Variation, and its possible causes, is an emerging theme in health debates. This paper attempted to examine factors influencing surgical decision making in the US. This survey had 907 respondents and the authors report that **surgeons tend to be less interventionist in their areas of specialisation**. In some ways this adds to other literature that shows clinicians tend to have less interventions in the care they and their families receive. Other factors that showed a correlation with tendency to operate included age (falling with age), ethnicity, and compensation model while malpractice concerns did not display a relationship.
DOI	http://dx.doi.org/10.1016/j.amjsurg.2013.08.018

Safe use of electronic health records and health information technology systems: trust but verify
Denham CR, Classen DC, Swenson SJ, Henderson MJ, Zeltner T, Bates DW
Journal of Patient Safety 2013;9(4):177-189.

How to Identify and Address Unsafe Conditions Associated with Health IT
Wallace C, Zimmer KP, Possanza L, Giannini R, Solomon R
Washington D.C. The Office of the National Coordinator for Health Information Technology, 2013.

Findings and Lessons from the AHRQ Ambulatory Safety and Quality Program
Agency for Health Care Research and Quality
Rockville, MD. Agency for Healthcare Research and Quality, 2013.

Patient engagement in the inpatient setting: a systematic review
Prey JE, Woollen J, Wilcox L, Sackeim AD, Hripcsak G, Bakken S, et al.
Journal of the American Medical Informatics Association 2013 [epub].

Notes	A number of items looking at health information technology (HIT). Denham et al discuss how implementation of health IT needs to be done in such a way as to not introduce new sources of error while addressing existing issues.

	Following the adage "**trust but verify**" they outline a framework to measure and monitor performance of health IT following implementation. Denham et al argue that "HIT safety hazards should be taken very seriously, and the need for proven, robust, and regular post-deployment performance verification measurement of EHR system operations in every health-care organization is critical to ensure that these systems are safe for every patient" In a related vein is the paper from Wallace et al from the (US) Office of the National Coordinator for Health Information Technology suggests how health care organisations may identify health information technology concerns and improve systems to reduce risks. The report states that "healthcare organizations **must operate as high-reliability organizations** to ensure the safety of their health IT systems. Their safety culture should foster a willingness to learn about unsafe conditions with their health IT systems that can lead to patient harm and to make improvements to the systems before accidents do occur." The US Agency for Healthcare Research and Quality (AHRQ) have published a report drawing together findings from projects that explored how health **information technology can augment quality and safety in ambulatory care**. The report is organised around 10 key aspects of ambulatory care that illustrate ways in which health IT can be used to improve safety and quality in ambulatory settings. The 10 aspects of ambulatory care are: 1. Developing and Testing Quality Measures 2. Capturing and Integrating Data to Support Quality Measurement and Improvement 3. Providing Clinicians With Patient-Specific Information, Clinical Knowledge, and Decision Support 4. Providing Clinician and Patient Access to Medical Information 5. Improving Shared Decision-making and Patient-Clinician Communication 6. Managing Medications 7. Supporting Patient Self-Management 8. Integrating Patient Information Across Transitions in Care 9. Coordinating Care 10. Improving Outcomes for Vulnerable Populations Prey et al reviewed 17 studies examining how IT can facilitate, encourage or enhance patient engagement. The authors report that in the limited literature, some articles "identified design requirements for inpatient engagement technology. The remainder described interventions, which we grouped into five categories: entertainment, generic health information delivery, patient-specific information delivery, advanced communication tools, and personalized decision support."
DOI	Denham et al http://dx.doi.org/10.1097/PTS.0b013e3182a8c2b2 Wallace et al http://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/guide-identify-address-unsafe-conditions-health/ AHRQ report http://healthit.ahrq.gov/sites/default/files/docs/page/alternate-findings-and-lessons-from-the-ahrq-ambulatory-safety-and-quality-program.pdf Prey et al http://dx.doi.org/10.1136/amiajnl-2013-002141

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

BMJ Quality and Safety
February 2014, Vol 23, Issue 2

Notes	A new issue of *BMJ Quality and Safety* 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 *BMJ Quality and Safety* include: • Editorial: **More dialogue, more learning, more action** (James Mountford, Martin Marshall) • Editorial: Facing up to the **reality of missed care** (Bonnie J Wakefield) • **Unintentional non-adherence**: can a spoon full of resilience help the medicine go down? (Dominic Furniss, Nick Barber, Imogen Lyons, Lina Eliasson, Ann Blandford) • Applying ethnography to the study of **context in healthcare quality and safety** (Myles Leslie, Elise Paradis, Michael A Gropper, S Reeves, S Kitto) • **Culture and behaviour** in the English National Health Service: overview of lessons from a large multimethod study (Mary Dixon-Woods, Richard Baker, Kathryn Charles, Jeremy Dawson, Gabi Jerzembek, G Martin, I McCarthy, L McKee, J Minion, P Ozieranski, J Willars, P Wilkie, M West) • **'Care left undone'** during nursing shifts: associations with workload and perceived quality of care (Jane E Ball, Trevor Murrells, Anne Marie Rafferty, Elizabeth Morrow, Peter Griffiths) • Prevalence, patterns and predictors of **nursing care left undone** in European hospitals: results from the multicountry cross-sectional RN4CAST study (Dietmar Ausserhofer, Britta Zander, Reinhard Busse, Maria Schubert, Sabina De Geest, Anne Marie Rafferty, Jane Ball, Anne Scott, Juha Kinnunen, Maud Heinen, Ingeborg S Sjetne, T Moreno-Casbas, M Kózka, R Lindqvist, M Diomidous, L Bruyneel, W Sermeus, L H Aiken, R Schwendimann, on behalf of the RN4CAST consortium) • **Governing patient safety**: lessons learned from a mixed methods evaluation of implementing a ward-level medication safety scorecard in two English NHS hospitals (Angus I G Ramsay, Simon Turner, Gillian Cavell, C Alice Oborne, Rebecca E Thomas, Graham Cookson, Naomi J Fulop) • **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) • A qualitative study examining the influences on **situation awareness** and the identification, mitigation and escalation of recognised patient risk (Patrick W Brady, Linda M Goldenhar) • '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) • **Improving outcomes** for patients with **type 2 diabetes** using general practice networks: a quality improvement project in east London (Sally Hull, Tahseen A Chowdhury, Rohini Mathur, John Robson)
URL	http://qualitysafety.bmj.com/content/23/2

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Caring for **critically ill children** in the community: a needs assessment (Jonathan Gilleland, Jennifer McGugan, S Brooks, M Dobbins, J Ploeg) • **Oral antibiotics at discharge** for children with acute osteomyelitis: a rapid cycle improvement project (Patrick W Brady, William B Brinkman, Jeffrey M Simmons, Connie Yau, Christine M White, Eric S Kirkendall, Joshua K Schaffzin, Patrick H Conway, Michael T Vossmeyer) • **Patient safety culture** in China: a case study in an outpatient setting in Beijing (Chaojie Liu, Weiwei Liu, Yuanyuan Wang, Z Zhang, P Wang) • Editorial: **Building knowledge, asking questions** (Greg Ogrinc, Kaveh G Shojania) • Developing a reliable and valid **patient measure of safety in hospitals** (PMOS): a validation study (Rosemary R C McEachan, Rebecca J Lawton, Jane K O'Hara, Gerry Armitage, Sally Giles, S Parveen, I S Watt, J Wright, on behalf of the Yorkshire Quality and Safety Research Group) • 'I think we should just listen and get out': a qualitative exploration of views and experiences of **Patient Safety Walkrounds** (Leahora Rotteau, Kaveh G Shojania, Fiona Webster) • Improving transition from paediatric to adult **cystic fibrosis care**: programme implementation and evaluation (Megumi J Okumura, T Ong, D Dawson, D Nielson, N Lewis, M Richards, C D Brindis, M E Kleinhenz)
URL	http://qualitysafety.bmj.com/content/early/recent

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: • Evaluating implementation of a **rapid response team**: considering alternative outcome measures (James P Moriarty, Nicola E Schiebel, Matthew G Johnson, Jeffrey B Jensen, Sean M Caples, Bruce W Morlan, Jeanne M Huddleston, Marianne Huebner, and James M Naessens) • **Quality of prescribing** in Belgian nursing homes: an electronic assessment of the medication chart (Monique M Elseviers, Robert R Vander Stichele, and Luc Van Bortel) • How many diagnosis fields are needed to capture **safety events in administrative data**? Findings and recommendations from the WHO ICD-11 Topic Advisory Group on Quality and Safety (Saskia E Drösler, Patrick S Romano, Vijaya Sundararajan, Bernard Burnand, Cyrille Colin, Harold Pincus, William Ghali, and for the World Health Organization Quality and Safety Topic Advisory Group)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

Evidence briefings on interventions to improve medication safety
http://www.safetyandquality.gov.au/publications-resources/publications/?acsqhc_programs=11
The Australian Commission on Safety and Quality in Health Care has published a series of *Evidence Briefings*. Included in this series are:

- *Bar code medication administration systems*
- *Automated dispensing systems*
- *Double-checking medication administration*
- *Interventions to reduce interruptions during medication preparation and administration*
- *Electronic medication administration records*

Lead Clinicians Group (LCG) Initiative consultation
http://www.hoi.com.au/projects
The Lead Clinicians Group (LCG) Initiative is being evaluated for the Department of Health by Health Outcomes International. The evaluation seeks the input and clinicians and others in the health sector.

[UK] Always Events
https://www.wwl.nhs.uk/Library/Trust_Board/Open_and_Honest/2013/WWL_Open_and_Honest_Oct13.pdf#!
As a corollary to 'never events' there has been some interest in defining things that should always happen. This is a list of 'always events' that the Wrightington, Wigan and Leigh NHS Foundation Trust in the UK has produced. These are the aspects of patient care that should always happen. They are:

1. Patients will always be addressed by their preferred name
2. Staff always introduce themselves when meeting a patient for the first time
3. Staff treat patients and their families with the level of respect they would expect for themselves or a member of their own family
4. Staff keep patients informed about their care in a way they can understand and find acceptable
5. Staff assist patients to the toilet immediately when requested
6. Patients always have access to appropriate food and drink
7. Patients are always told on admission what their expected date of discharge is and what this means
8. Medications are always administered correctly
9. All patients who die in our care will be treated with dignity and respect
10. Staff will always challenge colleagues if they are not doing the right thing

[USA] Transitioning Newborns from NICU to Home: A Resource Toolkit
http://www.ahrq.gov/professionals/systems/hospital/nicu_toolkit/
The US Agency for Healthcare Research and Quality (AHRQ) has produced a toolkit to help improve the safety of infants born preterm or with complex congenital conditions as they transition from the neonatal intensive care unit to their home.
The toolkit includes information on how to create a Health Coach Program, where the "Health Coach" serves as a teacher and facilitator who encourages open communication with the parents/caregivers to identify their needs and concerns and facilitates follow-up care for the infant by primary care providers. As an online product, the Health Coach Program can be used to customise a range of information for each family based on their needs and concerns. Included are

approximately 30 fact sheets, directed to either the clinician or the infant's family, on topics that range from medications to breastfeeding to insurance coverage tips.
