



On the Radar

Issue 165
10 March 2014

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.

Access to particular documents may depend on whether they are Open Access or not, and/or your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

On the Radar is available online, via email or as a PDF document from <http://www.safetyandquality.gov.au/publications-resources/on-the-radar/>

If you would like to receive *On the Radar* via email, you can subscribe on our website <http://www.safetyandquality.gov.au/> or by emailing us at mail@safetyandquality.gov.au. You can also send feedback and comments to mail@safetyandquality.gov.au.

For information about the Commission and its programs and publications, please visit <http://www.safetyandquality.gov.au>
You can also follow us on Twitter @ACSQHC.

On the Radar

Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

Reports

Helping measure person-centred care
de Silva D

London. The Health Foundation, 2014:80.

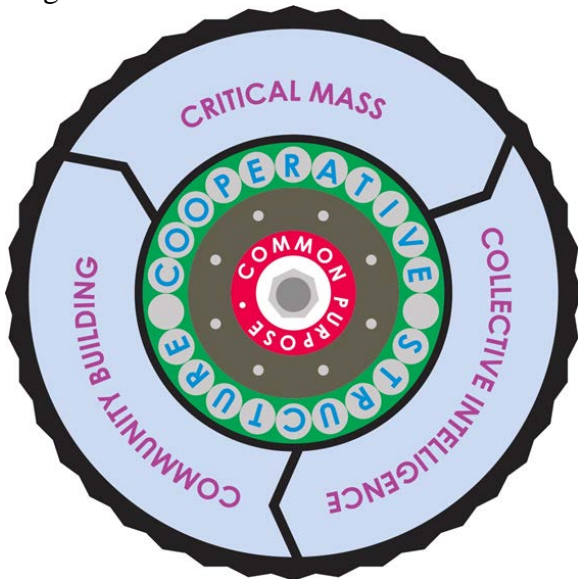
Notes	<p>The Health Foundation (UK) has published this Evidence Review paper as a review of evidence about commonly used approaches and tools used to help measure person-centred care.</p> <p>Three key questions guided the review:</p> <ul style="list-style-type: none">• How is person-centred care being measured in healthcare?• What types of measures are used?• Why and by whom is measurement taking place? <p>According to the Health Foundation's website, the "review shows that, while a large number of tools are available to measure person-centred care, there is no agreement about which tools are most worthwhile ... It also makes clear that there is no 'silver bullet' or best measure that covers all aspects of person-centred care. Combining a range of methods and tools is likely to provide the most robust measure of person-centred care."</p>
-------	--

	Also available is a spreadsheet listing 160 of the most commonly researched measurement tools. Users can search this according to the type of tool, who it targets and the main contexts it has been tested in. Hyperlinks to the abstracts of examples of research using each tool are also provided.
URL	http://www.health.org.uk/publications/helping-measure-person-centred-care/
TRIM	D14-6270

Effective networks for improvement: Developing and managing effective networks to support quality improvement in healthcare

The Health Foundation

London. The Health Foundation, 2014:24.

Notes	<p>This brief (24-page) ‘learning report’ from the UK’s Health Foundation presents the lessons from an evidence review and case study work undertaken by McKinsey Hospital Institute.</p> <p>From the Foundation’s website: “‘The review drew on the literature and empirical evidence about effective networks to describe the component parts of a successful improvement network. While the review found no ‘one size fits all’ formula for successful network design, it did identify five core features of effective networks. These are:</p> <ul style="list-style-type: none"> • common purpose • cooperative structure • critical mass • collective intelligence • community building. <p>These features are interdependent, and interact to give a network energy and momentum. They ensure a clear direction, credibility and increased scale and reach, while enhancing knowledge, encouraging innovation and creating meaningful relationships. All five features are mutually reinforcing, and their combined effect enables quality improvement, learning and change to happen.</p> <p>Together they can be represented diagrammatically as the 5C wheel (below) – a comprehensive framework for developing a network that can also serve as a diagnostic tool.</p>
	
	URL http://www.health.org.uk/publications/effective-networks-for-improvement/
	TRIM D14-6274

Standardise, educate, harmonise: Commissioning the conditions for safer surgery, Report of the NHS England Never Events Taskforce Patient Safety Domain, NHS England London. NHS England, 2014:121.

Notes	The Surgical Never Events Taskforce commissioned by NHS England was tasked with examining and clarifying the reasons for the persistence of these types of events and to develop recommendations on how they can be eradicated. The main recommendations of the report cover three themes. From the NHS England website: “Standardise - The development of high-level national standards of operating department practice that will support all providers of NHS-funded care to develop and maintain their own more detailed standardised local procedures. The report also recommends the establishment of an Independent Surgical Investigation Panel to externally review selected serious incidents; Educate – Consistency in training and education of all staff in the operating theatres, development of a range of multimedia tools to support implementation of standards and support for surgical safety training including human factors; and Harmonise – Consistency in reporting and publishing of data on serious incidents, dissemination of learning from serious incidents and concordance with local and national standards taken into account through regulation.”
URL	http://www.england.nhs.uk/ourwork/patientsafety/never-events/surgical/
TRIM	D14-4574

Integrating behavioral health across the continuum of care
 American Hospital Association
 Chicago IL. Health Research & Educational Trust., 2014:29.

Notes	The US Hospitals in Pursuit of Excellence – within the American Hospital Associations – have published this brief (29-page) guide. The authors discuss the value of integrating physical and behavioural health services and the importance of measuring such integration efforts. They describe several frameworks and models of behavioural health integration.
URL	http://www.hpoe.org/resources/guides/1588

Journal articles

Quality and safety in pediatric hematology/oncology
 Mueller BU
 Pediatric Blood & Cancer 2014 [epub].

Notes	Many issues of safety and quality hold true across the range of specialisations. However, there are also context-specific issues or issues that require special attention. This paper discusses some of the issues of import in the area of paediatric oncology , particularly that of medication safety . In this piece the author describes how to enhance safe medication through safety culture, high reliability principles, and teamwork training .
DOI	http://dx.doi.org/10.1002/pbc.24946

Speaking up for patient safety by hospital-based health care professionals: a literature review
 Okuyama A, Wagner C, Bijnen B
 BMC Health Services Research 2014;14(1):61.

Notes	<p>This review sought to examine the literature on ‘speaking up’ by health professionals. From the 26 studies included the authors note that “hesitancy to speak up can be an important contributing factor in communication errors and that training can improve speaking-up behaviour.” They also note a range of influencing factors reported:</p> <ul style="list-style-type: none"> • the motivation to speak up, such as the perceived risk for patients, and the ambiguity or clarity of the clinical situation • contextual factors, such as hospital administrative support, interdisciplinary policy-making, team work and relationship between other team members, and attitude of leaders/superiors • individual factors, such as job satisfaction, responsibility toward patients, responsibility as professionals, confidence based on experience, communication skills, and educational background • the perceived efficacy of speaking up, such as lack of impact and personal control • the perceived safety of speaking up, such as fear for the responses of others and conflict and concerns over appearing incompetent • tactics and targets, such as collecting facts, showing positive intent, and selecting the person who has spoken up.
DOI	http://dx.doi.org/10.1186/1472-6963-14-61

The Next Organizational Challenge: Finding and Addressing Diagnostic Error
 Graber ML, Trowbridge R, Myers JS, Umscheid CA, Strull W, Kanter MH
 Joint Commission Journal on Quality and Patient Safety 2014;40(3):102-110.

Notes	<p>In recent years one of the emerging areas has been that of diagnostic error. In this paper the authors are calling for ‘health care organisations’ (HCOs) to play a role in addressing diagnostic errors. The authors assert that:</p> <ol style="list-style-type: none"> 1. diagnostic errors are common and harmful 2. high quality health care requires high-quality diagnosis 3. diagnostic errors are costly, and 4. HCOs are well positioned to lead the way in reducing diagnostic error. <p>The suggestion is that organisations can play a role by raising awareness and implementing (innovative) programs to identify and address diagnostic error. In the paper two US organisation’s approaches are described. The Maine Medical Center established a voluntary diagnostic error reporting system allied with a revised root cause analysis process to determine both cognitive and systems causes of these errors. The other example is that of Kaiser Permanente who used their electronic medical record to establish electronic "safety nets" to identify patients at risk of diagnostic error. These focused on ensuring appropriate follow-up of abnormal lab tests (particularly cancer screening tests) and sufficient monitoring of high-risk medications.</p>
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2014/00000040/00000003/art0002

Notes	<p>A new issue of the <i>American Journal of Medical Quality</i> has been published. Articles in this issue include:</p> <ul style="list-style-type: none"> • The Transformation of Primary Care: Are General Practitioners Ready? (Tom Karagiannis, Vittorio Maio, Marco Del Canale, Massimo Fabi, Antonio Brambilla, and Stefano Del Canale) • Inpatient Glycemic Control: Best Practice Advice From the Clinical Guidelines Committee of the American College of Physicians (Amir Qaseem, Roger Chou, Linda L. Humphrey, Paul Shekelle, and for the Clinical Guidelines Committee of the American College of Physicians) • Measuring Patient Safety in the Emergency Department (Julius Cuong Pham, Leen Alblaihed, Dickson Sui Cheung, Frederick Levy, Peter Michael Hill, Gabor D Kelen, Peter J Pronovost, and Thomas D Kirsch) • Measuring Cardiac Waste: The Premier Cardiac Waste Measures (Timothy J Lowe, Chohreh Partovian, E Kroch, J Martin, and R Bankowitz) • A Simulation-Based Training Program Improves Emergency Department Staff Communication (Lynn A Sweeney, Otis Warren, Liz Gardner, Adam Rojek, and David G Lindquist) • Identifying Meaningful Outcome Measures for the Intensive Care Unit (Elizabeth A Martinez, Karen Donelan, J P Henneman, S M Berenholtz, P D Miralles, A E Krug, L I Iezzoni, J E Charnin, and P J Pronovost) • An Integrated Health Care System’s Approach to Development of a Process to Collect Patient Functional Outcomes on Total Joint Replacement Procedures (Amy M. Topel and Cynthia A. Schini) • Progress in Patient Safety: A Glass Fuller Than It Seems (Peter J Pronovost and Robert M. Wachter) • What Makes a Positive Deviant: Utilizing Common Themes in Best Practice Stroke Hospitals to Influence Institutional Quality Improvement (Marissa L Hudak, Alexandra Graves, Kirk A Reichelt, Joseph Sweigart, Elizabeth Harry, Jeffrey Glasheen, William Jones, and Ethan Cumbler) • New Zealand Health Care Professional Survey of Quality and Safety in Public Hospitals Provides Promising Baseline Information (Robin Gauld and Simon Horsburgh) • A Patient Safety Model for Patients With Ventricular Assist Devices Undergoing Noncardiac Procedures (Adam S. Evans and Marc E. Stone)
URL	http://ajm.sagepub.com/content/29/2?etoc

BMJ Quality and Safety online first articles

Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • How can the criminal law support the provision of quality in healthcare? (Karen Yeung, Jeremy Horder) • The interpretability of doctor identification badges in UK hospitals: a survey of nurses and patients (Bethan C Hickerton, Daniel John Fitzgerald, Elizabeth Perry, Alan R De Bolla) • Early warnings, weak signals and learning from healthcare disasters (Carl Macrae)
URL	http://qualitysafety.bmj.com/content/early/recent

Online resources

[USA] *Questions Are the Answer, Tips & Tools.*

<http://www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/tips-and-tools/index.html>

The US Agency for Healthcare Research and Quality (AHRQ) has developed this webpage containing a number of resources to assist patients to engage more deeply in their care. AHRQ offers free resources to help patients prepare for medical appointments, ask questions, and talk with their doctor and other members of the health care team. Care providers can use these materials to foster patient engagement and improve care delivery:

- A short, easy-to-read brochure with tips to help patients be prepared before, during, and after medical appointments.
- Seven minute waiting room video that features patients and clinicians discussing the importance of asking questions and sharing information.
- Notepads to help patients prioritize their questions before their visit.

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/>

[USA] *Guide to Patient and Family Engagement in Hospital Quality and Safety*

<http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/index.html>

Another consumer-oriented resource from AHRQ, this one is their *Guide to Patient and Family Engagement in Hospital Quality and Safety*. This guide is intended to help hospitals work as partners with patients and families to improve quality and safety.

Among other information, the free guide includes four specific strategies:

- **Working with Patients and Families as Advisors**—shows how hospitals can work with patients and family members as advisors at the organizational level.
- **Communicating to Improve Quality**—helps improve communication among patients, family members, clinicians, and hospital staff from the point of admission.
- **Nurse Bedside Shift Report**—supports the safe handoff of care between nurses by involving the patient and family in the change of shift report for nurses.
- **IDEAL Discharge Planning**—helps reduce preventable readmissions by engaging patients and family members in the transition from hospital to home.

[USA] *Improving Your Office Testing Process: A Toolkit for Rapid-Cycle Patient Safety and Quality Improvement*

<http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/office-testing-toolkit/index.html>

The US Agency for Healthcare Research and Quality (AHRQ) has produced this toolkit to help doctors, nurses and medical office staff focus on preventing problems associated with managing lab tests and results. This free resource helps improve processes for tracking, reporting, and following up with patients after medical laboratory tests and avoiding diagnostic errors.

The toolkit offers step-by-step instructions on how to evaluate an office testing process, identify areas where improvement is needed and address those areas. Practical tools are included that can be used to assess office readiness, plan activities, engage patients, audit efforts and incorporate electronic health records. The toolkit also includes a template for practices to ensure that laboratory test results are communicated effectively to patients.

Disclaimer

On the Radar is an information resource of the Australian Commission on Safety and Quality in Health Care. The Commission is not responsible for the content of, nor does it endorse, any articles or sites listed. The Commission accepts no liability for the information or advice provided by these external links. Links are provided on the basis that users make their own decisions about the accuracy, currency and reliability of the information contained therein. Any opinions expressed are not necessarily those of the Australian Commission on Safety and Quality in Health Care.