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On the Radar

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This week's content

Reports

A Process for Rapid Learning: Sharing Experience When Things Go Wrong in Out of Hours Services.
Retford, Notts, UK: NHS Alliance; 2011.

Notes	Report on an initiative to monitor errors and near misses in after-hours care in the United Kingdom. The report also discussed the lessons learned during its first year of implementation. The NHS Alliance has been working with the support of a wide range of national partners to develop an anonymised system for rapid sharing and learning between out-of-hours providers. The aim was to develop a system that allows people to learn from their mistakes and share the learning with others so as to improve patients' safety and out-of-hours services. While the event that spurred this work was related to after-hours care, in hours general practice 'faces similar issues, such as the blame culture and lack of a system that allows people to share information. Therefore, its outputs could be useful across the health care system.'
URL	Article: http://www.nhsalliance.org/press-releases/article/date/2011/11/rapid-learning-driving-up-patients-safety-across-out-of-hours-services/ Report: http://www.nhsalliance.org/fileadmin/files/pdf/PAPER%20-%20a%20process%20for%20rapid%20learning%20FINAL.pdf BMJ news item: http://www.bmj.com/content/343/bmj.d7841

Health care worker fatigue and patient safety.
Sentinel Event Alert. December 14, 2011;(48)
Joint Commission

Notes	The [US] Joint Commission has published an alert regarding health worker fatigue and patient safety. From the Joint Commission website: 'The link between health care worker fatigue and adverse events is well documented, with a substantial number of studies indicating that the practice of extended work hours contributes to high levels of worker fatigue and reduced productivity. These studies and others show that fatigue increases the risk of adverse events, compromises patient safety, and increases risk to personal safety and well-being. While it is acknowledged that many factors contribute to fatigue, including but not limited to insufficient staffing and excessive workloads, the purpose of this Sentinel Event Alert is to address the effects and risks of an extended work day and of cumulative days of extended work hours.'
URL	http://www.jointcommission.org/sea_issue_48/

Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS
Department of Health, NHS Improvement & Efficiency Directorate, Innovation and Service Improvement
London, December 2011.

Notes	A new report from the UK Department of Health that 'sets out an integrated set of measures that together will support the adoption and diffusion of innovation across the NHS and sets a delivery agenda that will significantly ramp up the pace and scale of change and innovation.' Recognising that innovation has a potential large role in improving outcomes and delivering value for money, it also recognises that adoption has often been slow and that innovation must be nurtured through coordinated planning. The actions indicated fall into the following categories: • Reducing variation and strengthening compliance • Metrics and information • Creating a system for deliver of innovation • Incentives and investment • Procurement • Developing people • Leadership for innovation • High-impact innovations
URL	http://www.dh.gov.uk/health/2011/12/nhs-adopting-innovation/

Journal articles

Effects of the Introduction of the WHO "Surgical Safety Checklist" on In-Hospital Mortality: A Cohort Study
van Klei WA, Hoff RG, van Aarnhem EE, Simmermacher RK, Regli LP, Kappen TH, et al.
Ann Surg 2012;255(1):44-49.

Notes	The topic of checklists has been popular for the last couple of years. In recent times there have been reports on the experience of implementing checklists, with mixed results. This paper looks at the uptake and the impact of the World Health Organization's surgical safety checklist at a Dutch tertiary care hospital.

	Using a retrospective cohort study covering 25,513 adult patients undergoing non-day case surgery the main outcome measure was in-hospital mortality within 30 days after surgery and effect estimates were adjusted for patient characteristics, surgical specialty and comorbidity. It is reported that complete use of the checklist was strongly associated with decreased postoperative mortality, but where the checklist was only partially completed, or not completed there was no benefit. It is considered that cultural and implementation factors influence checklist usage, and these factors need to be considered in implementing such tools.
DOI	http://dx.doi.org/10.1097/SLA.0b013e31823779ae

'Communication and Patient Safety' training programme for all healthcare staff: can it make a difference?
Lee P, Allen K, Daly M. A
BMJ Quality & Safety 2012;21(1):84-88.u

Notes	Paper reporting on a teamwork training program that focused on communication and included both clinical and non-clinical staff in 5 Queensland hospitals. Metro South District of Queensland Health (Australia) developed a communication skills training programme with 3 modules covering both staff-to-patient and staff-to-staff communication issues. Following positive evaluation data from the initial programme, the programme was expanded to all five hospitals in the district, and has now been completed by over 3000 staff. Results showed that participants find the courses useful and relevant, they learn and retain new material, and they report changes in behaviour at individual, team and facility levels. Feedback indicates that participants and managers perceive clear improvements in the 'communication culture' after a workplace team attended the courses.
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000297

For information on the Commission's work on clinical communications, see
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-05

Patient Safety in Emergency Medical Services: A Systematic Review of the Literature
Bigham BL, Buick JE, Brooks SC, Morrison M, Shojania KG, Morrison LJ
Prehospital Emergency Care 2012;16(1):20-35.

Notes	A systematic review of the literature attempting to identify the patient safety risks in emergency medical services (prior to admission to hospital). The authors suggest that pre-hospital emergency care is a field that represents an area of high risk for errors and harm, but has received relatively little attention in the patient safety literature. They report that the themes in the literature include adverse events and medication errors (22 articles), clinical judgment (13), communication (6), ground vehicle safety (9), aircraft safety (6), inter-facility transport (16), and intubation (16). However, they note that there is distinct lack of literature on this area and more work is 'needed to improve our understanding of problem magnitude and threats to patient safety and to guide interventions'
DOI	http://dx.doi.org/10.3109/10903127.2011.621045

Improving hand hygiene in a paediatric hospital: a multimodal quality improvement approach
Jamal A, O'Grady G, Harnett E, Dalton D, Andresen D.
BMJ Quality & Safety 2012;21(2):171-176.

Knowledge implementation in healthcare practice: a view from The Netherlands
Wensing M, Bal R, Friele R.
BMJ Quality & Safety 2011.

Notes	Two papers that both reflect the increasing awareness of context in the literature. One is a report of the successful implementation of a hand hygiene intervention in a Sydney children's hospital, the other a report on 'knowledge implementation' or knowledge transfer based on analysis of 79 projects in the Netherlands. Jamal et al. describe how 'a framework of multimodal evidence-based strategies' led to sustained improvement in hand hygiene. They note that 'it was not until several additional strategies were added to better suit our hospital's local environment that consistently high hand hygiene compliance was achieved.' Similarly, Wensing et al's review of 'knowledge implementation' reported one of its key findings for successful uptake are contextual factors and that these need to be taken into account more systematically when planning and evaluating implementations. What works and how can it work here are vital questions in examining and implementing interventions. The evidence base and then understanding the local context and how such an intervention may be applied are both important. The appreciation of the importance of adjusting to the local, of 'flexible standardisation' is being reflected in the literature.
DOI	Jamal et al. http://dx.doi.org/10.1136/bmjqs-2011-000056 Wensing et al. http://dx.doi.org/10.1136/bmjqs-2011-000540

For information on the Commission's work on healthcare associated infection, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-03
For information on Hand Hygiene Australia, see http://www.hha.org.au/

BMJ Quality and Safety
February 2012, Vol 21, 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: • Finding and fixing diagnosis errors: can triggers help? (Gordon D Schiff) • Electronic health record-based surveillance of diagnostic errors in primary care (H Singh, T D Giardina, S N Forjuoh, M D Reis, S Kosmach, M M Khan, E J Thomas) • Do nurse and patient injuries share common antecedents? An analysis of associations with safety climate and working conditions (J A Taylor, F Dominici, J Agnew, D Gerwin, L Morlock, M R Miller) • Do older patients' perceptions of safety highlight barriers that could make their care safer during organisational care transfers? (J Scott, P Dawson, D Jones) • Effects of a multicentre teamwork and communication programme on patient outcomes: results from the Triad for Optimal Patient Safety (TOPS) project (Andrew D Auerbach, Niraj L Sehgal, Mary A Blegen, Judith

	Maselli, Brian K Alldredge, Eric Vittinghoff, Robert M Wachter) • What drives hospital performance? The impact of comparative outcome evaluation of patients admitted for hip fracture in two Italian regions (L Pinnarelli, S Nuti, C Sorge, M Davoli, D Fusco, N Agabiti, M Vainieri, Carlo A Perucci) • Understanding how rapid response systems may improve safety for the acutely ill patient: learning from the frontline (N Mackintosh, HRainey, Jane Sandall) • Organisational characteristics associated with the use of daily interruption of sedation in US hospitals: a national study (Melissa A Miller, Sarah L Krein, Sanjay Saint, Jeremy M Kahn, Theodore J Iwashyna) • Association between implementation of an intensivist-led medical emergency team and mortality (Constantine J Karvellas, Ivens A O de Souza, R T Noel Gibney, Sean M Bagshaw) • System-related interventions to reduce diagnostic errors: a narrative review (H Singh, Mark L Graber, Stephanie M Kissam, Asta V Sorensen, Nancy F Lenfestey, Elizabeth M Tant, Kerm Henriksen, Kenneth A LaBresh) • Improving hand hygiene in a paediatric hospital: a multimodal quality improvement approach (Ahmed Jamal, G O'Grady, E Harnett, D Dalton, D Andresen)
URL	http://qualitysafety.bmj.com/content/vol21/issue2/

International Journal for Quality in Health Care
February 2012, Vol 24, Issue 1

Notes	A new issue of the *International Journal for Quality in Health Care* 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 the *International Journal for Quality in Health Care* include: • Analysis of Australian newspaper coverage of medication errors (Reece Hinchcliff, Johanna Westbrook, David Greenfield, Melissa Baysari, Max Moldovan, and Jeffrey Braithwaite) • Variations in hospital worker perceptions of safety culture (Tita Alissa Listyowardojo, Raoul E. Nap, and Addie Johnson) • Evaluation of the Pharmacy Safety Climate Questionnaire in European community pharmacies (D L. Phipps, J De Bie, H Herborg, M Guerreiro, C Eickhoff, FFernandez-Llimos, M L. Bouvy, CRossing, U Mueller, and D M. Ashcroft) • Regulating open disclosure: a German perspective (Stuart Mclennan, Katja Beitat, Jorg Lauterberg, and Jochen Vollmann) • The impact of patient and public involvement on UK NHS health care: a systematic review (Carole Mockford, Sophie Staniszewska, Frances Griffiths, and Sandra Herron-Marx) • What do we know about patients' perceptions of continuity of care? A meta-synthesis of qualitative studies (Sina Waibel, Diana Henao, Marta-Beatriz Aller, Ingrid Vargas, and Maria-Luisa Vazquez • Talking openly: using '6D cards' to facilitate holistic, patient-led communication (Julia Neufeind and Margaret Hannah) • Impact of format and content of visual display of data on comprehension, choice and preference: a systematic review (Zoe Hildon, Dominique

	Allwood, and Nick Black) • An empirical test of short notice surveys in two accreditation programmes (D Greenfield, M Moldovan, M Westbrook, D Jones, L Low, B Johnston, S Clark, M Banks, M Pawsey, R Hinchcliff, J Westbrook, and J Braithwaite) • Assessing adherence to guidelines for common mental disorders in routine clinical practice (Esther Van Fenema, Nic J.A. Van Der Wee, Mark Bauer, Cornelis J. Witte, and Frans G. Zitman) • Studies pertaining to the ACOVE quality criteria: a systematic review (Marjan Askari, Peter C. Wierenga, Saied Eslami, Stephanie Medlock, Sophia E. De Rooij, and Ameen Abu-Hanna) • How hospital leaders implemented a safe surgery protocol in Australian hospitals (Judith Mary Healy) • Process analysis to reduce MRI access time at a German University Hospital (S. Tokur, K. Lederle, D.D. Terris, M.N. Jarczok, S. Bender, S.O. Schoenberg, and G. Weisser)
URL	http://intqhc.oxfordjournals.org/content/vol24/issue1/index.dtl?etoc

Online resources

Ambulance to Emergency Department Handover Project
http://www.archi.net.au/resources/safety/clinical/nsw-handover/ambulance-ed
The NSW Ambulance-to-ED handover project was tasked with developing a handover protocol that ensured the smooth transfer of pre-hospital care into the acute setting.
The IMIST-AMBO protocol encompasses standardisation of the information to be handed over and the processes that surround handover. The IMIST-AMBO protocol uses a mnemonic to give structure to the way paramedics organise information and supports standardisation of the processes used in handover:
I – Identification
M – Mechanism/Medical complaint
I – Injuries/Information relative to the complaint
S – Signs
T – Treatment and Trends
A – Allergies
M – Medication
B – Background history
O – Other information

For information on the Commission's work on clinical communications, including handover, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-05
