



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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This week's content

Reports

Informing the Future: Critical Issues in Health, Sixth Edition
Institute of Medicine
Washington D.C., The National Academies Press, 2011.

Notes	The latest version of the IoM's review and scanning document. Includes sections: <ul style="list-style-type: none"> • Forging Connections in a Disconnected World • Building a Sustainable, High-Quality Healthcare System • Improving Food Safety, Nutrition, and Health • Strengthening the Healthcare Workforce • Measuring America's Health • Public Health: Protecting the Population • The Persistence of Chronic Diseases • Advancing Health Around the World
URL	http://www.nap.edu/openbook.php?record_id=13180
TRIM	59870

Journal articles

Optimisation of infection prevention and control in acute health care by use of behaviour change: a systematic review
Edwards R, Charani E, Sevdalis N, Alexandrou B, Sibley E, Mullett D, et al.
The Lancet Infectious Diseases 2012 [epub].

Notes	Report on a systematic review of the literature systematic review to assess the
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	<p>effectiveness and sustainability of interventions to change infection prevention control behaviour and for barriers to and facilitators of behaviour change. From 9,123 studies initially identified, 21 were selected for analysis. The intervention studies elicited behaviour change, reduction in infection risk, or both and the exploratory studies identified social and cultural factors that affect infection prevention and control behaviours</p> <p>The authors report that 'hand hygiene is an acquired habit rather than a reasoned process and that interventions designed to change behaviour are more effective if they target experiential thinking and socialisation factors.'</p>
DOI	http://dx.doi.org/10.1016/S1473-3099(11)70283-3

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

'Skating on thin ice?' Consultant surgeon's contemporary experience of adverse surgical events
 Skevington SM, Langdon JE, Giddins G
 Psychol Health Med 2012;17(1):1-16.

Notes	<p>Article on a qualitative investigation of surgeons' perspectives on how and why events occurred. The authors report findings including:</p> <p>'(1) pressures to work harder, faster and beyond capability within a blaming culture; (2) optimism bias from over-confidence and complacency; and (3) multiple pressures to 'finish' an operation or list, resulting in completion bias.'</p> <p>These pressures and the safety culture have an important influence in errors and error escalation. The authors report that the 'consultants felt powerless and helpless to change environmental, organisational and systemic problems' and that better communication and action channels, confidence building in team leadership are desirable. Recognising the surgical checklists can be very useful they argue that that social, environmental and organisational contributing factors need to be considered.</p>
DOI	http://dx.doi.org/10.1080/13548506.2011.592841

Patients' attitudes towards patient involvement in safety interventions: results of two exploratory studies

Davis RE, Sevdalis N, Pinto A, Darzi A, Vincent CA
 Health Expectations 2011 [epub]

Notes	<p>Paper discussing two studies into patients' perspectives on being involved in safety interventions. The engagement of patients in addressing safety issues has become more common. This work sought to examine patients' attitudes and ease in participating in the recommended behaviours by evaluating their attitudes to a video and leaflet aimed at encouraging patient involvement in safety-related behaviours. The study was conducted in six hospital wards on an inner-city London teaching hospital with 80 medical and surgical inpatients in each arm (video or leaflet).</p> <p>The authors report that the video and leaflet both increased patients' perceived comfort in engaging in some (but not all) safety-related behaviours.</p>
DOI	http://dx.doi.org/10.1111/j.1369-7625.2011.00725.x

For information on the Commission's work on patient and consumer centred care, see <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PCCC>

Learning from near misses: from quick fixes to closing off the Swiss-cheese holes

Jeffs L, Berta W, Lingard L, Baker GR

BMJ Quality & Safety 2012 [epub]

Notes	<p>The use of incident reports to identify and correct issues is commonplace in many settings, not just healthcare. The use of ‘near miss’ reporting is less common. This paper aimed to be an exploratory study into the nature of, and contributing factors to, organisational learning from near misses in clinical practice that included semi-structured interviews with 24 participants (16 clinicians and 8 administrators) from a large teaching hospital in Canada.</p> <p>The authors report finding three scenarios for the responses to near misses: The most common involved ‘doing a quick fix’ where clinicians recognised and corrected an error with no further action; The second scenario consisted of reporting near misses but not hearing back from management, which some participants characterised as ‘going into a black hole’; The third scenario was ‘closing off the Swiss-cheese holes’, in which a reported near miss generated corrective action at an organisational level.</p> <p>Each scenario has a different rationale, with the first considering the pervasiveness of near misses that cause no harm and fears associated with reporting a near miss. The ‘Closing off the Swiss-cheese holes’ occurred when managers perceived substantial potential for harm and preventability.</p> <p>The authors’ conclusion is that ‘organisations will need to determine which near misses are appropriate to be responded to as ‘quick fixes’ and which ones require further action at the unit and corporate levels.’</p>
DOI	<p>http://dx.doi.org/10.1136/bmjqs-2011-000256</p>

BMJ Quality and Safety online first articles

Notes	<p>In recent weeks the <i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles. These include:</p> <ul style="list-style-type: none"> • Attitudes towards infection prevention and control: an interview study with nursing students and nurse mentors (Deborah Jane Ward) • The ins and outs of change of shift handoffs between nurses: a communication challenge (J S Carroll, M Williams, T M Gallivan) • Benefits and risks of structuring and/or coding the presenting patient history in the electronic health record: systematic review (Bernard Fernando, Dipak Kalra, Zoe Morrison, Emma Byrne, Aziz Sheikh) • Major cultural-compatibility complex: considerations on cross-cultural dissemination of patient safety programmes (Heon-Jae Jeong, Julius C Pham, Minji Kim, Cyrus Engineer, Peter J Pronovost) • Surveillance of unplanned return to the operating theatre in neurosurgery combined with a mortality–morbidity conference: results of a pilot survey (Hélène Marini, Véronique Merle, Stéphane Derrey, Christine Lebaron, V Josset, O Langlois, M G Baray, N Frébourg, F Proust, P Czernichow) • Getting doctors to clean their hands: lead the followers (Sarah Haessler, Anju Bhagavan, Reva Kleppel, Kevin Hinchey, Paul Visintainer) • Learning from near misses: from quick fixes to closing off the Swiss-cheese holes (Lianne Jeffs, Whitney Berta, Lorelei Lingard, G Ross Baker)
URL	<p>http://qualitysafety.bmj.com/onlinefirst.dtl</p>

International Journal for Quality in Health Care online first articles

Notes	<p>In recent weeks the <i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles. These include:</p> <ul style="list-style-type: none"> • Predictors of perceived empathy among patients visiting primary health-care centers in central Ethiopia (Zewdie Birhanu, Tsion Assefa, Mirkuzie Woldie, and Sudhakar Morankar) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs001v1?papetoc • Disease-management partnership functioning, synergy and effectiveness in delivering chronic-illness care (Jane M Cramm and Anna Petra Nieboer) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs004v1?papetoc • Evaluation of a pilot surgical adverse event detection system for Italian hospitals (Caterina Caminiti, Francesca Diodati, D Bacchieri, P Carbognani, P Del Rio, E Iezzi, D Palli, I Raboini, E Vecchione, and L Cisbani) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr088v1?papetoc • Causes of inappropriate hospital days: development and validation of a French assessment tool for rehabilitation centres (Cecile Paille-Ricolleau, Christophe Leux, Romain Guile, Helene Abbey, P Lombrail, and L Moret) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr089v1?papetoc • Patient Safety Friendly Hospital Initiative: from evidence to action in seven developing country hospitals (S. Siddiqi, R. Elasady, I. Khorshid, T. Fortune, A. Leotsakos, M. Letaief, S. Qsoos, R. Aman, A. Mandhari, A. Sahel, M. El-Tehewy, and A. Abdellatif) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr090v1?papetoc • Quality improvement of nurse-led aftercare to outpatients with coronary heart disease: report of a case study (Helene R. Voogdt-Pruis, Hubertus J.M. Vrijhoef, George H.M.I. Beusmans, and Anton P.M. Gorgels) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs002v1?papetoc • Differences in patient reports on the quality of care in a diabetes pay-for-performance program between 1 year enrolled and newly enrolled patients (Pei-Ching Chen, Yue-Chune Lee, and Raymond Nienchen Kuo) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr091v1?papetoc • Does public disclosure of quality indicators influence hospitals' inclination to enhance results? (Kris H.A. Smolders, A. Lya Den Ouden, Willem A.H. Nugteren, and Gerrit Van Der Wal) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs003v1?papetoc
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BMJ Quality and Safety

March 2012, Vol 21, Issue 3

Notes	<p>A new issue of <i>BMJ Quality and Safety</i> has been published. Many of the papers in this issue have been referred to in previous editions of <i>On the Radar</i> (when they were released online). Articles in this issue of <i>BMJ Quality and Safety</i> include:</p> <ul style="list-style-type: none"> • Rapid response teams: a diagnostic dilemma (Andre Carlos Kajdacsy-Balla Amaral, Hannah Wunsch) • ‘Wading through treacle’: quality improvement lessons from the frontline (Alice Roueche, Jocelyn Hewitt) • Quality of in-hospital cardiac arrest calls: a prospective observational study (Naheed Akhtar, Richard A Field, Liz Greenwood, Robin P Davies, Sarah Woolley, Matthew W Cooke, Gavin D Perkins)
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	<ul style="list-style-type: none"> • Barriers to staff adoption of a surgical safety checklist (Aude Fourcade, Jean-Louis Blache, Catherine Grenier, Jean-Louis Bourgain, E Minvielle) • What do patients and relatives know about problems and failures in care? (Rick Iedema, Suellen Allen, Katherine Britton, Thomas H Gallagher) • Reducing post-caesarean surgical wound infection rate: an improvement project in a Norwegian maternity clinic (Ole A Dyrkorn, Marit Kristoffersen, Mette Walberg) • The importance of preparation for doctors' handovers in an acute medical assessment unit: a hierarchical task analysis (Michelle A Raduma-Tomàs, Rhona Flin, Steven Yule, Steven Close) • Patient safety in patients who occupy beds on clinically inappropriate wards: a qualitative interview study with NHS staff (Lucy Goulding, Joy Adamson, Ian Watt, John Wright) • Promoting patient-centred care through trainee feedback: Assessing Residents' C-I-CARE (ARC) Program (Timothy Wen, Brian Huang, Virgie Mosley, Nasim Afsar-manesh) • Perceptions of junior doctors in the NHS about their training: results of a regional questionnaire (Alexandra Gilbert, Peter Hockey, Rhema Vaithianathan, Nick Curzen, Peter Lees) • Health professional networks as a vector for improving healthcare quality and safety: a systematic review (Frances C Cunningham, Geetha Ranmuthugala, Jennifer Plumb, A Georgiou, J I Westbrook, J Braithwaite) • System tools for system change (C D Willis, C Mitton, J Gordon, A Best) • Striving to achieve best practice in heart failure disease management (J J Atherton, A Hickey, J Suna)
URL	http://qualitysafety.bmj.com/content/vol21/issue3/

Online resources

[UK] General Medical Council *Raising and acting on concerns about patient safety*

http://www.gmc-uk.org/guidance/ethical_guidance/raisingconcerns.asp

The UK's General Medical Council has published new guidance advising doctors on how to best alert employers and healthcare regulators about poor quality care. The guidance emphasises that doctors have a duty of care to report actions that may endanger patient safety and that this responsibility overrides personal and professional loyalties. The guidance is provided in two parts: Part 1: Raising a concern gives advice on raising a concern that patients might be at risk of serious harm, and on the help and support available to doctors.

Part 2: Acting on a concern explains doctors' responsibilities when colleagues or others raise concerns with them and how those concerns should be handled.

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