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On the Radar

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This week's content

Reports

OECD
Health Care Quality Reviews

Notes	The OCED has announced a new publication series: *OECD Health Care Quality Reviews*. The Reviews seek to examine what works and what does not work in different countries – both to benchmark the efforts of countries and to provide advice on reforms to improve their health system. Korea is the first country to be reviewed. Each report highlights best practices and offers recommendations for improvement. A final report on policies to drive improvements in health care quality across countries will be produced in 2014. Some of the Korean learnings are: • Policy reforms over the past decades have equipped Korea with an ideal institutional architecture from which to pursue further reforms. • Governments ought to take early action to develop primary care infrastructure and establish gate-keeping by primary care professionals. • There are risks of oversupply of hospital services at the expense of quality. Strong budgetary or regulation on supply, and payments that reward providers for doing better rather than doing more are important to avoid this. • Governments and purchasers should demand accountability for the quality of health care for the substantial payments they make to health care providers
DOI	http://www.oecd.org/health/qualityreviews

Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes
Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR
The Commonwealth Fund, 2012:33.

Notes	A Commonwealth Fund report outlining changes that US medical practices may need to make to become 'patient-centered medical homes'. The report details specific practice modifications that may be important in the change process. Includes the importance of patient registries and other information systems in identifying gaps in care for patients, including prior to a consultation, and decision support systems in helping clinicians make evidence-based choices.
URL	http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Feb/Guiding-Transformation.aspx

Hospital Survey on Patient Safety Culture: 2012 User Comparative Database Report
Agency for Healthcare Research and Quality. Rockville MD. 2012.

Notes	New US Agency for Health Research and Quality (ARHQ) report uses data from 1,128 U.S. hospitals to provide initial results that hospitals can use to compare their patient safety culture to other US hospitals. The 2012 report presents results showing change over time for 650 hospitals that submitted data more than once. The report consists of a narrative description of the findings and four appendixes, presenting data by hospital characteristics and respondent characteristics for the database hospitals overall and separately for the 650 trending hospitals. Media reports have noted that the report suggests that health professionals are reluctant to report errors, fearing a punitive hospital culture. Many report that they feel their mistakes and event reports are being held against them. ARHQ noted that four areas were seen as strengths for most hospitals: **Teamwork** Within Units; Supervisor/Manager Expectations and Actions **Promoting Patient Safety**; Organizational Learning; and Management **Support for Patient Safety**. ARHQ also noted 'areas with potential for improvement for most hospitals'. These included: Nonpunitive **Response to Error**; **Handoffs and Transitions**; and **Staffing**.
URL	http://www.ahrq.gov/qual/hospsurvey12/

Journal articles

Associations Between Web-Based Patient Ratings and Objective Measures of Hospital Quality
Greaves F, Pape UJ, King D, Darzi A, Majeed A, Wachter RM, et al.
Archives of Internal Medicine 2012 [epub].

Notes	The value and accuracy of patient perceptions and ratings has been debated. This paper suggests that patient ratings of hospitals do correlate with quantitative measures of safety and quality. Researchers at Imperial College London studied 10,274 patient ratings on the National Health Service (NHS) Choices website between 2009 and 2010 and report that hospitals with better patient ratings tend to have a lower death rate and lower readmission rate than those that scored worse. They also report that hospitals with high cleanliness ratings had a far lower rate of MRSA infections. Theses findings suggest that patient feedback on treatment may be more indicative of care quality than previously thought.
DOI	http://dx.doi.org/10.1001/archinternmed.2011.1675

Survey shows that at least some physicians are not always open or honest with patients
Iezzoni LI, Rao SR, DesRoches CM, Vogeli C, Campbell EG
Health Affairs 2012;31(2):383-391.

Notes	Report in *Health Affairs* on a 2009 survey of 1,891 US clinicians. The vast majority of physicians surveyed agreed that physicians should fully inform patients about the risks and benefits of interventions and should never disclose confidential information to unauthorized persons. Approximately one-third of those surveyed did not completely agree with disclosing serious medical errors to patients, almost 20% did not completely agree that physicians should never tell a patient something untrue, and nearly 40% did not completely agree that they should disclose their financial relationships with drug and device companies to patients. Just over 10% said they had told patients something untrue in the previous year. The authors note that these findings 'raise concerns that some patients might not receive complete and accurate information from their physicians, and doubts about whether patient-centred care is broadly possible without more widespread physician endorsement of the core communication principles of openness and honesty with patients'.
DOI	http://dx.doi.org/10.1377/hlthaff.2010.1137

For information on the Commission's work on open disclosure, see
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-02

A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis
Avery AJ, Rodgers S, Cantrill JA, Armstrong S, Cresswell K, Eden M, et al.
The Lancet 2012 [epub].

Notes	UK study on medication errors in primary care that sought to test whether a pharmacist-led, information technology-based intervention was more effective than simple feedback in reducing the number of patients at risk of measures related to hazardous prescribing and inadequate blood-test monitoring of medicines 6 months after the intervention. This was a pragmatic, cluster randomised trial that involved 72 UK general practices with a combined list size of 480,942 patients. The practices were randomly allocated to either computer-generated simple feedback for at-risk patients (control) or a pharmacist-led information technology intervention (PINCER), composed of feedback, educational outreach, and dedicated support. At 6 months' follow-up, patients in the PINCER group were significantly less likely to have been prescribed a non-selective NSAID if they had a history of peptic ulcer without gastroprotection; a β blocker if they had asthma; or an ACE inhibitor or loop diuretic without appropriate monitoring. The authors assert that 'PINCER has a 95% probability of being cost effective if the decision-maker's ceiling willingness to pay reaches £75 per error avoided at 6 months' and that the intervention is an effective method for reducing a range of medication errors in general practices with computerised clinical records.
DOI	http://dx.doi.org/10.1016/S0140-6736(11)61817-5

For information on the Commission's work on medication safety, see
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-06

Preventability of adverse drug events involving multiple drugs using publicly available clinical decision support tools
Wright A, Feblowitz J, Phansalkar S, Liu J, Wilcox A, Keohane CA, et al
American Journal of Health-System Pharmacy 2012;69(3):221-227.

Notes	The use of IT to aid in detecting and preventing medication errors has seen various papers. This addition to that literature describes a retrospective study that reports most preventable adverse drug events that arose from inadvertent drug duplication or drug–drug interaction could have been prevented through the use of existing decision support systems. The study examined 180 actual adverse drug events (ADEs) and 552 potential ADEs (PADEs) at six community hospitals in Massachusetts to determine the frequency and types of multiple-drug ADEs and the extent to which the ADEs might have been prevented using publicly available clinical decision-support (CDS) knowledge bases. The authors report that a total of 17 ADEs (rate, 1.4 per 100 admissions) and 146 PADEs (rate, 12.2 per 100 admissions) involving multiple drugs were identified. The documented events were related to drug duplication (n = 126), drug–drug interaction (n = 21), additive effects (n = 14), and therapeutic duplication (n = 7) or a combination of those factors. The majority of actual ADEs were due to drug–drug interactions, most commonly involving opioids, benzodiazepines, or cardiac medications; about 75% of the PADEs involved excessive drug doses resulting from order duplication or the prescribing of combination drugs with overlapping ingredients, usually products containing acetaminophen and an opioid. It was determined that 5 (29.4%) of the ADEs and 131 (89.7%) of the PADEs could have been detected through the use of the evaluated CDS tools.
DOI	http://dx.doi.org/10.2146/ajhp110084

Variations in surgical outcomes associated with hospital compliance with safety practices
Brooke BS, Dominici F, Pronovost PJ, Makary MA, Schneider E, Pawlik TM
Surgery 2012.

Notes	The link between practices believed to be conducive to safer care and the actual outcomes is the focus of this paper. This study examined whether the implementation of US National Quality Forum (NQF) safety practices improve outcomes after high-risk operations. After identifying 658 US hospitals who participated in the 2005 Leapfrog Group Hospital Quality & Safety survey, Medicare data for 79,462 patients who underwent a pancreatectomy, hepatectomy, esophagectomy, open aortic aneurysm repair, colectomy, or gastrectomy procedure in those hospitals from 2004 through 2006 were examined Of the 658 hospitals that responded to surveys, 41% had fully implemented NQF safe practices and 59% reported partial compliance with these standards. Hospitals with full compliance had an increased likelihood of diagnosing a complication after any of the 6 high-risk operations, but had a decreased likelihood of failure to rescue, and decreased odds of mortality. Thus the authors conclude that while 'having a greater rate of postoperative complications, hospitals fully complying with safe practices were associated with less failure to rescue and decreased mortality after high-risk operations. These results highlight the importance of having hospital systems in place to promote safety and manage postoperative complications.'
DOI	http://dx.doi.org/10.1016/j.surg.2011.12.001

Reducing Inappropriate Urinary Catheter Use: A Statewide Effort
Fakih MG, Watson SR, Greene MT, Kennedy EH, Olmsted RN, Krein SL, et al.
Archives of Internal Medicine 2012;172(3):255-260.

Notes	One dimension of the quality of care is that of appropriateness. Appropriateness can be a factor in both under- and over-use of health resources. This paper examines the appropriateness of urinary catheter use. Catheters can also be associated with infectious and non-infectious complications and may by used in the hospital setting without an appropriate indication. This study sought to evaluate the results of a state-wide quality improvement effort to reduce inappropriate urinary catheter use in Michigan, USA using data 163 inpatient units in 71 participating hospitals. The intervention consisted of educating clinicians about the appropriate indications for urinary catheter use and promoting the daily assessment of urinary catheter necessity during daily nursing rounds. The main outcome measures were change in prevalence of urinary catheter use and adherence to appropriate indications. The study found that urinary catheter use rate decreased from 18.1% at baseline to 13.8% at the end of year 2. The proportion of catheterized patients with appropriate indications increased from 44.3% to 57.6% by the end of year 2.
DOI	http://dx.doi.org/10.1001/archinternmed.2011.627

Commentary: how can we make diagnosis safer?
Schiff GD, Leape LL
Academic Medicine 2012;87(2):135-138.

Notes	There has been something of an emphasis on the issues of safety in surgery and other areas of clinical practice in discussion of patient safety. This commentary looks at the issue of diagnosis and the relationship between errors in the diagnostic process, missed or delayed diagnoses, and preventable adverse events, and how IT could possibly aid in reducing diagnostic error risk. The authors consider whether the routine use of algorithms or guidelines could aid safer diagnoses. They propose an approach: six-part checklists for the top 20 or 30 clinical symptoms or problems. The elements of these checklists for minimising diagnostic errors include 'essential data elements, don't-miss diagnoses, red-flag symptoms, potential drug causes, required referral(s), and follow-up instructions. These checklists could-and should-be developed by collaborative efforts of the main users, primary care physicians, and emergency physicians, working with specialist physicians on specific symptoms and diagnoses.'
DOI	http://dx.doi.org/10.1097/ACM.0b013e31823f711c

Medical leadership in health care systems: from professional authority to organizational leadership
Baker GR, Denis J-L
Public Money & Management 2011;31(5):355-362.

Notes	Abstract: Transforming health care organizations to improve performance requires effective strategies for engaging doctors and developing medical leadership. Most efforts in the US and UK to develop medical leadership have focused on structural changes that integrate doctors into administrative structures, but these have had limited impact. Recognizing the distributed and collective character of effective leadership, some health care organizations are now attempting to create **greater alignment between clinical and managerial goals, focusing on improving quality of care.** These initiatives aim to create effective systems at a team and organizational level, not just the development of medical leadership competencies.
DOI	http://dx.doi.org/10.1080/09540962.2011.598349

Engaging medical staff in clinical governance: introducing new technologies and clinical practice into public hospitals
Dwyer AJ, Becker G, Hawkins C, McKenzie L, Wells M
Australian Health Review 2012;36(1):43-48.

Notes	Change and management of change can be problematic for any organisation. In health care this can seem particularly so given the degree of leadership and autonomy that many 'actors' in a given setting may desire. This Australian paper looks at the importance of medical leadership and engagement in change, in this case in introducing new practices and/or technologies. The authors report on the development, implementation and evaluation of a framework for introducing new technologies and clinical practice to a major tertiary health service. Evaluation includes survey of medical Heads of Units on the framework's effectiveness, and comparison of level of medical staff engagement against a best-practice model. The authors note that such introduction needs to be safe, efficient, effective and appropriate for patients and the organisation, and actively engage medical staff in overseeing such responsibility. They argue that the framework developed produced an effective and successful clinical governance process for introducing new technologies and clinical practice and was supported by moderate levels of medical staff engagement. On suspects that such a framework would not always be directly transferable to a different setting or context, but may be amenable to tweaking to suit.
DOI	http://dx.doi.org/10.1071/AH10952

Safety of telephone triage in out-of-hours care: A systematic review
Huibers L, Smits M, Renaud V, Giesen P, Wensing M.
Scandinavian Journal of Primary Health Care 2011;29(4):198-209.

Notes	The use of telephone triage to provide an initial out-of-hours health service is now reasonably commonplace. This Dutch study is a systematic review of the research in order to assess the evidence on safety of telephone triage in out-of-hours primary care. Two types of studies were distinguished: observational studies in contacts with real patients (unselected and highly urgent contacts), and prospective observational studies using high-risk simulated patients (with a highly urgent health problem). Thirteen observational studies showed that on average triage was safe in 97% of all patients contacting out-of-hours care and in 89% of patients with high urgency. Ten studies that used high-risk simulated patients showed that on average 46% were safe. Adverse events described in the studies included mortality (n = 6 studies), hospitalisations (n = 5), attendance at emergency department (n=1), and medical errors (n = 6) From these, the authors suggest that 'There is room for improvement in safety of telephone triage in patients who present symptoms that are high risk. As these have a low incidence, recognition of these calls poses a challenge to health care providers in daily practice.'
DOI	http://dx.doi.org/10.3109/02813432.2011.629150 http://informahealthcare.com/doi/abs/10.3109/02813432.2011.629150

Navigation roles support chronically ill older adults through healthcare transitions: a systematic review of the literature
Manderson B, McMurray J, Piraino E, Stolee P
Health & Social Care in the Community 2012;20(2):113-127.

Notes	A number of healthcare facilities have created 'navigator' roles to assist patients and consumers in their literal and metaphorical journey through a facility. This paper offers a systematic review of the literature pertaining to such roles in relation to aiding older patients with chronic conditions as they pass between various services. Handovers and transitions are known areas of risk. As the authors note, they 'can be confusing and complicated for patients, formal and informal caregivers' and 'these challenges are compounded for older adults with chronic disease, as they receive care from many providers in multiple care settings'. The authors conducted a systematic literature review to describe existing navigator models relevant to chronic disease management for older adults and to investigate the potential impact of each model. 15 articles documenting nine discrete studies were selected. The review offers 'some evidence that integrated and coordinated care guided by a navigator, using a variety of interventions such as care plans and treatment goals, is beneficial for chronically ill older adults transitioning across care settings'.
DOI	http://dx.doi.org/10.1111/j.1365-2524.2011.01032.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

Goal-Oriented Patient Care — An Alternative Health Outcomes Paradigm
Reuben DB, Tinetti ME
New England Journal of Medicine 2012;366(9):777-779.

Shared Decision Making — The Pinnacle of Patient-Centered Care
Barry MJ, Edgman-Levitan S
New England Journal of Medicine 2012;366(9):780-781.

Defining "Patient-Centered Medicine"
Bardes CL
New England Journal of Medicine 2012;366(9):782-783.

Notes	The current issue of the New England Journal of Medicine (366:9) contains a number of items on patient-centred care.
DOI	Rueben & Tinetti: http://dx.doi.org/10.1056/NEJMp1113631 Barry & Edgman-Levitan: http://dx.doi.org/10.1056/NEJMp1109283 Bardes: http://dx.doi.org/10.1056/NEJMp1200070

Human Factors and Ergonomics in Manufacturing & Service Industries, 22(1).

Notes	The January/February 2012issue of *Human Factors and Ergonomics in Manufacturing & Service Industries* is a special/themed issue with theme of Patient Safety. This entire issue is free to access. • Health care and patient safety: The failure of traditional approaches – how human factors and ergonomics can and MUST help (James P. Bagian) • Using knowledge in the world to improve patient safety: Designing affordances in health care equipment to specify a sequential "checklist"

	(Jonathan Z. Bakdash and Frank A. Drews) • Protocol adherence in the intensive care unit (Frank A. Drews, Jane Wallace, Jose Benuzillo, Boaz Markewitz and Matthew Samore) • Staff and patient safety: Issues surrounding the use of fall-injury-protection bedside floor mats at a large southeastern VA medical center community living center (Melville Bradley) • Patient safety and reprocessing: A usability test of the endoscope reprocessing procedure (Jonathan D. Jolly, Emily A. Hildebrand, Russell J. Branaghan, T. B. Garland, D. Epstein, J. Babcock-Parziale and V. Brown) • Usability testing in the hospital (Judith Anderson, Julia Wagner, Mary Bessesen and Linda C. Williams) • Human factors and ergonomics in patient safety curriculum (Linda Williams, Bradley V. Watts, Scott McKnight and James P. Bagian) • Medication review software to improve the accuracy of outpatient medication histories: protocol for a randomized controlled trial (Blake J. Lesselroth, David A. Dorr, Kathleen Adams, Victoria Church, Shawn Adams, Dennis Mazur, Yelizaveta Russ, Robert Felder and D. M. Douglas) • Using magic to throw light on tricky healthcare systems: Patient safety problem solving (Linda C. Williams)
URL	http://onlinelibrary.wiley.com/doi/10.1002/hfm.v22.1/issuetoc

BMJ Quality and Safety online first articles

Notes	In recent weeks the *BMJ Quality and Safety* has published a number of 'online first' articles. These include: • Assessment of adverse events in medical care: lack of consistency between experienced teams using the global trigger tool (Kristina Schildmeijer, Lena Nilsson, Kristofer Årestedt, Joep Perk)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

Doctors make mistakes. Can we talk about that?
http://www.ted.com/talks/brian_goldman_doctors_make_mistakes_can_we_talk_about_that.html
A TEDx Toronto presentation by Brian Goldman in which he discusses some of the mistakes he has made and how he sees a culture of blame inhibiting error disclosure. He advocates a change in medical culture so clinicians can learn from errors.

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