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On the Radar

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This week's content

Books

A Socio-cultural Perspective on Patient Safety
Rowley E, Waring J, editors
Farnham: Ashgate Publishing Limited, 2011. ISBN:

Notes	A recent book examining some of the social and cultural aspects of patient safety, aspects that can influence individuals and organisations. The book contains: Introduction: A Socio-cultural Perspective on Patient Safety (Emma Rowley and Justin Waring) *Part 1 Patients and Publics* 1 'All News is Bad News': Patient Safety in the News Media (Cecily Palmer and Toby Murcott) 2 Broadening the Patient Safety Movement: Listening, Involving and Learning from Patients and the Public (Josephine Ocloo) *Part 2 Clinical Practice* 3 Narrowing the Gap Between Safety Policy and Practice: The Role of Nurses' Implicit Theories and Heuristics (Anat Drach-Zahavy and Anit Somech) 4 Resources of Strength: An Exnovation of Hidden Competences to Preserve Patient Safety (Jessica Mesman) *Part 3 Technology* 5 Deviantly Innovative: When Risking Patient Safety is the Right Thing To Do (Emma Rowley) 6 The Precarious Gap between Information Technology and Patient Safety: Lessons from Medication Systems (Habibollah Pirnejad and Roland Bal)

	Part 4 Knowledge Sharing 7 T he Politics of Learning: The Dilemma for Patient Safety (Justin Waring and Graeme Currie) 8 Exploring the Contributions of Professional-Practice Networks to Knowledge Sharing, Problem-Solving and Patient Safety (Simon Bishop and Justin Waring) *Part 5 Learning* 9 Challenges to Learning from Clinical Adverse Events: A Study of Root Cause Analysis in Practice (Jeanne Mengis and Davide Nicolini) 10 Patient Safety and Clinical Practice Improvement: The Importance of Reflecting on Real-time, In Situ Care Processes (Rick Iedema) Concluding Remarks: The Gaps and Future Directions for Patient Safety Research (Justin Waring and Emma Rowley)
URL	http://www.ashgate.com/default.aspx?page=637&calcTitle=1&title_id=9855&edition_id=13294

Journal articles

Medical Journal of Australia
Volume 196, Issue 4

Notes	The 5 March 2012 issue of the MJA has a number of editorials and articles on device safety, including post-market surveillance. For many of these issues a possible solution and source of accurate information may appear in the form of clinical quality registries. It could be argued that a single national register for high-risk devices may be the most efficient and cost-effective option.
URL	https://www.mja.com.au/journal/2012/196/4

Association of National Hospital Quality Measure adherence with long-term mortality and readmissions
Shahian DM, Meyer GS, Mort E, Atamian S, Liu X, Karson AS, et al
BMJ Quality & Safety 2012 [epub].

Notes	The question of whether to focus on outcome or process measures can reveal rather diverging views on the value of process measures, often around their suggested relationship to outcomes. Process measures may be used where stable outcomes may be some time in the future. This paper examines the relationship between process measures (US National Hospital Quality Measures) and outcomes for three conditions. The study included all patients discharged from Massachusetts General Hospital between 1 July 2004 and 31 December 2007 with a principle diagnosis of acute myocardial infarction (AMI), heart failure (HF) or pneumonia (PN). The number of patients analysed varied by measure (374 to 3,020). Hospital data were linked with state administrative data to determine mortality and readmissions. All patients had follow-up for at least 1 year or until death or readmission. The author found that **adherence with recommended AMI and PN care processes is associated with improved long-term outcomes**, whereas the results for HF measures are inconsistent. They conclude that the 'evidence base for all process measures must be critically evaluated, including the strength of association between these care processes and outcomes in real-world populations'. As with the previous item, this may suggest another role for clinical quality registries as the best sources of information on the real-world population's experience.
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000615

Standardising practices improves clinical diabetic foot management: the Queensland Diabetic Foot Innovation Project, 2006–09
Lazzarini PA, O'Rourke SR, Russell AW, Derhy PH, Kamp MC
Australian Health Review 2012;36(1):8-15.

Notes	Developing and implementing process measures, as the previous item discussed, needs agreed processes. Clinical quality registries can be vital in identifying what processes, treatments, etc. are effective for which real-world patients. This paper looks at how, once best practice has been identified/agreed, guidelines and adherence to them can **reduce variation in care and enhance outcomes** for patients. In this example the management of foot care in diabetics.
URL DOI	http://www.publish.csiro.au/nid/270/paper/AH10978.htm http://dx.doi.org/10.1071/AH10978

For information on the Commission's work on clinical quality registries, see
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-08_clinical1

Weekend hospitalization and additional risk of death: An analysis of inpatient data
Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Shahian D, et al
Journal of the Royal Society of Medicine 2012;105(2):74-84.

Notes	An addition to the literature on out-of-hours hospitalisation and mortality. The paper reports on a large scale retrospective observational survivorship study that analysed all admissions to the English National Health Service (NHS) during the financial year 2009/10. This meant 14,217,640 admissions were included in the principal analysis, with 187,337 in-hospital deaths reported within 30 days of admission. This work gives further weight to the risks of **weekend admission as it is associated with increased risk of subsequent death within 30 days of admission**. However, it is notable that they found that the likelihood of death actually occurring is actually less on a weekend day than on a mid-week day.
DOI	http://dx.doi.org/10.1258/jrsm.2012.120009

The importance of preparation for doctors' handovers in an acute medical assessment unit: a hierarchical task analysis
Raduma-Tomàs MA, Flin R, Yule S, Close S
BMJ Quality & Safety 2012;21(3):211-217.

Notes	Paper describing how hierarchical task analysis was used to examine the ideal and actual processes of doctors' handovers in an acute medical assessment unit. The work sought to identify any discrepancies between the ideal shift handover process as described by doctors, and the actual shift handover process. From their analysis, the authors argue that the 'pre-handover phase is critical in providing a foundation for a thorough handover meeting and potentially helping doctors who have started a shift to prioritise patient care. These findings suggest that quality improvements for clinical handovers should include a designated time for preparation of care transfer information.'
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000220

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

Look-alike and sound-alike medicines: risks and 'solutions'
Emmerton L, Rizk M
International Journal of Clinical Pharmacy 2012;34(1):4-8.

Notes	Look-alike and sound-alike medications pose an obvious risk and there is work being undertaken to add health workers and consumers in avoiding medication errors. The authors' intent here is to 'fuel discussion surrounding how drug name nomenclature and similar packaging between medicines can lead to selection errors, the need for enhanced approval systems for medicine names and packaging, and best practice solutions.' They note that environmental factors contributing to such errors include **distractions** during dispensing; **workflow controls** should minimise the 'human factors' element of errors. Technological solutions that they discuss include **font variations**, such as Tall Man lettering, **automated alerts**, **barcode scanning** and **real-time reporting** programmed into dispensing software.
DOI	http://dx.doi.org/10.1007/s11096-011-9595-x

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

The Costs of Adverse Drug Events in Community Hospitals
Hug BL, Keohane C, Seger DL, Yoon C, Bates DW
Joint Commission Journal on Quality and Patient Safety 2012;38(3):120-126.

Notes	As medication usage is so prevalent – in any 2 week period about 70% of Australians take at least one medicine – the risk of error and harm is significant. This paper examines the impact of adverse drug events (ADEs) in US community hospitals. The authors report that ADEs incur an average cost of more than $US3000 and are associated with an increase in length of stay of 3.1 days. These findings suggest community hospitals may need to invest in medication safety and the authors suggest computerised provider order entry (CPOE), bar-coding systems, and other strategies.
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2012/00000038/00000003/art00004

Effect of Patient- and Medication-Related Factors on Inpatient Medication Reconciliation Errors
Salanitro A, Osborn C, Schnipper J, Roumie C, Labonville S, Johnson D, et al
Journal of General Internal Medicine [epub].

Notes	This study found that medication reconciliation errors occurred frequently at transition into and out of hospital, with 42% (174 of 413) of patients had at least one error in their preadmission medication list (PAML). At discharge, 39% (158 of 405) had at least 1 discharge medication error, and 126 had clinically relevant discharge medication errors. Clinically relevant PAML and admission order errors were associated with older age and the number of preadmission medications involved. These errors were found to be less likely when a recent medication list was available in the electronic health record. Discharge medication errors were more likely for every PAML error and the number of medication changes during hospitalisation.
DOI	http://dx.doi.org/10.1007/s11606-012-2003-y

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

Building capacity for evidence informed decision making in public health: a case study of organizational change
Peirson L, Ciliska D, Dobbins M, Mowat D
BMC Public Health 2012;12(1):137.

Notes	Canadian study examining how an Ontario public health unit is progressing in its efforts to being an 'evidence informed decision making organization'. Part way through a 10-year initiative the authors report that the factors and dynamics involved include: 'clear vision and strong **leadership**, **workforce and skills development**, ability to **access research** (library services), fiscal **investments**, acquisition and development of **technological resources**, a knowledge management **strategy**, effective **communication**, a receptive organizational **culture**, and a focus on **change management**.'
DOI	http://www.biomedcentral.com/1471-2458/12/137/abstract

Evaluating a new rapid response team: NP-led versus intensivist-led comparisons
Scherr K, Wilson DM, Wagner J, Haughian M
AACN Adv Crit Care 2012;23(1):32-42.

Notes	The use of MET teams or other rapid responses has become relatively commonplace. Often these are lead by intensive care unit personnel. This paper reports on a nurse practitioner-led rapid response team in two Canadian hospitals. The authors assert that the **nurse practitioner-led team demonstrated similar outcomes to an intensivist physician–led team**.
DOI	http://dx.doi.org/10.1097/NCI.0b013e318240e2f9

For information on the Commission's work on recognising and responding to clinical deterioration, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/prog-patientsrisk-lp

Diagnostic Errors in Primary Care: Lessons Learned
Ely JW, Kaldjian LC, D'Alessandro DM
The Journal of the American Board of Family Medicine 2012;25(1):87-97.

Notes	This paper reports on the analysis of more than 200 responses to a survey of primary care diagnosis errors. The researchers contacted a random sample of 200 family physicians, 200 general internists, and 200 general paediatricians practicing in Iowa asking them to describe an important diagnostic error using a 1-page, mailed questionnaire. From the 202 responses the authors report that common presenting complaints included abdominal pain (13%); fever (9%); and fatigue (7%). Common initial (incorrect) diagnoses included benign viral infections (17%); musculoskeletal pain (10%); and chronic obstructive pulmonary disease/asthma (6%). The 202 responding physicians described 254 personal lessons learned, that were used to develop a taxonomy of 24 generic lessons. Three common lessons were: (1) consider diagnosis X in patients presenting with symptom Y; (2) look beyond the initial, most obvious diagnosis; and (3) be alert to atypical presentations of disease. The authors conclude that 'diagnostic errors often were preceded by common symptoms and common, relatively benign initial diagnoses. The lessons learned often involved various aspects of broadening the differential diagnosis.' **Keep an open mind**.
DOI	http://dx.doi.org/10.3122/jabfm.2012.01.110174

A study of innovative patient safety education
Smith SD, Henn P, Gaffney R, Hynes H, McAdoo J, Bradley C
The Clinical Teacher 2012;9(1):37-40.

Effects of an educational patient safety campaign on patients' safety behaviours and adverse events
Schwappach DLB, Frank O, Buschmann U, Babst R
Journal of Evaluation in Clinical Practice 2012.

Notes	A pair of items on patient safety education, but from differing perspectives. The first, Smith et al., describes how a 'high-fidelity simulation' was developed for teaching patient safety principles to senior year medical students with apparently positive response. The second, Schwappach et al, describes a patient safety education campaign aimed at patients that led to decreased experiences of adverse events and unsafe situations. In this case two groups of surgical patients of a Swiss large non-university hospital were studied. One group (202 patients) received a safety advisory at their first clinical encounter while the control group (218 patients) did not. Outcomes were assessed using a questionnaire at discharge. Patients in the intervention group were less likely to feel poorly informed about medical errors and were less likely to experience any safety-related incident or unsafe situation. The authors conclude that these results suggest that the safety advisory raises 'awareness and perceived behavioural control without increasing concerns for safety and can thus serve as a useful instrument for communication about safety between health care workers and patients.'
DOI	Smith et al http://dx.doi.org/10.1111/j.1743-498X.2011.00484.x Schwappach et al http://dx.doi.org/10.1111/j.1365-2753.2012.01820.x

Risk factors in patient safety: minimally invasive surgery versus conventional surgery
Rodrigues S, Wever A, Dankelman J, Jansen F
Surgical Endoscopy 2012;26(2):350-356.

Notes	Minimally invasive surgery is often more appealing, for a variety of reasons. However, such approaches can bring their own risks. This paper – reporting on the study of 53 gynaecologic surgical procedures – suggests that the technological complexity of such procedures may require consideration, including the development and use of a customised surgical checklist that specifically addresses the technological issues.
DOI	http://dx.doi.org/10.1007/s00464-011-1874-z http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261399/

The implementation of a perioperative checklist increases patients' perioperative safety and staff satisfaction
Böhmer AB, Wappler F, Tinschmann T, Kindermann P, Rixen D, Bellendir M, et al
Acta Anaesthesiologica Scandinavica 2012;56(3):332-338.

Notes	Safety and quality initiatives are not always generalisable or transferable. However, to make an initiative suit a new context does not necessarily involve major re-working and a context-sensitive planning and implementation with appropriate 'tweaks' can be effective. This paper describes the implementation of a modified version of the Surgical Safety Checklist that led to improved communication among members of the operative team.
DOI	http://dx.doi.org/10.1111/j.1399-6576.2011.02590.x

Major cultural-compatibility complex: considerations on cross-cultural dissemination of patient safety programmes
Jeong H-J, Pham JC, Kim M, Engineer C, Pronovost PJ
BMJ Quality & Safety 2012 [epub].

Notes	In recent times there has been a growing recognition of the importance of culture. Here the authors consider how patient safety interventions can be effectively transferred between different cultural settings. This paper is focussing on the national scale, but in some ways the lessons are applicable at other scales. Just as mainstream culture varies more-or-less between nations, so does the local safety culture in health facilities. As has been noted elsewhere in this issue of *On the Radar*, **context matters** and often interventions or initiatives may need to customised to maximise their take-up and impact.
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000283

Measuring perceptions of safety climate in primary care: a cross-sectional study
de Wet C, Johnson P, Mash R, McConnachie A, Bowie P
Journal of Evaluation in Clinical Practice 2012;18(1):135-142.

Evaluation of organizational culture among different levels of healthcare staff participating in the institute for healthcare improvement's 100,000 lives campaign
Sinkowitz-Cochran RL, Garcia-Williams A, Hackbarth AD, Zell B, Baker GR, McCannon CJ, et al
Infection Control and Hospital Epidemiology 2012;33(2):135-143.

Notes	Two further pieces on safety culture, one from the UK focussing on primary care and the other from the USA examining health care workers involved in the 100,000 Lives Campaign. Survey responses from 563 team members from 49 randomly selected west of Scotland primary care teams form the basis for de Wet et al's effort to measure perceptions of the safety climate in primary care. They report 'significant differences in safety climate perceptions …at the practice team level and for specific characteristics: …years of experience, whether they were community or practice based, … professional roles and practices' training status. Practice managers and GPs perceived the safety climate more positive[ly] than other[s]' They conclude that 'perceptions of the prevailing safety climate were generally positive. This may reflect ongoing efforts to build a strong safety culture in primary care or alternatively point to an overestimation of the effectiveness of local safety systems. The significant variation in perception between certain staff groups has potential safety implications and may have to be aligned for a positive and strong safety culture to be built.' Sinkowitz-Cochran et al surveyed staff at various levels within a number of hospitals participating in the Institute for Healthcare Improvement's (IHI) 100,000 Lives Campaign in order to study hospital organizational and cultural factors related to the implementation of quality initiatives. The study survey 135 executive leadership (17.8%, midlevel (43.7%), and frontline (38.5%) staff at 6 hospitals. 93% of participants were aware of the campaign in their hospital and perceived that 58% of improvements in quality at their hospital were a direct result of the campaign. There were significant differences between staff levels on the organizational culture items, with executive-level staff having higher scores than midlevel and frontline staff.

	However, all the focus groups perceived that the campaign interventions were sustainable and that **data feedback**, **buy-in**, **hardwiring** (into daily activities), and **leadership** support were essential to sustainability.
DOI	de Wet et al http://dx.doi.org/10.1111/j.1365-2753.2010.01537.x Sinkowitz-Cochran et al http://dx.doi.org/10.1086/663712

Health Affairs
Volume 31, No. 3

Notes	The latest issue of *Health Affairs* has something of a focus on reporting. The following is extracted/adapted from an email from *Health Affairs*. The March 2012 issue of *Health Affairs* explores the successes and limitations of public reporting as well as ways in which it may be improved It's been argued that by making data public, underperforming providers will be motivated to improve, and consumers will use the information to pick the highest-quality providers offering care at the best value. The papers in this issue suggest that the actual evidence about how much public reporting has spurred quality improvement or prompted consumers to make better choices is mixed. Two papers describe the successes of public reporting efforts. • Smith et al . studied Wisconsin physician groups and clinics that have publicly reported their performance on diabetes care since 2004. They found that groups and clinics that adopted formal focus on one or more diabetes metrics in response to public reporting were more likely than other clinics to adopt diabetes improvement interventions. **Public reporting helped drive** both early **implementation** of a single intervention and ongoing implementation of multiple simultaneous interventions. • Young found that multistakeholder regional collaboratives have led the way in producing public reports about health care providers' performance. These have **built trust and cooperation** among stakeholders, **improving provider performance** and enabling consumers to choose providers that best meet their needs. Three papers detail some of the limitations of public reporting. • Ryan et al. examined the US Medicare's public reporting initiative, **Hospital Compare**. They found that it had **no impact on reducing death rates** for heart attack and pneumonia and only a modest reduction in mortality for heart failure. • Laverty et al. examined admissions trends for nonemergency care at three London hospitals. They found that **high-profile investigations of lapses in care had no impact** on admissions in two of the hospitals; at the third, there were only short-term declines, and six months later admission volume had returned to normal. • Teleki and Shannon report on how the California Hospital Association's board of trustees has voted to withdraw from a reporting initiative for several reasons, including the increasing availability of hospital performance data from a variety of sources, such as the Centers for Medicare and Medicaid Services' Hospital Compare website. Four other papers discuss ways to improve how public reporting is disseminated and communicated. Research shows that consumers are more interested in the quality of health care than in its cost, and assume that low-cost providers are also low quality.

	• Hibbard et al. report on an experiment to test ways in which **consumers could be encouraged to pick providers who were "high value"**—that is, they offered both high quality and lower costs. They studied how roughly 1,400 employees responded to different presentations of quality and costs for physicians and hospitals. They found that if consumers were given very clear information that signalled that a provider was high quality, fears that lower-cost providers gave substandard care were overcome, and consumers were more likely to make high-value choices. • Sinaiko et al. looked at why public "**report cards**" about health care providers have not had more impact on consumer choices and what improvements can be made. They found widespread agreement that the reports **weren't sufficiently user-friendly**. • Freidberg and Damberg offer a five-point **methodological checklist to improve the methods used to generate the performance scores** that are the basis for these reports. They believe that if public reports clearly explain how reporting entities address each checklist item, this increased transparency should improve the underlying integrity of provider profiling efforts and, in turn, improve care and help patients find the best providers. • Luft proposes the creation of a **public-private data aggregator of standardised quality data**, which would receive data from payers, and indirectly from patients, about care from providers. An independent and neutral partner, he says, will be able to help meet expected demand for information about providers' quality while protecting patient confidentiality.
URL	http://content.healthaffairs.org/content/current http://content.healthaffairs.org/content/vol31/issue3/index.dtl

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: • Association of National Hospital Quality Measure adherence with long-term mortality and readmissions (David M Shahian, Gregg S Meyer, E Mort, S Atamian, Xiu Liu, A S Karson, L D Ramunno, Hui Zheng) • Medical emergency team calls in the radiology department: patient characteristics and outcomes (Lora K Ott, Michael R Pinsky, Leslie A Hoffman, Sean P Clarke, Sunday Clark, Dianxu Ren, Marilyn Hravnak) • Exploring the role of salient distracting clinical features in the emergence of diagnostic errors and the mechanisms through which reflection counteracts mistakes (Sílvia Mamede, Ted A W Splinter, Tamara van Gog, Remy M J P Rikers, Henk G Schmidt) • Identifying, understanding and overcoming barriers to medication error reporting in hospitals: a focus group study (Nicole Hartnell, Neil MacKinnon, Ingrid Sketris, Mark Fleming) • Defining impact of a rapid response team: qualitative study with nurses, physicians and hospital administrators (Andrea L Benin, Christopher P Borgstrom, Grace Y Jenq, Sarah A Roumanis, Leora I Horwitz) • Economic evaluation in patient safety: a literature review of methods (Bruna Alves de Rezende, Zeynep Or, Laure Com-Ruelle, Philippe Michel)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care
April 2012, Vol 24, Issue 2

Notes	A new issue of the *International Journal for Quality in Health Care* has been published. A number 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: • Tearing down walls: opening the border between hospital and ambulatory care for quality improvement in Germany (Joachim Szecsenyi, Bjoern Broge, Joerg Eckhardt, G Heller, P Kaufmann-Kolle, and M Wensing) • Adverse events in Spanish intensive care units: the SYREC study (Paz Merino, Joaquin Alvarez, Mari Cruz Martin, Angela Alonso, and Isabel Gutierrez SYREC Study Investigators) • 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) • 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) • 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) • Look back and talk openly: responding to and communicating about the risk of large-scale error in pathology diagnoses (Rosemary Aldrich, Peter Finlayson, Kim Hill, and Margaret Sullivan) • 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) • Changes in clients' care ratings after HIV prevention training of hospital workers in Malawi (A F Chimwaza, J L Chimango, C P N Kaponda, K F Norr, J L Norr, D L Jere and S I Kachingwe) • Predictors of perceived empathy among patients visiting primary health-care centers in central Ethiopia (Zewdie Birhanu, Tsion Assefa, Mirkuzie Woldie, and Sudhakar Morankar) • Health system responsiveness for delivery care in Southern Thailand (Tippawan Liabsuetrakul, Porntip Petmanee, Sunittha Sanguanchua, and Nurleesa Oumudee) • Assessing the effect of estimation error on risk-adjusted CUSUM chart performance (Mark A. Jones and Stefan H. Steiner) • Putting theory into practice: the introduction of obstetric near-miss case reviews in the Republic of Moldova (V Baltag, V Filippi, and A Bacci) • 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)
URL	http://intqhc.oxfordjournals.org/content/vol24/issue2/index.dtl?etoc

Online resources

[UK] Transforming Patient Experience: the essential guide
http://www.institute.nhs.uk/patient_experience/guide/home_page.html
[UK] NHS Institute for Innovation and Improvement website providing information on understanding and using patient and staff experiences to improve services.

[UK] 'Harm free' care
http://www.harmfreecare.org/
'Harm free' care is the UK national roll out of the pilot Safety Express QIPP programme. It helps teams in their aim to eliminate four types of harm – pressure ulcers, falls, urinary tract infections in patients with a catheter and new VTE – through one plan that builds on existing improvement work and can be integrated with existing routines. Progress towards 'harm free' care, as defined by the absence of these harms, can be measured using the NHS Safety Thermometer.

[UK] NHS Safety Thermometer
http://www.harmfreecare.org/measurement/nhs-safety-thermometer/
Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day, for example at shift handover or during ward rounds. The NHS Safety Thermometer provides a 'temperature check' on harm and can be used alongside other measures of harm to measure local and system progress.

[USA] Patient Safety Awareness Week
http://www.npsf.org/events-forums/patient-safety-awareness-week/
The [US] National Patient Safety Foundation website for Patient Safety Awareness Week (4-12 March)
http://www.ahrq.gov/questions/
The [US] Agency for Healthcare Research and Quality website "Questions Are the Answer" is a public education initiative to encourage patients and their clinicians to engage in effective two-way communication to ensure safer care and better health outcomes. To promote safer care and the importance of Patient Safety Awareness Week the site includes:

- A 7-minute video featuring patients and clinicians who give firsthand accounts on the importance of asking questions and sharing information.
- A new brochure, titled "Be More Involved in Your Health Care: Tips for Patients," that offers helpful suggestions to follow before, during and after a medical visit.
- An interactive "Question Builder" tool that enables patients to create, prioritize and print a personalized list of questions based on their health condition.
