



On the Radar

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This week's content

Reports

Moving Forward with Wellness Incentives Under the Affordable Care Act: Lessons from Germany
Schmidt H, Stock S, Doran T
New York. The Commonwealth Fund, 2012.

Notes	The use and promotion of wellness programs, by health insurers and others, has been increasing. The Commonwealth Fund Issue Brief looks at the experience in Germany where participation in such programs almost doubled between 2004 and 2008, reaching one-quarter of the publicly insured population. An evaluation of one large wellness program there found that it reduced costs. Population-level survey data suggest that individuals with low incomes or poor health are less likely to enrol. This may raise issues about how to target such programs, whether they reach those who would derive the greatest benefit or tend to be utilised by the 'worried well' who tend to be better off.
URL	http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/May/Moving-Forward-with-Wellness-Incentives-Under-the-ACA.aspx

Patient Safety Thought Papers
 London. The Health Foundation, 2012

Notes	<p>The Health Foundation in the UK has released a series of five thought papers from patient safety experts. They are:</p> <ul style="list-style-type: none"> • The role of the patient in clinical safety (Lawton R, Armitage G) –looks at ways to involve patients in clinical safety, and the readiness of patients and health professionals to adopt new roles. • Proactive approaches to safety management (Hollnagel E) –explores the importance of proactive approaches to safety management. Hollnagel argues that “safety management must look ahead and not only try to avoid things going wrong, but also try to ensure that they go right.” • Personal accountability in healthcare: searching for the right balance (Wachter R) – looks at the issue of personal accountability in healthcare and describes how accountability for performance is a key element for a safe system. • How can leaders influence a safety culture? (Leonard M, Frankel A) – explores how effective leadership and organisational fairness are essential for patient safety within healthcare services. Also discusses how leaders can influence their organisations to help create a robust safety culture. • Reinventing healthcare delivery (Spear S) –argues that “in order to ensure that good people and good science are facilitated, rather than overwhelmed, by systems, leaders have to expand their attention from ‘what individuals do’ to ‘how the pieces come together’. High quality care and great performance involves leaders making problem solving, improvement, and innovation part of the regular routine of daily practice.”
URL	http://health.org.uk/publications/?keywords=&refData_44=&refData_53=2989&se_archSubmit=&siid=60

Using Care Bundles to Improve Health Care Quality. IHI Innovation Series white paper
 Resar R, Griffin FA, Haraden C, Nolan TW
 Cambridge, Massachusetts. Institute for Healthcare Improvement, 2012.

Notes	<p>Short white paper from the [US] Institute for Healthcare Improvement (IHI) updating their knowledge on care bundles and their potential for enhancing the quality of care. In this white paper they cover the history, theory of change, design concepts, and outcomes associated with the development and use of bundles over the past decade. The authors reflect on what they have learned and make suggestions for further research and implementation of the bundle approach.</p>
URL	http://www.ihl.org/knowledge/Pages/IHIWhitePapers/UsingCareBundles.aspx
TRIM	63649

Preventing Central Line–Associated Bloodstream Infections: A Global Challenge, a Global Perspective

The Joint Commission
 Oak Brook, IL: Joint Commission Resources, 2012.

Notes	<p>A major target of many safety programs has been that of healthcare associated infections. One significant target has been that of central line associated bloodstream infections (CLABSI). The Joint Commission has just published this 152-page monograph offering guidance, tools, and techniques for hospitals to help decrease central line–associated bloodstream infections.</p>
URL	http://www.jointcommission.org/assets/1/18/CLABSI_Monograph.pdf
TRIM	63709

For information on the Commission’s work on healthcare associated infections, see <http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/>

Journal articles

Nighttime Intensivist Staffing and Mortality among Critically Ill Patients

Wallace DJ, Angus DC, Barnato AE, Kramer AA, Kahn JM

New England Journal of Medicine 2012 [epub]

Notes	<p>A large study conducted in the US using data from 65,752 patients admitted to 49 ICUs in 25 hospitals examined the degree to which nighttime intensivist staffing was associated with reduced mortality. The study found that “in ICUs with low-intensity daytime staffing, nighttime intensivist staffing was associated with a reduction in risk-adjusted in-hospital mortality (adjusted odds ratio for death, 0.62; P=0.04). Among ICUs with high-intensity daytime staffing, nighttime intensivist staffing conferred no benefit with respect to risk-adjusted in-hospital mortality (odds ratio, 1.08; P=0.78).”</p> <p>This study reconciles the findings of two previous investigations into the effect of nighttime intensivist staffing which had produced seemingly conflicting results, by highlighting the important difference in outcomes based on daytime staffing levels. The study may have implications for quality improvement measures in ICUs given the scarcity of intensivist staffing resources, and suggests that a “blanket endorsement of 24-hour intensivist coverage is premature, although such coverage appears to be useful in some clinical settings”.</p>
DOI	<p>http://dx.doi.org/10.1056/NEJMsa1201918</p>

Clinical influences on antibiotic prescribing decisions for lower respiratory tract infection: a nine country qualitative study of variation in care

Brookes-Howell L

BMJ Open 2012 [epub]

Notes	<p>Multi-country qualitative interview study involving 80 primary care clinicians randomly selected from primary care research networks based in nine European cities. The study looked at variation in antibiotic prescribing for lower respiratory tract infections (LRTI) in primary care, aiming to “investigate clinicians' accounts of clinical influences on antibiotic prescribing decisions for LRTI to better understand variation and identify opportunities for improvement.”</p> <p>The study found that “clinicians emphasised the importance of auscultation, fever, discoloured sputum and breathlessness, general impression of the illness course, familiarity with the patient, comorbidity, and age in informing their antibiotic prescribing decisions for LRTI. As some of these factors may be overemphasised given the evolving evidence base, greater standardisation of assessment and integration of findings may help reduce unhelpful variation in management.”</p>
DOI	<p>http://dx.doi.org/10.1136/bmjopen-2011-000795</p>

Making the Transition to Nursing Bedside Shift Reports

Wakefield DS, Ragan R, Brandt J, Tregnago M

Joint Commission Journal on Quality and Patient Safety 2012;38(6):243-253.

Implementing SBAR Across a Large Multihospital Health System

Compton J, Copeland K, Flanders S, Cassity C, Spetman M, Xiao Y, et al

Joint Commission Journal on Quality and Patient Safety 2012;38(6):261-268.

Can We Make Postoperative Patient Handovers Safer? A Systematic Review of the Literature

Segall N, Bonifacio AS, Schroeder RA, Barbeito A, Rogers D, Thornlow DK, et al

Anesth Analg 2012 [epub].

Notes	<p>Handovers (of handoff in American parlance) are a relatively common topic. This makes sense when you consider how often transitions, handovers or handoffs occur and that each has potential for miscommunication, error or contributions to lapses in safety and quality of care.</p> <p>The Wakefield et al article in the <i>Joint Commission Journal</i> examines one intervention that implemented bedside nursing handoffs at shift change as a patient-centred approach to reducing communication gaps. The authors report significant improvements in nursing-sensitive patient satisfaction scores compared with other non-participating units. However, they note that sustainability declined after the first 6 months. The importance of extensive planning, training, and gradual implementation and the barriers associated with nursing resistance to bedside shift reports are discussed as are the need for ongoing monitoring and repeat(ed) interventions.</p> <p>Compton et al, also in the <i>Joint Commission Journal</i>, also examined a communication intervention. This time looking at the use of the structured communication tool SBAR in a “large multi-hospital health system”. The Baylor Health Care System initiated a campaign to implement SBAR and train staff in SBAR techniques across its 13 hospitals. They then conducted 156 nurse surveys and 155 physician audits. The authors report SBAR was generally well understood and that challenges included inconsistent uptake across facilities, lack of physician education about SBAR, and a tendency to view SBAR as a document rather than a verbal technique.</p> <p>Segal et al report on their systematic review of the literature on making post-operative patient handovers safer. From more than 500 papers selected they found 31 dealing with postoperative handover. The report that 24 included recommendations for structuring the handover process or information transfer. Several recommendations were broadly supported, including</p> <ol style="list-style-type: none">(1) standardise processes(2) task sequencing – complete urgent clinical tasks before information transfer;(3) focus – allow only patient-specific discussions during verbal handovers;(4) inclusion – require that all relevant team members be present; and(5) provide training in team skills and communication. <p>Most of the papers were cross-sectional studies that identified barriers to safe, effective postoperative handovers including the incomplete transfer of information and other communication issues, inconsistent or incomplete teams, absent or inefficient execution of clinical tasks, and poor standardization. An association between poor-quality handovers and adverse events was also demonstrated.</p>
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URL/ DOI	Wakefield et al. http://www.ingentaconnect.com/content/jcaho/jcjq/2012/00000038/00000006/art0001 Compton et al. http://www.ingentaconnect.com/content/jcaho/jcjq/2012/00000038/00000006/art0003 Segall et al. http://dx.doi.org/10.1213/ANE.0b013e318253af4b
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For information on the Commission’s work on clinical communications, including handover, see <http://www.safetyandquality.gov.au/our-work/clinical-communications/>

The effects of a ‘discharge time-out’ on the quality of hospital discharge summaries

Mohta N, Vaishnava P, Liang C, Ye K, Vitale M, Dalal A, et al

BMJ Quality & Safety 2012 [epub].

Notes	Another form of handover or transition is discharge. This paper reports on an intervention that attempted to introduce a ‘time out’ around the discharge process in the hope that this would improve the process and reduce errors. During 2006–7, the authors trained hospitalists to provide two interventions at their discretion. Either: (1) feedback on one discharge summary to each intern using a standardised form or (2) a discharge time out (DTO), modelled on the surgical time-out, in which key questions about the patient's hospital course and discharge plan are answered verbally by the intern during rounds on the day of discharge. To evaluate these interventions, trained clinicians, blinded to group assignment, performed an explicit review of two discharge summaries before and after intervention implementation. The authors compared 14 interns who only received a 1-hour lecture and a small-group resident-led training session with 13 interns who had also received feedback and 12 interns who received feedback and a DTO. Besides greater improvement in the documentation of tasks to be completed after discharge by interns receiving an intervention, most domains were unaffected by having received a DTO and/or feedback. The authors concluded that possibly “standardised feedback and a DTO integrated into attending rounds have limited potential to improve discharge summaries as currently designed”.
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000441

For information on the Commission’s work on safety in e-health, including electronic discharge, summary systems see <http://www.safetyandquality.gov.au/our-work/safety-in-e-health/>

Successfully reforming orthopaedic outpatients

Schoch PA, Adair L

Australian Health Review 2012;36(2):233-237.

Notes	Case study on how one Australian health provider, Barwon Health, has re-organised their orthopaedic outpatient care. Issues that caused concern included “an increasing number of referrals, inefficient referral management and triage, long waiting times for non-urgent appointments, high ‘Did Not Attend’ (DNA) rates and poor utilisation of conservative therapies before referral to surgeon.” A number of interventions were implemented including: “ waiting list audits, triage guidelines, physiotherapy-led clinics, a DNA policy, an orthopaedic lead nurse role and a patient-focussed booking system. ”
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	Following these modifications the authors report “a 66% reduction in the number of patients waiting for their first appointment; an 87% reduction in the waiting time from referral to first appointment; a 10% reduction in new patient DNAs; and more efficient referral management and communication processes. Patients are now seen in clinically appropriate time frames and offered earlier access to a wider range of conservative treatments.”
DOI	http://dx.doi.org/10.1071/AH11040

BMJ Quality and Safety online first articles

Notes	<i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including: <ul style="list-style-type: none"> Insightful practice: a reliable measure for medical revalidation (Douglas J Murphy, Bruce Guthrie, F M Sullivan, S W Mercer, A Russell, D A Bruce)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[US] *Roadmap to Disclosure, Apology and Offer*

<http://www.macoalition.org/roadmap-to-disclosure.shtml>

The Massachusetts Coalition for the Prevention of Medical Errors – a group of seven Massachusetts hospitals – has implemented a Disclosure, Apology and Offer program. This is a program where clinicians and hospitals respond to an adverse event with clear facts, an appropriate apology and timely, and fair financial compensation if warranted. It is a proposed alternative to medical liability litigation that they consider has the potential to reduce health care costs.

For information on the Commission’s work on open disclosure, see

<http://www.safetyandquality.gov.au/our-work/open-disclosure/>

[US] *ProPublica Patient Harm Community on Facebook*

<http://www.propublica.org/article/introducing-the-propublica-patient-harm-community-on-facebook>

<https://www.facebook.com/groups/209024949216061/>

US ‘public interest journalism’ group Pro Publica has launched a ‘Facebook community’ as “a space to bring together those who have been harmed and others concerned about the problem” of patients being harmed during their treatment.

Pro Publica say that they “want to build a community of people — patients as well as doctors, nurses, regulators and health-care executives and others — who are interested in discussing patient harm, its causes and solutions. Among other things, we’ll post Q&As with experts and provide links to the latest reports, research and policy proposals.”

[US] *AHRQ Quality Indicators Toolkit for Hospitals*

<http://www.ahrq.gov/qual/qitoolkit/index.html>

The US Agency for Healthcare Research and Quality has developed its *Quality Indicators Toolkit for Hospitals*. The toolkit is designed to address the [US] 17 Patient Safety Indicators and 28 Inpatient Quality Indicators and provides resources to help hospitals to drive quality improvement.

[US] AHRQ Toolsets to Help Pharmacists and Physicians Implement E-Prescribing
<http://healthit.ahrq.gov/eprescribingtoolsets>

ARHQ has also released two ‘toolsets’, one for physicians in small practices and one for independent pharmacies, for supporting e-prescribing implementation. The toolsets are designed to offer a step-by-step guide for preparing for and launching an e-prescribing system. They include advice on topics ranging from planning the implementation process, launching the system, troubleshooting common problems, and navigating into more advanced practice and pharmacy services.

For information on the Commission’s work on safety in e-health, including electronic medication management systems, see <http://www.safetyandquality.gov.au/our-work/safety-in-e-health/>

[US] Consumer Reports Releases First-Ever Doctor Practice Ratings
<http://www.mhqp.org/default.asp?nav=010000>

The Robert Wood Johnson Foundation announced that *Consumer Reports* has released its first patient experience ratings of primary care physician groups. The ratings cover nearly 500 practices in Massachusetts and were developed by Massachusetts Health Quality Partners (MHQP). The Foundation suggests that the report promotes opportunities for patients to become more involved in their care and to build stronger partnerships with their doctors. MHQP’s results are based on 64,000 responses to a comprehensive, scientific, state-wide survey completed by patients and parents. The survey asked about the areas of care that patients know and care about most, including how well physicians communicate, coordinate medical care, and know their patients, and whether patients would be willing to recommend their doctor to family and friends.

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