



## On the Radar

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### This week's content

#### Reports

*Improving Care at the End of Life*

Hostetter M, Klein S

Quality Matters 2012;June/July 2012.

Notes	The latest issue of the Commonwealth Fund's <i>Quality Matters</i> newsletter contains this item on quality of care at the end of life. The piece covers some of the efforts that a number of providers have been undertaking (many of which feature communication) and provides links to some resources.
URL	<a href="http://www.commonwealthfund.org/Newsletters/Quality-Matters/2012/June-July.aspx?view=newsletter_print">http://www.commonwealthfund.org/Newsletters/Quality-Matters/2012/June-July.aspx?view=newsletter_print</a>

#### Journal articles

*BMJ Quality and Safety*

Notes	<i>BMJ Quality and Safety</i> has published a number of 'online first' articles, including: <ul style="list-style-type: none"><li>• Editorial: Deaths due to medical error: jumbo jets or just small propeller planes? (Kaveh G Shojania)</li></ul>
URL	<a href="http://qualitysafety.bmj.com/onlinefirst.dtl">http://qualitysafety.bmj.com/onlinefirst.dtl</a>

*Improving primary care in Australia through the Australian Primary Care Collaboratives Program: a quality improvement report*

Knight AW, Caesar C, Ford D, Coughlin A, Frick C

BMJ Quality & Safety 2012 [epub].

Notes	<p>Paper reporting on the activities and progress of the Australian Primary Care Collaboratives Program. This is a large-scale quality improvement collaborative addressing diabetes, coronary heart disease (CHD), access, chronic obstructive pulmonary disease (COPD), patient self-management, Aboriginal health and diabetes prevention involving 1185 GPs and Aboriginal medical services across Australia. The authors report that measures showed improvement in all topics except access, and that 397,111 patients were on the disease registers of participating health services.</p> <p>The authors conclude that the ‘collaborative methodology is transferable to primary care in Australia’ and that ‘<b>collaboratives are a useful tool in a program of clinical quality improvement</b>’. They also note that team dynamics and local support are important success factors.</p>
DOI	<p><a href="http://dx.doi.org/10.1136/bmjqs-2011-000165">http://dx.doi.org/10.1136/bmjqs-2011-000165</a></p>

*Diagnostic errors in the intensive care unit: a systematic review of autopsy studies*

Winters B, Custer J, Galvagno SM, Colantuoni E, Kapoor SG, Lee H, et al

BMJ Quality & Safety 2012 [epub].

Notes	<p>The intensive care unit (ICU) can differ quite markedly from other units, for example, in terms of the severity of cases, the level of resources, etc. This study reports on issues of diagnosis in the ICU.</p> <p>This systematic review sought to determine whether potentially fatal ICU misdiagnoses are more common than in the general inpatient population (~5%), and whether they may involve more infections or vascular events.</p> <p>The systematic review examined 31 observational studies examining autopsy-confirmed diagnostic errors in the adult ICU and describing 5,863 autopsies. The prevalence of <b>misdiagnoses</b> ranged from <b>5.5%–100%</b> with 28% of autopsies reporting at least one misdiagnosis and 8% identifying a Class I diagnostic error. Vascular events and infections were the leading lethal misdiagnoses (41% each). The authors conclude that their analysis suggests ‘that as many as 40,500 adult patients in an ICU in USA may die with an ICU misdiagnoses annually. Despite this, diagnostic errors receive relatively little attention’.</p>
DOI	<p><a href="http://dx.doi.org/10.1136/bmjqs-2012-000803">http://dx.doi.org/10.1136/bmjqs-2012-000803</a></p>

*Impact of a hospital-wide hand hygiene initiative on healthcare-associated infections: results of an interrupted time series*

Kirkland KB, Homa KA, Lasky RA, Ptak JA, Taylor EA, Splaine ME

BMJ Quality & Safety 2012 [epub].

Notes	<p>Report on a hand hygiene (HH) initiative implemented in a US rural hospital that sought to improve healthcare workers' HH, and reduce healthcare-associated infections. The study was a 3-year interrupted time series with multiple sequential interventions and 1-year post-intervention follow-up and measured monthly changes in observed HH compliance (%) and rates of healthcare-associated infection (HAI) (including <i>Staphylococcus aureus</i> infections, <i>Clostridium difficile</i> infections and bloodstream infections) per 1000 inpatient days.</p> <p>The authors report that <b>compliance increased significantly from 41% to 87%</b> during the initiative, and improved further to 91% the following year.</p>
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	<p><b>Nurses achieved higher HH compliance</b> (93%) than physicians (78%) – similar results have been reported by Hand Hygiene Australia.</p> <p>The authors argue that there was a <b>significant and sustained decline in the HAI</b> rate from 4.8 to 3.3 per 1000 inpatient days.</p>
DOI	<a href="http://dx.doi.org/10.1136/bmjqs-2012-000800">http://dx.doi.org/10.1136/bmjqs-2012-000800</a>

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

*Dying for the Weekend: A Retrospective Cohort Study on the Association Between Day of Hospital Presentation and the Quality and Safety of Stroke Care*

Palmer WL, Bottle A, Davie C, Vincent CA, Aylin P

Archives of Neurology 2012 [epub].

Notes	<p>Ill-health, trauma and the like can affect us at any time. However, many health facilities function on a 9-to-5 model. There have been studies on after-hours and weekend care and this is an addition to that literature. This paper reports on a retrospective cohort study of nearly 100,000 stroke patients admitted to UK hospitals.</p> <p>The authors report <b>significantly lower performance</b> across 5 of 6 quality and safety indicators <b>for patients admitted on the weekend</b>.</p> <p>For example, the rate of 7-day in-hospital mortality for Sunday admissions was 11.0%, compared with 8.9% for weekday admission.</p> <p>The authors argue that 350 in-hospital deaths may be avoidable each year if stroke care provided on weekends was of the same standard as that of weekdays.</p>
DOI	<a href="http://dx.doi.org/10.1001/archneurol.2012.1030">http://dx.doi.org/10.1001/archneurol.2012.1030</a>

*Failure to utilize functions of an electronic prescribing system and the subsequent generation of ‘technically preventable’ computerized alerts*

Baysari MT, Reckmann MH, Li L, Day RO, Westbrook JI

Journal of the American Medical Informatics Association 2012 [epub].

Notes	<p>A further addition to the recent literature on computerised prescribing systems. This paper reports an Australian study suggesting that <b>clinicians may be not using the features</b> of such systems that are meant <b>to improve efficiency and safety</b> and this could be because they would need to change their workflow and practices.</p> <p>This working around those features apparently leads to clinically irrelevant alerts, which may add to alert fatigue and thereby degrading the overall safety performance of the system. Issues such as human factors research, user psychology, usability testing and <b>integration of technology into existing clinician workflows</b> logically follow.</p>
DOI	<a href="http://dx.doi.org/10.1136/amiajnl-2011-000730">http://dx.doi.org/10.1136/amiajnl-2011-000730</a>

For information on the Commission’s work on medication safety, see <http://www.safetyandquality.gov.au/our-work/medication-safety/>

*International Journal for Quality in Health Care online first articles*

Notes	<p><i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• <b>Medical recordkeeping</b>, essential but overlooked aspect of quality of care in resource-limited settings (C M. Pirkle, A Dumont, and M-V Zunzunegui) <a href="http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs034v1?papetoc">http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs034v1?papetoc</a></li> </ul>
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	<ul style="list-style-type: none"> <li>• The value of open-ended questions in surveys on <b>patient experience</b>: number of comments and perceived usefulness from a hospital perspective (Erik Riiskjaer, Jette Ammentorp, and Poul-Erik Kofoed) <a href="http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs039v1?papetoc">http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs039v1?papetoc</a></li> <li>• Cross-cultural evaluation of the relevance of the <b>HCAHPS survey</b> in five European countries (A Squires, L Bruyneel, L H. Aiken, K Van den Heede, T Brzostek, R Busse, A Ensio, M Schubert, D Zikos, and W Sermeus) <a href="http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs040v1?papetoc">http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs040v1?papetoc</a></li> <li>• Quality in practice: implementation of hospital guidelines for <b>patient identification</b> in Malawi (Tom Latham, Olive Malomboza, Loveness Nyirenda, Paul Ashford, Jean Emmanuel, Bridon M'Baya, and I Bates) <a href="http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs038v1?papetoc">http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs038v1?papetoc</a></li> </ul>
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*BMJ Quality and Safety*

August 2012, Vol 21, Issue 8

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"> <li>• Editorial: Evaluating the effect of a <b>national collaborative</b>: a cautionary tale (Anne Sales, Sanjay Saint)</li> <li>• Editorial: Improving <b>communication of critical laboratory results</b>: know your process (Brian M Wong, Edward E Etchells)</li> <li>• Design and trial of a new <b>ambulance-to-emergency department handover</b> protocol: 'IMIST-AMBO' (R Iedema, C Ball, B Daly, J Young, T Green, P M Middleton, C Foster-Curry, M Jones, S Hoy, D Comerford)</li> <li>• Should measures of <b>patient experience in primary care</b> be adjusted for case mix? Evidence from the English General Practice Patient Survey (Charlotte Paddison, Marc Elliott, Richard Parker, Laura Staetsky, Georgios Lyratzopoulos, John L Campbell, Martin Roland)</li> <li>• Challenges of making a <b>diagnosis in the outpatient</b> setting: a multi-site survey of primary care physicians (Urmimala Sarkar, D Bonacum, W Strull, C Spitzmueller, N Jin, A López, T D Giardina, A N D Meyer, H Singh)</li> <li>• Insightful practice: a reliable measure for medical revalidation (Douglas J Murphy, B Guthrie, F M Sullivan, S W Mercer, A Russell, D A Bruce)</li> <li>• Innovative strategy for effective critical <b>laboratory result</b> management: end-to-end process using automation and manual call centre (Lian Kah Ti, Sophia Bee Leng Ang, Sharon Saw, Sunil Kumar Sethi, James W L Yip)</li> <li>• Findings from a <b>national improvement collaborative</b>: are improvements sustained? (Justin M Glasgow, Michael L Davies, Peter J Kaboli)</li> <li>• Signal and noise: applying a laboratory trigger tool to identify <b>adverse drug events</b> among primary care patients (Stacey Brenner, Alissa Detz, Andrea López, Claire Horton, Urmimala Sarkar)</li> <li>• The H-PEPSS: an instrument to measure <b>health professionals' perceptions</b> of patient safety competence at entry into practice (Liane Ginsburg, Evan Castel, Deborah Tregunno, Peter G Norton)</li> <li>• Can <b>patients report patient safety</b> incidents in a hospital setting? A systematic review (Jane K Ward, Gerry Armitage)</li> </ul>
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	<ul style="list-style-type: none"> <li>• A collaborative project to improve identification and management of patients with <b>chronic kidney disease</b> in a primary care setting in Greater Manchester (John Humphreys, Gill Harvey, Michelle Coleiro, Brook Butler, Anna Barclay, Maciek Gwozdziejewicz, D O'Donoghue, J Hegarty)</li> </ul>
URL	<a href="http://qualitysafety.bmj.com/content/vol21/issue8/">http://qualitysafety.bmj.com/content/vol21/issue8/</a>

## Online resources

[USA] *Just Culture and its critical link to patient safety*

<http://www.ismp.org/Newsletters/acutecare/showarticle.asp?id=22>

<http://www.ismp.org/Newsletters/acutecare/showarticle.asp?id=26>

The Institute for Safe Medication Practices (ISMP) has devoted two issues of its *Medication Safety Alert* to the issue of a ‘just culture’ and its links to patient safety.

[USA] *Improving Patient Safety in Long-Term Care Facilities*

<http://www.ahrq.gov/qual/ptsafetyltc/>

The US Agency for Healthcare Research and Quality (AHRQ) has released a set of training modules to help educate nursing home staff on key patient safety concepts critical to improving the safety of nursing home residents. The modules, *Improving Patient Safety in Long-Term Care Facilities* include the following:

- *Detecting Change in a Resident’s Condition*
- *Communicating Change in a Resident’s Condition*
- *Falls Prevention and Management*

Each of the modules has an instructor’s guide and a student workbook.

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