On the Radar

Issue 38
2 May 2011

In the previous issue it had been suggested that this issue would not appear until 9 May. Fortuitously (?), that is not the case.

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

Variations in Health Care: The good, the bad and the inexplicable
London: The King’s Fund, 2011.

| Notes | Variations in health care are a persistent and ubiquitous problem. But which variations are acceptable or warranted – for example, variations driven by clinical need and informed patient choice – and which are not? How to promote ‘good’ variation and minimise ‘bad’ variation? This short report (32 pages) report explores the possible causes of variation, ways in which variations can be measured, and analyses variations in rates of elective hospital admissions for selected procedures. Shared-decision making and patient centred care are among the factors that promote ‘good’ variation. Measurement, analysis and publication of unwarranted variation are seen as essential to address this form of variation. There is a need to identity those variations that have the most impact on ‘equity, effectiveness, efficiency and patient health outcomes.’ |
| TRIM URL | 47642 |
| http://www.kingsfund.org.uk/publications/healthcare_variation.html |

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Notes

Update on the scale of medication-related adverse outcomes in US hospitals. Drug adverse outcomes covers adverse drug reactions, adverse drug events and medication errors.

This 17-page statistical brief reports that in 2008 drug-related adverse outcomes were noted in nearly 1.9 million inpatient hospital stays (4.7% of all stays), and 838,000 treat-and-release ED visits (0.8% of all visits) in the USA. In the period 2004–2008 there has been a 52 percent increase in drug-related adverse outcomes in the inpatient setting in the USA; but it is not clear how much of this may be due to better reporting as opposed to worsening incidence. For inpatient stays with a drug-related adverse outcome, 3.0% of cases died in hospital, compared to 2.0% for all stays.

URL

http://www.hcup-us.ahrq.gov/reports/statbriefs/sb109.jsp

Journal articles


Notes

The April issue of BMJ Quality and Safety has been published. The majority of its contents have been discussed in previous issues of On the Radar (as the articles were published online), but a number are discussed elsewhere in this issue. The content of the May issue of BMJ Quality and Safety includes:

- Addressing the sociotechnical drivers of quality improvement: a case study of post-operative DVT prophylaxis computerised decision support
- Telephone triage by nurses in primary care out-of-hours services in Norway: an evaluation study based on written case scenarios
- The influence of formulation and medicine delivery system on medication administration errors in care homes for older people
- The efficacy of computer-enabled discharge communication interventions: a systematic review
- Description of the development and validation of the Canadian Paediatric Trigger Tool
- Improving patient safety: the comparative views of patient-safety specialists, workforce staff and managers
- Flu and pneumococcal immunisations in HIV-infected children: methodological quality of current recommendations
- Risks and suggestions to prevent falls in geriatric rehabilitation: a participatory approach
- Complaints, shame and defensive medicine
- The role of theory in research to develop and evaluate the implementation of patient safety practices
- Effective quality improvement of thromboprophylaxis in acute medicine

URL

http://qualitysafety.bmj.com/content/vol20/issue5/
**Effective quality improvement of thromboprophylaxis in acute medicine**
Clark BM, d'Ancona G, Kinirons M, Hunt BJ, Hopper A.

| Notes | British study documenting the VTE journey of a London hospital. A 2006 audit of medical patients at Guy's and St Thomas' NHS Foundation Trust revealed a lack of documentation of VTE risk assessment and poor use of thromboprophylaxis in ‘at risk’ patients. This lead to the development and approval of guidelines in 2007. The guideline was launched and implemented using a multidisciplinary and multiple intervention approach involving education and feedback, IT intervention, verbal and written reminders, regular audit and process redesign. A 2008 showed that the rate of adherence had increased from 56% pre-guideline to 96%. However, a repeat audit in 2009 suggested that even though the majority of patients were receiving appropriate thromboprophylaxis, risk assessment documentation was poor. The authors conclude that ‘the most effective means of achieving VTE guideline adherence is to establish a thromboprophylaxis culture’.

| DOI | http://dx.doi.org/10.1136/bmjqs.2010.044503 |

**For information on the 2009 Clinical Practice Guideline for the Prevention of Venous Thromboembolism (Deep Vein Thrombosis and Pulmonary Embolism) in Patients Admitted to Australian Hospitals, see** http://www.nhmrc.gov.au/nics/programs/vtp/prevention.htm

**Hospital discharge documentation and risk of rehospitalisation.**
BMJ Quality & Safety 2011 [epub].

| Notes | US study into discharge, particularly documentation, and whether standard discharge process can reduce rehospitalisation. The authors conducted a case-control study of 1,039 patients who were rehospitalised within 30 days of discharge and 981 patients who were not rehospitalised, with patients matched on admission diagnosis, discharge disposition, and severity of illness. The authors measured the relationship between readmission and discharge summary completion, contents of discharge summary, completion and contents of discharge instructions, presence of caregiver for discharge instruction, completion of medication reconciliation, and arrangement of ambulatory follow-up prior to discharge. The study failed to find an association between readmission and most components of the discharge process, including medication reconciliation, transmission of discharge summary to an outpatient physician, or documentation of any specific aspect of discharge instruction. Associations were found between readmission and discharge with follow-up arranged and increasing number of medicines. The study concludes that ‘documentation of discharge process components in the medical record may not reflect actual discharge process activities. Alternatively, mandated discharge processes are ineffective in preventing readmission. The observed absence of an association between discharge documentation and readmission indicates that discharge quality improvement initiatives should target metrics of discharge process quality beyond improving rates of documentation.’

| DOI | http://dx.doi.org/10.1136/bmjqs.2010.048470 |
For information on safety and quality impacts of implementing an electronic discharge summary (EDS) system, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-05-CH-EEDSS

Determinants of patient-reported medication errors: a comparison among seven countries
Lu CY, Roughead E
International Journal of Clinical Practice 2011 [epub].

Medication errors are known to be a cause of adverse drug events and as a major concern for patient safety. This study examined patient-reported error over a two year period using data from seven countries (Australia, Canada, New Zealand, the United Kingdom, the United States, Germany and the Netherlands). The authors conducted a cross-sectional study using the 2007 Commonwealth Fund International Health Policy Survey data. 11,910 survey respondents included 1,291 (11%) who had experienced error. Poor coordination of care was a shared concern of all seven countries. Cost-related barriers to medical services/medicines was also a predictor in six countries. Other common risk factors across countries included seeing multiple specialists, multiple chronic conditions, hospitalisation and multiple emergency room visits. Number of medications, number of doctor visits, household income and education level were not associated with error in most countries. The authors conclude that poor coordination of care is a key risk factor in all seven countries and that the ‘major challenge for all countries for error prevention is better communication among multiple healthcare providers and more structured organisation of care across healthcare settings’.

DOI http://dx.doi.org/10.1111/j.1742-1241.2011.02671.x

Critical conversations: A call for a nonprocedural “time out”
Sehgal NL, Fox M, Sharpe BA, Vidyarthi AR, Blegen M, Wachter RM

Communication lies at the heart of many adverse events and safety incidents. This paper is an attempt at extending communication tools or practices to non-procedural settings, building upon the use of checklists and time outs in surgery. The authors identify specific times that see patients at risk due to communication failures including admission, at a change in clinical condition, and discharge. The authors have termed direct communication among healthcare providers at these junctures as ‘Critical Conversations’. These can be a chance to clarify plans of care, address or anticipate concerns, and foster greater teamwork. The project developed a combination of checklist-type items and more open-ended questions but they ultimately create a structure and expectation for communication at these ‘Critical Conversations’. As noted, to implement such an approach needs education and buy-in. The authors also report that measuring adherence, capturing stories of success, and demonstrating effectiveness may enhance implementation and continuous improvement in the process. The authors suggest that ‘Critical Conversations’ are “an innovative communication tool, intervention, and policy that potentially limits communication failures at critical junctures to ensure high quality and safe patient care.”

DOI http://dx.doi.org/10.1002/jhm.853
The first two of these papers (Pryor et al. and Joyce et al.) report on major safety and quality initiatives undertaken at two US hospital systems. Both these are paper reports of successful and ambitious projects. In these two hospital systems (one of 69 hospitals with more than 700,000 patient discharges in 2010 and the other 6 hospitals with a total of 1,578 beds) they eschewed small-scale, incremental initiatives (improvement by stealth). Rather they went for high-profile, extensive, enterprise-wide campaigns that spoke to how important the issues are and a ‘how we do things’ approach. Each campaign had a relatively small number of very clear objectives – and report achieving these ahead of schedule.

In 2003, Ascension Health (Pryor et al.) set a goal of reducing preventable deaths by 900 each year by 2008. By 2010 preventable deaths had been reduced by at 1,500 annually. Legacy Health (Joyce et al.) achieved a 44.6 percent reduction in infections and a 13.5 percent reduction in mortality, along with annual savings of more than US$6.8 million in each of the first two years of its Big Aims initiative. Reading these papers brought to mind comments in Øvretveit et al., when in attempting to develop a framework for understanding and analysing the importance of context for the success (or otherwise) of patient safety practices, noted that aspects of local settings such as readiness to change and being a learning organisation have been considered important. These case studies would appear to substantiate that claim. They also appear to substantiate the importance of broad engagement across an organisation, broad ownership (including by clinicians) and leadership as all being important contributing factors. These factors are again borne out in the final paper (Conley et al.), reporting on how surgical safety checklists have been effectively implemented.

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| DOI | Pryor et al. [http://dx.doi.org/10.1377/hlthaff.2010.1276](http://dx.doi.org/10.1377/hlthaff.2010.1276)  
Joyce et al. [http://dx.doi.org/10.1377/hlthaff.2011.0024](http://dx.doi.org/10.1377/hlthaff.2011.0024)  
Øvretveit et al. [http://dx.doi.org/10.1136/bmjqs.2010.047035](http://dx.doi.org/10.1136/bmjqs.2010.047035)  
Conley et al. [http://dx.doi.org/10.1016/j.jamcollsurg.2011.01.052](http://dx.doi.org/10.1016/j.jamcollsurg.2011.01.052) |
Online Resources

[USA] Institute for Healthcare Improvement
IHI Open School Course: Fostering a Culture of Safety
Requires (free) registration and login. Duration: 1 hour (approx).
http://www.ihi.org
http://www.ihi.org/lms/coursedetailview.aspx?CourseGUID=789d9cbb-7dd3-4fe9-8df2-e0c63725b350&CatalogGUID=6cb1c614-884b-43ef-9abd-d90849f183d4
From the IHI email: ‘As long as human beings provide health care, mistakes and errors will occur. However, health care providers can reduce the likelihood of such mistakes and errors, and limit their impact, by fostering a culture of safety. This is an environment that encourages people to speak up about safety concerns, makes it safe to talk about mistakes and errors, and supports learning from these events. The IHI Open School is excited to offer a new online course, PS 106: Introduction to the Culture of Safety. … Through three lessons students will learn both why a culture of safety is so important, and how to contribute to establishing and maintaining one in their own organization.’

[USA] Robert Wood Johnson Foundation
Quality/Equality / Aligning Forces for Quality / Resources for communities
http://www.rwjf.org/qualityequality/af4q/forcommunities.jsp
A page on this US foundation’s web page listing materials that document ways to improve quality at the local or regional level.

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