On the Radar

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This week’s content

Reports
NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data
West M, Dawson J, Admasachew L, Topakas A

Notes
Reporting on a project undertaken by a team of independent researchers at Aston Business School, funded by the UK Department of Health, that examined NHS staff survey results. The project examined how the experience of NHS staff at work relate to performance measures.

According to the website, the work indicates that: "Good management of NHS staff leads to higher quality of care, more satisfied patients and lower patient mortality. Good staff management offers significant financial savings for the NHS, as its leaders respond to the challenge of sustainability in the face of increasing costs and demands". The website adds that the reports suggest that ‘good management needs to be based on the staff engagement ‘star’ model. The model shows that staff engagement is increased by achieving in five principle areas:

- delivering a healthy, safe work environment,
- ensuring every role counts,
- promoting great management and leadership,
- supporting personal development,
- enabling involvement in decision making.’

Further, it is suggested that this indicates that ‘all organisations need to continually focus on improvements that will help increase their levels of staff engagement, as this will improve the quality of the services they provide’.

**How Do Quality Improvement Interventions Succeed? Archetypes of Success and Failure**  
O'Neill, Sean Michael  

| Notes | Recent thesis examining how and why reproducing local quality improvement interventions (QII) succeed (or not). The work sought to identify the predominant themes and patterns likely to be associated with producing successful QIIs. It is suggested that further research should ‘attempt to operationalize and validate the archetypes suggested by this study’ and that doing so ‘will produce broadly generalizable and practical tools for explaining how quality improvement results are generated, and for strategizing for success when implementing interventions in different settings’. |

**Practice-level indicators of safety and quality for primary health care: Consultation Paper**  
Australian Commission on Safety and Quality in Health Care

| Notes | The Commission is undertaking consultation with the aim of developing a national set of practice-level indicators of safety and quality for primary health care. These indicators will be designed for voluntary inclusion in quality improvement strategies at the local practice or service level and may be used by organisations and individuals providing primary health care services. Recommendations regarding indicators for general practice are not in scope for the project outcomes, as the Royal Australian College of General Practitioners is conducting a dedicated project to develop indicators for general practice. The Commission has released a Consultation Paper, and is seeking comment from interested organisations and individuals on the candidate set of indicators. Responses will inform the development of the final set of practice-level indicators of safety and quality for primary health care to be presented at a national forum. The paper, including information on how to provide a submission, is available from the Commission’s website. |

**Journal articles**

**What is the value and impact of quality and safety teams? A scoping review**  

| Notes | This paper reports on an effort to do a review of the literature on the establishment and impact of quality and safety team initiatives in acute care. The researchers sought qualitative or quantitative studies that occurred in acute care, describing a) how quality and safety teams were established or implemented, b) the impact of teams, or c) described the barriers and/or facilitators of teams were included. From an initial 6,674 articles, 99 were included in the study. Quantitative data analyses was not possible and the authors report there was limited information about attributes of successful and unsuccessful team initiatives, barriers and facilitators to team initiatives, unique or combined contribution of selected interventions, or how to effectively establish these teams. |
|DOI | [http://dx.doi.org/10.1186/1748-5908-6-97](http://dx.doi.org/10.1186/1748-5908-6-97) |
Systematic review of safety checklists for use by medical care teams in acute hospital settings - limited evidence of effectiveness
Ko H, Turner T, Finnigan M.
BMC Health Services Research 2011;11(1):211.

The role and value of checklists has been much discussed and enacted in recent years. This paper seeks to assess the effectiveness of checklists in acute care. The researchers searched for English language publications for randomised controlled trials of checklists before September 2009. Just 9 cohort studies with historical controls studies from four hospital care settings were included- intensive care unit, emergency department, surgery, and acute care. The studies used a variety of designs of safety checklists, and implemented them in different ways. The studies suggest some improvements in patient safety arising from use of safety checklists, but these were not consistent across all studies or for all outcomes.

DOI http://dx.doi.org/10.1186/1472-6963-11-211

Variations in amenable mortality—Trends in 16 high-income nations
Nolte E, McKee M
Health policy 2011 [epub].

The latest paper on amenable mortality from Ellen Nolte and Martin McKee. This updates their earlier work and also reflects how amenable mortality has been trending in a number of countries. The value of amenable mortality as a performance indicator is somewhat contentious. Amenable mortality is defined as ‘premature death from causes that should occur in the presence of timely and effective health care’. This paper looks at amenable mortality under age 75 in 16 countries for 1997/98 and 2006/07. The authors found that amenable mortality ‘remains an important contributor to premature mortality in these countries, accounting for 24% of deaths under age 75’. Logically, the story is not the same for all countries. The paper notes that by 2006/0-7 ‘levels of amenable mortality were lowest in France, at 55 deaths per 100,000 population, closely followed by Australia (56.92 per 100,000) and Italy (59.88).’ The highest levels in the 16 countries examined were in the USA (95.54), UK (82.54) and Denmark (80.13).

DOI http://www.healthpolicyjrnl.com/article/S0168-8510(11)00159-X/abstract

Going Home on the Right Medications
Kahn JM, Angus DC

Editorial on the issues of medications and transitions of care pointing out that transitions are both an opportunity and a risk.

DOI http://dx.doi.org/10.1001/jama.2011.1209

For information on the Commission’s work on clinical handover, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-05

For information on the Commission’s work on medication safety, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-06
An ethicist's journey as a patient: are we sliding down the slippery slope to sloppy healthcare?
McCullough M
BMJ Quality & Safety 2011 [epub].

Notes
Disturbing but compelling experience of a patient well-versed in the ways of the health system that emphasises the need for genuine and active patient-centredness of care.

DOI http://dx.doi.org/10.1136/bmjqs-2011-000235

For information on the Commission’s work on patient-centred care, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PCCC

For want of a four-cent pull chain
Villette M
BMJ Quality & Safety 2011 [epub].

Notes
Published at about the same time as the above item, this paper provides another patient perspective. In this instance a French ethnographer describes the experience of admission for a hip replacement. The value is the observations of experience that many clinicians may not perceive. The view is one of non-coordination of care, of an ongoing series of ‘little nothings’, each of which cause ‘unnecessary suffering, anxiety or discomfort’ even if not serious danger, and can ‘cohere into a story that shapes a patient’s overall image of the healthcare system’.

DOI http://dx.doi.org/10.1136/bmjqs-2011-000221

Concerns raised over new US resident physician work hours

Notes
The issue of (junior) doctors work/duty hours is one that recurs quite frequently. This report in The Lancet follows in the wake of changes to work hours for US hospital residents. New stipulate that first-year residents should work a maximum of 16-hour shifts, but from the second year onwards residents will be allowed to work 28-hours shifts. Gee notes that ‘Advocates of the new rules say that they strike a careful balance between keeping fatigue at an acceptable level while ensuring that residents receive adequate training and that patients are not harmed as a result of being rotated through too many physicians.’ Gee points to the evidence showing that people who are fatigued experience more functional impairments, such as attentional failures and increased forgetfulness, than do those who are not and that studies have shown that working for longer than 24 hours increases the likelihood of interns getting needle-stick injuries and having car accidents after their shifts end. There is also an increase in errors rates. A randomised trial found 55% more serious medical errors that reached patients, though did not harm them, when interns worked more than 24 hours consecutive as opposed to no longer than 16 hours. However, it is also argued that shortening shifts will increase the number of care transitions and thus potentially lead to more errors there.

DOI http://dx.doi.org/10.1016/S0140-6736(11)61361-5

BMJ Quality and Safety online first articles

Notes
In recent days the BMJ Quality and Safety has published a number of ‘online first’ articles. These include:

- Lean thinking transformation of the unsedated upper gastrointestinal endoscopy pathway improves efficiency and is associated with high levels of patient satisfaction (Theresa Hydes, Navjyot Hansi, Timothy M Trebble)
• Using health status to measure NHS performance: another step into the dark for the health reform in England (J M Valderas, R Fitzpatrick, M Roland)
• Using health status to measure NHS performance: casting light in dark places (David Parkin, Nancy J Devlin)

URL http://qualitysafety.bmj.com/onlinefirst.dtl

BMJ Quality and Safety
October 2011, Vol 20, Issue 10

Notes
A new issue of BMJ Quality and Safety has been published. Many 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 BMJ Quality and Safety include:

• Patient-centred communication: a sophisticated procedure (Wendy Levinson)
• Health and social services expenditures: associations with health outcomes (Elizabeth H Bradley, Benjamin R Elkins, Jeph Herrin, Brian Elbel)
• Prospective comparison of three guideline development methods for treatment of actinic keratosis (Rinke J Borgonjen, Jannes J van Everdingen, Cathelijne M Bik, Mariska K Tuut, Phyllis I Spuls, Peter C van de Kerkhof)
• Hospital survey on patient safety culture: psychometric analysis on a Scottish sample (Cakil Sarac, Rhona Flin, Kathryn Mearns, Jeanette Jackson)
• Teamwork and team performance in multidisciplinary cancer teams: development and evaluation of an observational assessment tool (Benjamin W Lamb, Helen W L Wong, Charles Vincent, James S A Green, Nick Sevdalis)
• Lessons learnt from incidents reported by postgraduate trainees in Dutch general practice. A prospective cohort study (Dorien L M Zwart, Wendelien S Heddema, Margit I Vermeulen, Elizabeth L J van Rensen, Theo J M Verheij, Cor J Kalkman)
• Patient safety factors in children dying in a paediatric intensive care unit (PICU): a case notes review study (Kim Monroe, Deli Wang, Charles Vincent, Maria Woloshynowycz, Graham Neale, David P Inwald)
• Random variation and rankability of hospitals using outcome indicators (Anne-Margreet van Dishoeck, Hester F Lingsma, Johan P Mackenbach, Ewout W Steyerberg)
• Alternatives to potentially inappropriate medications for use in e-prescribing software: triggers and treatment algorithms (Anne L Hume, Brian J Quillian, Roberta Goldman, Charles Eaton, Kate L Lapane)
• The ability of a behaviour-specific patient questionnaire to identify poorly performing doctors (Bård Fossli Jensen, Fredrik A Dahl, Dana Gelb Safran, Andrew M Garratt, Edward Krupat, Arnstein Finset, Pål Gulbrandsen)
• Quality improvement project to reduce perioperative opioid oversedation events in a paediatric hospital (D Vermaire, Michelle C Caruso, Anne Lesko, Elizabeth Kloppenborg, Jason Olivea, Raymond Pruett, Marika Paul, Pamela J Schoettker, Michael Seid, Kartik R Varadarajan, Patrick Conway)
• Systematic kidney disease management in a population with diabetes mellitus: turning the tide of kidney failure (Hugh C Rayner, Lee Hollingworth, Robert Higgins, Simon Dodds)

URL http://qualitysafety.bmj.com/content/vol20/issue10/
Online resources

[US] Commonwealth Fund, Quality Matters
"Hospital at Home" Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers
Posting by the Commonwealth Fund discussing the value of ‘hospital at home’ programs. The item’s finds that hospital at home programs that enable patients to receive acute care at home have proven effective in reducing complications while cutting the cost of care by 30 percent or more. However, the piece also notes that widespread adoption has been hampered by concerns about patient safety, as well as legal risk, and the reluctance of some funders/payers. The piece cites a 2010 MJA piece on Victorian Department of Health Review of their Hospital in the Home Program.

[US] Million Hearts
http://millionhearts.hhs.gov/
The US Department of Health and Human Services has launched the Million Hearts program. Million Hearts is a national initiative to prevent 1 million heart attacks and strokes over the next five years. The initiative will focus on five key areas. First, clinical prevention will be strengthened by the ABCS approach (aspirin, blood pressure, cholesterol, and smoking). A second key focus of is the use of health information technology to improve management of risk factors and preventive care. A third strategy is to make better use of team-based care and to include allied health workers. The fourth strand is a renewed anti-tobacco effort. The fifth area focuses on community preventive health strategies.

[US] LA Times: 12 hospitals are fined over medical errors
Report in the Los Angeles Times noting that Californian public health officials had fined 12 California hospitals for medical errors that hurt or killed patients. According to the report, since 2007, the California Department of Public Health has issued 198 penalties to 124 hospitals and had collected $4.6 million in fines. The money goes to a special fund for improving patient safety.

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