On the Radar

Issue 59
17 October 2011

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

Windows into Safety and Quality in Health Care 2011
Sydney: Australian Commission on Safety and Quality in Health Care, 2011.

| Notes | Windows into Safety and Quality in Health Care 2011 provides perspectives on aspects of healthcare safety and quality in 2011 and builds upon, and extends, the coverage of the Commission’s previous Windows reports. Each chapter of Windows into Safety and Quality in Health Care 2011 focuses on a specific area of safety and quality in health care. Topics covered in the report include the challenge of implementation: the theory and science of changing practice to improve health care, supporting local implementation and developing a positive safety culture. Other chapters focus on improving safety and quality through partnerships with patients and consumers, improving safety and quality in mental health care, patient safety in primary health care, supporting safety in e-health and improving the surveillance of healthcare associated infection. |
Books


From the publisher’s summary:
‘The human factors approach refuses to lay the responsibility for safety and risk solely at the feet of people at the sharp end. That is where we should intervene to make things safer, to tighten practice, to focus attention, to remind people to be careful, to impose rules and guidelines. The book defines an approach that looks relentlessly for sources of safety and risk everywhere in the system—the designs of devices; the teamwork and coordination between different practitioners; their communication across hierarchical and gender boundaries; the cognitive processes of individuals; the organization that surrounds, constrains, and empowers them; the economic and human resources offered; the technology available; the political landscape; and even the culture of the place’

URL http://www.crcpress.com/product/isbn/9781439852255

Journal articles

Aging Gracefully? Patient Safety Advocates Call for Ongoing Skills Assessments for Older Physicians
McKenna M

Commentary piece raising the issue of the skills and competency of ageing clinicians. The author suggests ongoing skills assessment to ensure aging physicians can practice safely and a mandatory retirement age.

DOI http://dx.doi.org/10.1016/j.annemergmed.2011.07.003

Influence of house-staff experience on teaching-hospital mortality: The “July Phenomenon” revisited
van Walraven C, Jennings A, Wong J, Forster AJ

The arrival of a new cohort of junior clinicians into hospitals is commonly considered a risk issue. This paper examines the reality of the phenomena in a Canadian teaching hospital and found no found of worsened patient outcomes. The study examined 259,748 encounters involving 164,318 people in the period 15 April 2004 and 31 December 2008. The mortality rate was 3.0%. The ratio of observed to expected number of weekly deaths was not associated with collective house-staff experience. The lack of association between risk of death in hospital and house-staff experience did not vary by admission type (urgent vs elective) or specialty (medicine vs surgery). Thus the authors conclude that in the studied hospital they found no association between the arrival of new house-staff and the adjusted risk of death in hospital. They go on to argue that ‘these data, along with the results of the vast majority of previous studies in this field, make the existence of the “July Phenomenon” for inpatient mortality extremely unlikely’.

DOI http://dx.doi.org/10.1002/jhm.917
Electronic Prescribing Within an Electronic Health Record Reduces Ambulatory Prescribing Errors
Abramson EL, Barr n Y, Quaresimo J, Kaushal R

Notes
Following recent items in On the Radar looking at how electronic health records can help enhance quality of care is this paper that indicates that electronic prescribing from a electronic health record system can have an impact on medication errors.

URL http://www.ingentaconnect.com/content/jcaho/jcjqs/2011/00000037/00000010/art00007

BMJ Quality and Safety online first articles

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

- Patient experiences: a commentary (Wendy Levinson, Kaveh G Shojania)
- Understanding how rapid response systems may improve safety for the acutely ill patient: learning from the frontline (Nicola Mackintosh, Helen Rainey, Jane Sandall)
- Bad experiences in the hospital: the stories keep coming (Wendy Levinson, Kaveh G Shojania)
- Reducing MRI access times by tackling the appointment-scheduling strategy (Jasper R C van Sambeek, Paul E Joustra, Saskia F Das, Piet J Bakker, Mario Maas)
- Electronic health record-based surveillance of diagnostic errors in primary care (Hardeep Singh, Traber Davis Giardina, Samuel N Forjuoh, Michael D Reis, Steven Kosmach, Myrna M Khan, Eric J Thomas)
- Determination of the psychometric properties of a behavioural marking system for obstetrical team training using high-fidelity simulation (Pamela J Morgan, Deborah Tregunno, Richard Pittini, Jordan Tarshis, Glenn Regehr, Susan Desousa, Matt Kurrek, Ken Milne)
- Factors that influence the expected length of operation: results of a prospective study (Brigid M Gillespie, Wendy Chaboyer, Nicole Fairweather)

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

Online resources

[US] IHI Open School
The Institute for Healthcare Improvement’s ‘Open School’, has created a new online course, Patient- and Family-Centered Care 101: Dignity and Respect. According to the IHI, ‘learning and then practicing the specific skills in this course will help clinicians deliver on the promises of true patient- and family-centered care’.


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The Measures Application Partnership (MAP) – a public-private partnership convened by the National Quality Forum – has released reports identifying specific opportunities for more coordinated approaches to making healthcare safer and enhancing clinician performance. One report, *Readmissions and Healthcare-Acquired Conditions Performance Measurement Strategy Across Public and Private Payers*, identifies three areas for public and private efforts to reduce healthcare-acquired conditions and readmissions:

- the need for a national core set of safety measures that are applicable to all patients;
- the need to collect data elements necessary for calculating the measures in the safety core set on all patients, regardless of care setting, age, or who pays their healthcare bills; and
- the need to help public- and private-sector entities coordinate their efforts to make care safer; shared “carrots” or incentives are key.

The second report, *Clinician Performance Measurement Coordination Strategy*, identifies characteristics of a performance measure set for assessing clinician performance. The identified characteristics include alignment with National Quality Strategy priorities and high-impact conditions; measures which are appropriate for use with the intended care settings and levels of analysis; an appropriate mix of measure types necessary for the specific program objectives; longitudinal measures; as well as considerations for healthcare disparities, undesirable consequences, and efficient use of resources for data collection and reporting. It also covers measure selection criteria as a tool to evaluate and recommend measure sets for specific public reporting and performance-based payment programs.


The US Agency for Healthcare Research and Quality (ARHQ) has put together a website containing evidence, tools, and case examples to help organizations for problems associated with implementation and use of electronic health records. The stated purpose in developing the Guide was to provide practical, troubleshooting knowledge and resources.

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