AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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100 issues

This is the 100th edition of *On the Radar*. Over the 100 issues there have been various changes, including the recent format and delivery change. Other modifications are already being investigated. A couple that you may see shortly are an occasional 'noted and notable' section in which a number of papers or sources on a specific topic will be brought together. Another may be a regular item on what have been the most popular items in past issues.

We enjoy bringing *On the Radar* to you each week and hope that you enjoy reading it and find it useful. As always, we welcome your comments and suggestions and thank you for your support over the previous 100 editions. We look forward to bringing you many more.

This week's content

Reports

Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety
Oakbrook Terrace, IL: The Joint Commission; September 2012.

Notes	The seventh annual Joint Commission report summarizes the performance of hospitals across 45 accountability measures. The first annual report, published in 2007, included data from 2002-2005 and covered 15 measures of performance. This year's report covers 45 measures and reflects from one to 10 years of improvement results. Three new accountability measure sets are included in the calculation for the first time: stroke, venous thromboembolism (VTE), and inpatient psychiatric services.

	620 US hospitals were ranked as 'Top Performers' and are about 18% of all Joint Commission-accredited hospitals that report core measure performance data. According to the report, 'performance on accountability measures has improved significantly over time, greatly enhancing the quality of care provided in America's hospitals. Still, more improvement is needed and is expected to continue.' The report notes that the US hospitals involved 'have significantly improved the quality of care provided to heart attack, pneumonia, surgical care, children's asthma care, inpatient psychiatric, venous thromboembolism, and stroke patients, according to composite accountability measure results.'
URL	http://www.jointcommission.org/improving_americas_hospitals_joint_commission_annual_report_quality_safety_2012/ http://www.jointcommission.org/assets/1/18/TJC_Annual_Report_2012.pdf

Journal articles

Correction

Why patients need leaders: introducing a ward safety checklist
Amin Y, Grewcock D, Andrews S, Halligan A
Journal of the Royal Society of Medicine 2012;105(9):377-383.

Notes	In the last issue of *On the Radar* the DOI for this article was incorrect – a 'u' had been accidentally appended to the correct DOI.
DOI URL	http://dx.doi.org/10.1258/jrsm.2012.120098 http://jrsm.rsmjournals.com/content/105/9/377.abstract http://jrsm.rsmjournals.com/content/105/9/377.full.pdf+html

Anatomy of an Incident Disclosure: The Importance of Dialogue
Iedema R, Allen S
Joint Commission Journal on Quality and Patient Safety 2012;38(10):435-442.

Notes	Case study of an adverse event and the subsequent disclosure process. The experiences of a woman whose husband died forms the basis for a case study of how she and her family and friends were able to renegotiate clinicians' understandings of what had gone wrong and influence their views of what needed to be done in response. The patient, having been diagnosed with multiple myeloma in 2006, was hospitalised in January 2009 following a hip replacement. While in the hospital, he received a vasopressin overdose and then died in February 2009. While the starting point of the disclosure process was the drug error, the process allowed for a more wide-ranging and detailed dialogue that 'informed the clinicians as much as the family'. The author's argue that such case can enhance 'our understanding of **what is possible as part of disclosure communication**. Patients and family members can and should play a critical role in quality improvement and patient safety, given their knowledge and questions about the trajectory of care and their passion for ensuring that similar incidents do not recur to harm others'.
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2012/00000038/00000010/art00001
TRIM	69269

For information on the Commission's work on open disclosure, see
http://www.safetyandquality.gov.au/our-work/open-disclosure/

Improving patient handovers from hospital to primary care: a systematic review
Hesselink G, Schoonhoven L, Barach P, Spijker A, Gademan P, Kalkman C, et al.
Annals of Internal Medicine 2012;157(6):417-428.

Notes	A review compiling the published interventions for handover/ discharge from hospital to primary care. Using 36 studies, the authors report that **effective interventions** included **medication reconciliation**; **electronic tools** to facilitate quick, clear, and **structured summary** generation; **discharge planning**; **shared involvement** in follow-up by hospital and community care providers; use of **electronic discharge notifications**; and Web-based **access to discharge information** for general practitioners. Statistically significant effects were mostly found in reducing hospital use (e.g., rehospitalisations), improvement of continuity of care (e.g., accurate discharge information), and improvement of patient status after discharge.
URL DOI	http://annals.org/article.aspx?volume=157&page=417 http://dx.doi.org/10.7326/0003-4819-157-6-201209180-00006

For information on the Commission's work on clinical communications, including clinical handover, see http://www.safetyandquality.gov.au/our-work/clinical-communications/

Improving Teamwork on General Medical Units: When Teams Do Not Work Face-to-Face
McComb SA, Henneman EA, Hinchey KT, Richardson CJ, Peto RR, Kleppel R, et al
Joint Commission Journal on Quality and Patient Safety 2012;38(10):471-478.

Notes	Paper discussing the challenges and possibilities for teamwork communication on a general medical unit, where team members are often physically separated in space and time. The authors note that "team-based, collaborative health care delivery" has been advocated as "it has the potential to improve the quality of patient care, the overall working environment, and the efficiency of care delivery." However, this can be problematised when team members do not physically work together, and perhaps particularly in a General Medical Unit where the breadth of issues, conditions and roles may be greater than in more specialised units. In discussing the various challenges and approaches one aspect that emerges is that such solutions will need to context-specific and dynamic.
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2012/00000038/00000010/art00007

The Cancer Patient Experiences Questionnaire (CPEQ): reliability and construct validity following a national survey to assess hospital cancer care from the patient perspective
Iversen HH, Holmboe O, Bjertnæs ØA
BMJ Open 2012;2(5)

Notes	This study describes the development and psychometric evaluation of the Cancer Patient Experiences Questionnaire (CPEQ) in Norway. The survey asked about nurse contact, doctor contact, provision of information, organisation of services, patient safety, contact with next of kin, and hospital standard. It was distributed nationally by post to adult cancer patients who had either attended an outpatient clinic or who had been discharged from an inpatient ward, and received 7212 responses. The authors found satisfactory evidence of internal consistency, test–retest reliability and construct validity, indicating that the CPEQ can be considered a high-quality instrument.
DOI	http://dx.doi.org/10.1136/bmjopen-2012-001437

Inviting Patients to Read Their Doctors' Notes: A Quasi-experimental Study and a Look Ahead
Delbanco T, Walker J, Bell SK, Darer JD, Elmore JG, Farag N, et al.
Annals of Internal Medicine 2012;157(7):461-470

Notes	The OpenNotes initiative, funded through a grant by the Robert Wood Johnson Foundation and others, made patients' medical visit notes available to them through a secure online portal. The year-long trial of the system, involving 13 564 patients and 105 primary care physicians in Seattle, Boston and Pennsylvania, sought to **evaluate the effect on doctors and patients of facilitating patient access to visit notes**. The results of the trial are now reported in this article. By monitoring use of the portal and surveying users, the authors showed that in this cohort, **access to their doctors' notes made patients feel more in control of their health care**, better understand their medical issues, and report that they are more likely to take their medications as prescribed. It is interesting to consider the potential for e-health technologies to enhance patient-doctor collaboration in this way and increase patient involvement in discussions and decisions about their care.
DOI	http://dx.doi.org/10.7326/0003-4819-157-7-201210020-00002

Double checking the administration of medicines: what is the evidence? A systematic review
Alsulami Z, Conroy S, Choonara I
Archives of Disease in Childhood 2012;97(9):833-837.

Notes	This systematic review sought to examine whether double checking medication administration was effective. The limited literature was reported – 16 articles of which only 3 were quantitative studies, and only one a randomised controlled clinical trial in a clinical setting. This single study showed a statistically significant **reduction** in the medication error rate from **2.98 to 2.12 per 1000** medications administered with double checking. One study reported a reduction in dispensing errors, by a hospital pharmacy, from 9.8 to 6 per year following the introduction of double checking. The authors conclude that there 'is **insufficient evidence** to either support or refute the practice of double checking the administration of medicines'
DOI	http://dx.doi.org/10.1136/archdischild-2011-301093

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

Bringing diagnosis into the quality and safety equations
Graber ML, Wachter RM, Cassel CK
Journal of the American Medical Association 2012;308(12):1211-1212.

Notes	A further addition to the literature drawing our attention to role of (mis)diagnosis in safety and quality. The authors assert that 'Cases of **delayed, missed, and incorrect diagnosis are common**, with an incidence in the range of **10% to 20%**'. While many such errors are either inconsequential or discovered in time, others are not. The authors noted, using findings from large autopsy series, Lucien Leape and colleagues estimated that **diagnostic error accounts for 40 000 to 80 000 deaths per year**, and the number of patients who are injured must be substantially higher. They also note a survey of more than 6000 physicians reported that 96% felt that diagnostic errors were preventable.. This commentary suggests emphasising **diagnosis skills and decision-making in medical education**.
DOI URL	http://dx.doi.org/10.1001/2012.jama.11913 http://jama.jamanetwork.com/article.aspx?articleid=1362034

Patient safety in dentistry - state of play as revealed by a national database of errors
Thusu S, Panesar S, Bedi R
British Dental Journal 2012;213(3):E3-E3.

Notes	Much of the focus on safety and quality tends to be upon the acute hospitals. However, a vast proportion of health care is delivered in other settings. This paper reports on some of the issues revealed in (British) dentistry. The authors suggest that 'modern **dentistry has become increasingly invasive** and sophisticated' and thus 'the risk to the patient has increased.' The study investigated the types of incidents that occur in dentistry and the accuracy of the UK National Patient Safety Agency (NPSA) database in identifying those attributed to dentistry by examining the database all incidents of iatrogenic harm in dentistry in 2009. The study found 2,012 incident reports that were classified into ten categories. The commonest was due to clerical errors – 36%. Five areas of patient safety incident were further analysed: **injury (10%), medical emergency (6%), inhalation/ingestion (4%), adverse reaction (4%)** and **wrong site extraction (2%)**.
DOI	http://dx.doi.org/10.1038/sj.bdj.2012.669

Standardized patient identification and specimen labeling: A retrospective analysis on improving patient safety
Kim JK, Dotson B, Thomas S, Nelson KC
J Am Acad Dermatol 2012 [epub].

Notes	Patient identification – and the linking of information to the correct patient – are vital activities undertaken literally millions of times a day. This paper examines labelling in pathology and reports on the results of an intervention. The authors sought to identify operational areas for improvement around specimen handling with the institution of a standardised specimen labelling protocol. The average rates of specimen labelling events before and after implementation of this protocol were analysed to determine the efficacy of their systematic approach. The authors that before implementation, specimen **labelling events** occurred at a rate of **5.79 events per 1000** with a **decrease to 3.53 events per 1000** after integration of this system. The authors conclude that 'Low-cost, process-driven interventions are effective in the reduction of specimen handling errors.'
DOI	http://dx.doi.org/10.1016/j.jaad.2012.06.017

Computers in the examination room and the electronic health record: physicians' perceived impact on clinical encounters before and after full installation and implementation
Doyle RJ, Wang N, Anthony D, Borkan J, Shield RR, Goldman RE
Family Practice 2012;29(5):601-608.

Notes	Study based on interviews with doctors before and after installation and use of computers and the transition to full implementation of an electronic health record. Prior to installation and usage, issues such as improved information accessibility, ease of use, confidentiality and impact on quality of care were noted. The authors report that subjects 'reported that their concerns did not persist. Many anticipated benefits were realized, appearing to facilitate **collaborative physician–patient relationships**. Physicians reported a greater teaching role with patients and sharing online medical information and treatment plan decisions'.
DOI	http://dx.doi.org/10.1093/fampra/cms015

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Editorial: Recipes for checklists and bundles: one part active ingredient, two parts measurement (Vineet Chopra, Kaveh G Shojania) • Quality improvement initiative: enhanced communication of newly identified, suspected GI malignancies with direct critical results messaging to surgical specialist (Travis Browning, Jared Kasper, Neil M Rofsky, Geoffrey Camp, John Mang, Adam Yopp, Ronald Peshock) • Personalised performance feedback reduces narcotic prescription errors in a NICU (Kevin M Sullivan, Sanghee Suh, Heather Monk, John Chuo) • Comparison of traditional trigger tool to data warehouse based screening for identifying hospital adverse events (Kevin J O'Leary, Vikram K Devisetty, Amitkumar R Patel, David Malkenson, Pradeep Sama, William K Thompson, Matthew P Landler, Cynthia Barnard, Mark V Williams) • Narrative synthesis of health service accreditation literature (Reece Hinchcliff, David Greenfield, Max Moldovan, Johanna Irene Westbrook, Marjorie Pawsey, Virginia Mumford, Jeffrey Braithwaite) • Quality measures: bridging the cultural divide (LJ Donaldson, Ara Darzi)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

http://www.archi.net.au/our-services/nn/2012
The October edition of the Australian Resource Centre for Healthcare Innovations (ARCHI) News has been released. This issue includes items on:

- **Stranded Sam to the Rescue of Long Stay Patients** – an organisation-wide communication strategy established to improve patient flow and safety at St Vincent's Hospital, Darlinghurst.
- **Trauma Team Redesign** – a multidisciplinary team from Westmead Emergency Department and Trauma Services redesigned the trauma team and developed a contextualised, simulated, multi-specialty training course to improve the trauma patient journey within the Emergency Department.
- **St Vincent's Hospital Surgery Redesign**– a program of work to improve theatre efficiency and redesign surgical patient flow at St Vincent's Hospital, Darlinghurst.

On the Radar
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