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On the Radar

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On the Radar
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This week's content

Reports

Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems
National Association for Healthcare Quality
Glenview, IL. National Association for Healthcare Quality, 2012.

Notes	The US National Association for Healthcare Quality has published this 'Call to Action' offering a framework to ensure the quality of reporting patient safety issues and that organisations respond appropriately. The 'Framework for Action: Integrity in Healthcare Quality and Safety has four 'actionable components': • Establish accountability for the integrity of quality and safety systems. • Protect those who report quality and safety findings. • Report quality and safety data accurately. • Respond to quality and safety concerns with robust improvement.
URL	http://www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf

The Never Events Policy Framework: An update to the never events policy
Department of Health (UK)
London. Department of Health, 2012.

Notes	The English Department of Health has updated the policy framework so as to address areas of uncertainty and provide greater clarity about never events, and the recommended response to them. This framework provides a reference for boards, clinicians, staff and patients. The document also contains data on the number and types of never events reported in 2011-12 and 2010-11. The NHS in England specifies **25 never events**. These are: • Wrong site surgery • Wrong implant/prosthesis • Retained foreign object post-operation • Wrongly prepared high-risk injectable medication • Maladministration of potassium-containing solutions • Wrong route administration of chemotherapy • Wrong route administration of oral/enteral treatment • Intravenous administration of epidural medication • Maladministration of Insulin • Overdose of midazolam during conscious sedation • Opioid overdose of an opioid-naïve Patient • Inappropriate administration of daily oral methotrexate • Suicide using non-collapsible rails • Escape of a transferred prisoner • Falls from unrestricted windows • Entrapment in bedrails • Transfusion of ABO-incompatible blood components • Transplantation of ABO incompatible organs as a result of error • Misplaced naso- or oro-gastric tubes • Wrong gas administered • Failure to monitor and respond to oxygen saturation • Air embolism • Misidentification of Patients • Severe scalding of Patients • Maternal death due to post partum haemorrhage after elective caesarean section The aim is to reduce never events to zero as never events are "**intolerable and inexcusable**". It is also stated that the "first step must be to understand why it happened and seek to learn from it, not simply to apportion unfair blame to an individual."
URL	https://www.wp.dh.gov.uk/publications/files/2012/10/never-events-policy-framework-update-to-policy.pdf
TRIM	70502

Journal articles

Large-System Transformation in Health Care: A Realist Review
Best A, Greenhalgh T, Lewis S, Saul JE, Carroll S, Bitz J
The Milbank Quarterly 2012;90(3):421-456

Notes	Translating research into effective policy and good practice can be challenging, particularly when applied across complex, adaptive systems where the influence of political and institutional context can be strong. Cochrane-style systematic reviews and meta-analyses may have limited application in guiding policy for large system transformation (LST) as they are framed in narrow, experimental terms where context is often controlled for. Realist review may offer an alternative to these methods. It is an interpretive, narrative summary that attempts to understand and explain how and why different outcomes have been observed in a sample of primary studies, and generate broad principles to enable application to a variety of settings. It considers context and incorporates human agency and reasoning (rational and irrational, cognitive and emotional), linking resources provided for a change effort to the outcomes achieved. This paper describes the application of a realist review to inform policy initiatives of the provincial Saskatchewan Ministry of Health (Canada) in four strategic areas: patient-centred care, primary healthcare improvement, 'lean' management, and shorter surgical wait times. A description of the methodology is provided, and findings are presented as five 'simple rules' for LST, each with a set of contextual factors and mechanisms. These reflect other change management principles and literature: 1. **Distributed leadership** (engaging individuals at all levels in the change efforts) 2. Establish **feedback loops** (use good quality data for continual monitoring and improvement) 3. Attend to **history** of the organisation (learn form past failures and successes) 4. **Engage clinicians** 5. **Involve patients and families**.
DOI	http://dx.doi.org/10.1111/j.1468-0009.2012.00670.x

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, Feldman HJ, Mejilla R, Ngo L, Ralston JD, Ross SE, Trivedi N, Vodicka E, Levielle SG
Annals of Internal Medicine 2 October 2012; 157 (7): 461-470

Notes	This paper describes the findings of a post intervention survey undertaken with participants of a one year OpenNotes pilot. The OpenNotes program provides patients with electronic access to their doctor's notes. The researchers found that the majority of patients involved in the pilot who had access to their notes reported an increased sense of control, recall and understanding of their medical issues. The patients also reported being more likely to follow medication regimens as a result of this increased understanding and access. Providers reported that the program only modestly affect their work. There were some limitations to the study and the results may not be generalisable at this point in time.
DOI	http://dx.doi.org/10.7326/0003-4819-157-7-201210020-00002

For more information about the Commission's work on patient and consumer centred care, see http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Retained Surgical Items: A Problem Yet to Be Solved
Stawicki SP, Moffatt-Bruce SD, Ahmed HM, Anderson HL, 3rd, Balija TM, Bernescu I, et al.
Journal of the American College of Surgeons 2012 [epub].

Notes	Among the most disturbing of errors for many people are surgical errors, such as wrong site surgery or retained material. This paper reports on a study of **retained surgical items** that identified a number of risk factors, including **longer duration** of surgery, lack of **safety documentation**, and **incorrect counts** during procedures. A common strategy is to use counts, but in this study 45 of 59 cases had counts that were erroneously deemed as 'correct'. Notably, the authors report that the presence of a trainee during the operation appeared to decrease the risk for retained surgical items.
DOI	http://dx.doi.org/10.1016/j.jamcollsurg.2012.08.026

Assessment of teamwork during structured interdisciplinary rounds on medical units
O'Leary KJ, Boudreau YN, Creden AJ, Slade ME, Williams MV
Journal of Hospital Medicine 2012 [epub].

Notes	The role and value of teamwork in creating a safer clinical environment is largely accepted. Interdisciplinary rounds (IDR) have been used as a means to assemble hospital team members and improve collaboration. This cross-sectional observation study of 6 medical units using IDRs sought to examine teamwork during IDRs. 7–8 independent observations for each unit (total = 44) and 20 joint observations were conducted. The authors report that teamwork scores were generally high, but found differences across units. The authors consider that the study showed their measurement instrument is reliable for assessing teamwork during structured IDRS and that the "Variation in performance suggests a need to **improve consistency** of teamwork and emphasizes the **importance of leadership**."
DOI	http://dx.doi.org/10.1002/jhm.1970

E-prescribing: A focused review and new approach to addressing safety in pharmacies and primary care
Odukoya OK, Chui MA
Research in social & administrative pharmacy 2012 [epub].

Notes	E-prescribing is seen as offering considerable safety and quality benefits. There is already a literature on how this can – and cannot – be the case in acute care. Poorly designed or implemented such technologies can create a risk. This paper examines some of the safety issues related to e-prescribing in primary care settings and pharmacies. The authors propose using human factors engineering concepts to study e-prescribing safety in pharmacies and primary care settings to identify safety problems and possible mechanisms for improvement.
DOI	http://dx.doi.org/10.1016/j.sapharm.2012.09.004

For more information about the Commission's work on medication safety, including safe electronic medications management, see http://www.safetyandquality.gov.au/our-work/medication-safety/

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • The key actor: a qualitative study of **patient participation in the handover** process in Europe (Maria Flink, G Hesselink, L Pijnenborg, H Wollersheim, M Vernooij-Dassen, E Dudzik-Urbaniak, C Orrego, G Toccafondi, L Schoonhoven, P J Gademan, J K Johnson, G Öhlén, H Hansagi, M Olsson, P Barach, on behalf of the European HANDOVER Research Collaborative) • Beliefs and experiences can influence **patient participation in handover** between primary and secondary care—a qualitative study of patient perspectives (Maria Flink, Gunnar Öhlén, H Hansagi, P Barach, M Olsson) • Perceived causes of **prescribing errors by junior doctors** in hospital inpatients: a study from the PROTECT programme (Sarah Ross, Cristín Ryan, Eilidh M Duncan, Jillian J Francis, Marie Johnston, Jean S Ker, A J Lee, M J MacLeod, S Maxwell, G McKay, J McLay, D J Webb, C Bond) • **Handover training**: does one size fit all? The merits of mass customisation (Wendy Kicken, Marcel Van der Klink, Paul Barach, HPA Boshuizen) • "It's like two worlds apart": an analysis of **vulnerable patient handover** practices at discharge from hospital (Raluca Oana Groene, Carola Orrego, Rosa Suñol, Paul Barach, Oliver Groene) • Comparing the utility of a novel **neonatal resuscitation** cart with a generic code cart using simulation: a randomised, controlled, crossover trial (Ritu Chitkara, Anand K Rajani, Henry C Lee, S F Snyder Hansen, L P Halamek) • Editorial: **Safety climate research**: taking stock and looking forward (Sara J Singer, Timothy J Vogus) • Are patients discharged with care? A qualitative study of perceptions and experiences of patients, family members and care providers(Gijs Hesselink, Maria Flink, Mariann Olsson, Paul Barach, Ewa Dudzik-Urbaniak, Carola Orrego, Giulio Toccafondi, Cor Kalkman, Julie K Johnson, Lisette Schoonhoven, Myrra Vernooij-Dassen, Hub Wollersheim, on behalf of the European HANDOVER Research Collaborative) • Searching for the missing pieces between the hospital and primary care: mapping the **patient process during care transitions** (Julie K Johnson, Jeanne M Farnan, Paul Barach, Gijs Hesselink, Hub Wollersheim, Loes Pijnenborg, Cor Kalkman, Vineet M Arora, on behalf of the HANDOVER Research Collaborative) • **Stakeholder perspectives on handovers** between hospital staff and general practitioners: an evaluation through the microsystems lens (Beryl Göbel, Dorien Zwart, Gijs Hesselink, Loes Pijnenborg, Paul Barach, Cor Kalkman, Julie K Johnson)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Editorial: Quality of care in low- and middle-income settings: what next? (Elizabeth H. Bradley and Christina T. Yuan) http://intqhc.oxfordjournals.org/content?papetoc • A nationwide quality improvement project to accelerate Ghana's progress toward Millennium Development Goal Four: design and implementation

	progress (Nana A. Y. Twum-Danso, George B. Akanlu, Enoch Osafo, Sodzi Sodzi-Tettey, Richard O. Boadu, Solomon Atinbire, Ane Adondiwo, Isaac Amenga-Etego, Francis Ashagbley, Eric A. Boadu, Ireneous Dasoberi, Ernest Kanyoke, Elma Yabang, Ivan T. Essegbey, George A. Adjei, Gilbert B. Buckle, J. Koku Awoonor-Williams, Alexis Nang-Beifubah, Akwasi Twumasi, C. Joseph Mccannon, and Pierre M. Barker) http://intqhc.oxfordjournals.org/content/early/2012/10/31/intqhc.mzs060.abstract.html?papetoc • Comparison of health service accreditation programs in low- and middle-income countries with those in higher income countries: a cross-sectional study (Jeffrey Braithwaite, Charles D. Shaw, Max Moldovan, David Greenfield, Reece Hinchcliff, Virginia Mumford, Marie Brunn Kristensen, Johanna Westbrook, Wendy Nicklin, Triona Fortune, and Stuart Whittaker) http://intqhc.oxfordjournals.org/content/early/2012/10/30/intqhc.mzs064.abstract.html?papetoc • Assessment of infection control practices in maternity units in Southern Nigeria (Okonofua Friday, Okpokunu Edoja, Aigbogun Osasu, Nwandu Chinenye, Mokwenye Cyril, Kanguru Lovney, and Hussein Julia) http://intqhc.oxfordjournals.org/content/early/2012/10/18/intqhc.mzs057.abstract.html?papetoc • The association of health workforce capacity and quality of pediatric care in Afghanistan (Anbrasi Edward, Binay Kumar, Haseebullah Niayesh, Ahmad Jan Naeem, Gilbert Burnham, and David H. Peters) http://intqhc.oxfordjournals.org/content/early/2012/10/18/intqhc.mzs058.abstract.html?papetoc
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

[US] Safe Care Campaign
http://www.safecarecampaign.org/Welcome.html
This web site offers patient safety resources, including posters and videos with information on hand hygiene, infection prevention, and medication errors.
The SAFE CARE Patient Safety Education program was developed to assist (US) health care organisations in educating patients to help prevent medical errors. The campaign features videos from The Joint Commission's Speak Up™ campaign, the Centers for Disease Control and Prevention (CDC), Kimberly-Clark, thePatient Channel® from The Wellness Network, and Safe Care Campaign. The goal of the program is to save lives, prevent harm and help patients receive safer care.

[Europe] European Directory of Health Apps 2012-2013
http://www.patient-view.com/uploads/6/5/7/9/6579846/pv_appdirectory_final_web_300812.pdf
This Directory contains facts about 200 smartphone health apps capable of helping patients self-manage their medical conditions. The health apps described have all been recommended by patient groups and empowered consumers, then categorised and indexed in several ways (including by local language), to make the details easy for readers to find. Another distinction about the Directory is that it lists health apps on all of the major operating systems (Android, Apple, BlackBerry, Nokia, and Windows Phone).

[US] Toolkit for Reduction of Clostridium difficile *Infections Through Antimicrobial Stewardship*
http://www.gnyha.org/6763/Default.aspx
US toolkit designed to aid hospitals in reducing *Clostridium difficile* infections by developing a stewardship initiative to prevent antimicrobial misuse.

For more information about the Commission's work on healthcare associated infection, including antimicrobial stewardship, see http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/
