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On the Radar

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On the Radar
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Reports

Current Knowledge About Interprofessional Teams in Canada
Canadian Alliance for Sustainable Health Care

Barriers to Successful Interprofessional Teams
Canadian Alliance for Sustainable Health Care

Notes	A pair of reports from the Canadian Alliance for Sustainable Health Care emanating from their Improving Primary Health Care Through Collaboration program. The first—*Current Knowledge About Interprofessional Teams in Canada*—gives an overview of the inter-professional primary care (IPC) team models currently used in Canada. An IPC team is a group of professionals from different disciplines who communicate and work together in a formal arrangement to care for a patient population in a primary care setting. The second—*Barriers to Successful Interprofessional Teams*—highlights some of the major barriers to inter-professional collaboration in IPC teams. It specifically looks at those barriers to optimization that can be changed at the individual, practice, and system levels and that are relevant to the Canadian context. Although abundant literature exists on the barriers to IPC team optimization, it remains unclear as to how these barriers can be overcome.
URL	http://www.conferenceboard.ca/e-library/abstract.aspx?did=5157 http://www.conferenceboard.ca/e-library/abstract.aspx?did=5181

The NHS Outcomes Framework 2013/14
Department of Health
London. Department of Health, 2012.

Notes	This framework sets out the outcomes and corresponding indicators that will be used to identify improvements in health outcomes. This version builds on the previous two versions and contains measures to help the health and care system to focus on measuring outcomes. It describes how the NHS Outcomes framework will work in the wider system, and highlights the indicator changes since the December 2011 edition.
URL	https://www.wp.dh.gov.uk/publications/files/2012/11/121109-NHS-Outcomes-Framework-2013-14.pdf

Journal articles

The Economics of Health Care: Quality and Medical Errors
Andel C, Davidow SL, Hollander M, Moreno DAM
Journal of Health Care Finance 2012;39(1):39-50.

Notes	The authors of this commentary estimate that the economic impact of quality and medical errors in the USA is perhaps nearly **$1 trillion annually** when quality-adjusted life years (QALYs) are applied to those that die. The authors also argue that "**Quality care is less expensive care. It is better, more efficient, and by definition, less wasteful. It is the right care, at the right time, every time. It should mean that far fewer patients are harmed or injured.…poor quality is costing payers and society a great deal.** However, health care leaders and professionals are focusing on quality and patient safety in ways they never have before because the economics of quality have changed substantially." The paper also covers the efforts of four hospitals to reduce costs and improve health care quality.
URL	http://www.mediregs.com/economics_of_quality_care http://www.mediregs.com/files/1007-1/JHCF_Fall12_Andel_etal.pdf
TRIM	71633

Design and Use of Performance Measures to Decrease Low-Value Services and Achieve Cost-Conscious Care
Baker DW, Qaseem A, Reynolds PP, Gardner LA, Schneider EC
Annals of Internal Medicine 2012 [epub].

Notes	There seems to be a growing interest in the issue of low value/overuse, often allied with wishes to reduce spending or make care more cost-effective. For example, there is the Choose Wisely initiative. This paper describes the American College of Physicians' *High-Value Care Initiative* that is intended to help clinicians and patients understand the benefits, harms, and costs of interventions and determine whether services provide good value. The authors offer to give an overview of performance measures that target low-value services in order to help further understanding of the strengths and limitations of these measures, discuss examples of measures that assess use of low-value services, and how these measures can be used in clinical practice and policy.
DOI	http://dx.doi.org/10.7326/0003-4819-158-1-201301010-00560

"Team time-out" and surgical safety—experiences in 12,390 neurosurgical patients
Oszvald Á, Vatter H, Byhahn C, Seifert V, Güresir E
Neurosurgical Focus 2012;33(5):E6.

Interventions for reducing wrong-site surgery and invasive procedures
Mahar P, Wasiak J, Batty L, Fowler S, Cleland H, Gruen Russell L
Cochrane Database of Systematic Reviews. John Wiley & Sons, Ltd, 2012.

Notes	A pair of items on surgical safety. One a report from a German neurosurgery unit reporting on more than 12,000 patients and the other a systematic review on interventions for reducing wrong-site surgery and invasive procedures. In the first, the implementation of an advanced perioperative checklist led to improved patient safety in a German neurosurgery department. In 2007 the authors used a perioperative checklist in all elective procedures and extended the checklist in January 2011. The advanced **perioperative checklist** includes parts for **patient identification**, preoperative **assessments**, **team time-out**, **post-operative treatment**, and **imaging controls**. All parts are signed by the responsible doctor except for the team time-out, which is performed and signed by the theatre nurse on behalf of the surgeon immediately before skin incision. The authors report that between January 2007 and December 2010, 1 wrong-sided bur hole in an emergency case and 1 wrong-sided lumbar approach in an elective case (of 8795 surgical procedures) occurred. Using the advanced perioperative checklist including the team time-out principles, **no error occurred in 3595 surgical procedures** (January 2011–June 2012). The author report that "the advanced perioperative checklist developed according to the team time-out principles improves preoperative workup and the focus of the entire team. The focus is drawn to the procedure, expected difficulties of the surgery, and special needs in the treatment of the particular patient. Especially in emergency situations, the team time-out synchronizes the involved team members and helps to improve patient safety." The second paper is rather more sanguine about such interventions. As rather tends to be the way with systematic reviews, the authors report that their accumulated evidence on interventions to reduce wrong site surgery is somewhat underwhelming. The review sought to evaluate the effectiveness of organisational and professional interventions for reducing wrong-site surgery (including wrong-site, wrong-side, wrong-procedure and wrong-patient surgery), including non-surgical invasive procedures such as regional blocks, dermatological, obstetric and dental procedures and emergency surgical procedures not undertaken within the operating theatre. However, the study initially identified 3210 potential articles of which they only determined 18 of value. This was then whittled down to a single study – on cases of wrong-site tooth extraction during 1996 to 1998, which were used to develop a specific educational intervention that was implemented from 1999 to 2001 in a university hospital in Taiwan. Given this, it is perhaps a rather scant basis for both the review and the title of the paper. The [US] ARHQ PSNet noted "This systematic review did not identify any high-quality studies of successful methods to prevent wrong-site, wrong-patient, or wrong-procedure errors."
DOI / URL	Ozvald et al. http://dx.doi.org/10.3171/2012.8.FOCUS12261 Ozvald et al. http://thejns.org/doi/full/10.3171/2012.8.FOCUS12261 Mahar et al. http://dx.doi.org/10.1002/14651858.CD009404.pub2

Health complaint commissions in Australia: Time for a national approach to data collection
Walton M, Smith-Merry J, Healy J, McDonald F
Australian Review of Public Affairs 2012;11(1):1-18.

Notes	There has been some conjecture that analysing healthcare complaints could reveal useful information for safety and quality improvements (discussed in the Commission's *Windows into Safety and Quality in Health Care 2009*). One of the barriers is that identified in this paper – the **lack of a consistent definitions, collection and recording** of such information in Australia.
URL	http://www.australianreview.net/journal/v11/n1/walton_etal.html

Trends in Survival after In-Hospital Cardiac Arrest
Girotra S, Nallamothu BK, Spertus JA, Li Y, Krumholz HM, Chan PS
New England Journal of Medicine 2012;367(20):1912-1920.

Notes	Paper using registry data that reveals the impact of guidelines. The study used data on all adults (84,625 patients) who had an in-hospital cardiac arrest at 374 hospitals in the Get with the Guidelines–Resuscitation registry between 2000 and 2009 and lead the authors to conclude "Both **survival and neurologic outcomes** after in-hospital cardiac arrest have **improved** during the past decade at hospitals participating in a large national quality-improvement registry."
DOI	http://dx.doi.org/10.1056/NEJMoa1109148

A systematic approach to the identification and classification of near-miss events on labor and delivery in a large, national health care system
Clark SL, Meyers JA, Frye DR, McManus K, Perlin JB
American Journal of Obstetrics and Gynecology 2012.

Notes	Maternity care in Australia is generally regarded as safe with Australia have lower levels of infant and maternal mortality. It is also a very large domain of care. This US paper offers an approach to identify, classifying and understanding events and near misses in maternity care. The paper used voluntarily reported data on 203,708 normal births, with **near miss events** reported in **0.69% of cases**. The authors report that the most common near misses (medication errors and patient identification errors) were preventable and generally had low potential for harm. However, near misses involving clinician responsiveness and decision-making were rare, but potentially much more harmful to patients.
DOI	http://dx.doi.org/10.1016/j.ajog.2012.09.011

Risks related to patient bed safety
Sharkey JE, Van Leuven K, Radovich P
Journal of Nursing Care Quality 2012;27(4):346-351.

Notes	A source of risk that is not always appreciated is that posed by the infrastructure. This paper discusses risks associated with patient beds and recommends a risk assessment program to ensure hospital beds meet safety standards. The three chief contributors to hazards associated with hospital bed systems are **fire**, **entrapment**, and **pressure ulcers**.
DOI	http://dx.doi.org/10.1097/NCQ.0b013e318264744b

Using end of life care pathways for the last hours or days of life
Boyd K, Murray S
BMJ 2012;345:e7718

Notes	A brief editorial about end of life care and the use of care pathways. There has been some recent controversy regarding the use of the Liverpool Care Pathway in the UK. This article examines some of the issues. They highlight that there is a lack of evidence regarding any harm caused by the content of the pathway and that issues that have arisen relate more to its application. They conclude that in order **to use care pathways safely and effectively, considerable attention needs to be paid to implementation, education, evaluation, and sustainability**.
DOI	http://dx.doi.org/10.1136/bmj.e7718

International Journal for Quality in Health Care online first articles
Vol. 24, No. 6
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Notes	The latest issue of the *International Journal for Quality in Health Care* is a special issue on "Quality of Care in Low and Middle Income Countries".
URL	http://intqhc.oxfordjournals.org/content/24/6?etoc

Online resources

[Scotland] The Knowledge Network
http://www.knowledge.scot.nhs.uk
This site is designed to support (Scottish) practitioners to apply knowledge in frontline delivery of care, helping to translate knowledge into better health-care outcomes through safe, effective, person-centred care. The Knowledge Network is an initiative to facilitate evidence-based practice and quality improvement by providing information about the effectiveness of clinical interventions ('know-what') and about how to implement this knowledge to support individual patients ('know-how').

[Canada] Health Systems Evidence
http://www.mcmasterhealthforum.org/healthsystemsevidence-en
Health Systems Evidence is being enhanced and now contains complete inventories of economic evaluations of health system reforms published since 2007, descriptions of health systems around the world, and descriptions of health system reforms. These inventories complement the existing comprehensive inventories of six types of documents related to governance, financial and delivery arrangements in health systems and implementation strategies within health systems:

- evidence briefs for policy
- overviews of systematic reviews
- systematic reviews addressing effectiveness questions
- systematic reviews adding a range of other types of questions
- systematic review protocols
- registered titles of systematic reviews

The usefulness of the systematic reviews contained in Health Systems Evidence are further enhanced by links to user-friendly summaries written by any of the eight groups in the world writing such summaries for health system policymakers and stakeholders, and by links to all of the studies contained in each review.

[England and Wales] NHS Staff Engagement Toolkit
http://www.nhsemployers.org/SiteCollectionDocuments/Staff%20engagement%20toolkit.pdf
This toolkit for National Health Service organisations contains a range of information including: an introduction to staff engagement; practical working examples; evidence on the benefits of an engaged workforce (including improved patient outcomes); and access to a series of tools and resources. It is aimed at all staff groups, from clinicians, HR managers and communications teams to senior managers.