On the Radar

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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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On the Radar
Editor: Niall Johnson. Contributors: Niall Johnson, Justine Marshall, Shaun Larkin, Chris Baggoley, Peter Hibbert

Reports

Working towards People Powered Health. Insights from Practitioners
Nesta
London. Nesta. 2012.

Notes	NESTA is a UK charity "with a mission to help people and organisations bring great ideas to life. We do this by providing investments and grants and mobilising research, networks and skills." They have published this report on clinician voews of what they term 'People Powered Health'. They define People Power Health as "creating a healthcare system in which clinicians and patients collaborate to enable people to live better with their conditions. We know that 'co-production' is challenging for both professionals and for patients." This document looms at the (perceived) challenges for health professionals and workforce culture that can allow co-production. Nesta asked a range of experts — clinical, academic, policy as well as commissioners and service providers — to document their concerns and ideas so as to provide "a snapshot of the perspectives of experienced professionals working in and around co-production and health. Some focus on incentive structures, such as recruitment, training and appraisal systems, while others focus on less tangible changes to professional practice, culture and behaviour."

URL	http://www.nesta.org.uk/publications/reports/assets/features/working_towards_people_powered_health http://www.nesta.org.uk/library/documents/Working-towards-People-Powered-Health.pdf

Report from the Commission to the Council
on the basis of Member States' reports on the implementation of the Council Recommendation (2009/C 151/01) on patient safety, including the prevention and control of healthcare associated infections
European Commission
Brussels. European Commission. 2012.

Notes	This snappily titled document focuses on the state of implementation of a number of actions to increase patient safety agreed to by the EU's member states in 2009. The report concludes that Member States have implemented various measures such as **embedding patient safety** in public health polices and identifying competent authorities on patient's safety; however more effort is needed towards actions **targeting patients**, e.g. patient empowerment, and **health professionals**, e.g. more education and training. They note that "research shows that between **13 and 16% of hospital costs are due to healthcare related injuries and ill health**" and that given the existing financial conditions there may be a financial, as well as health, imperative. The report recognises that efforts have been undertaken, but also suggests that more needs to be done, including ensuring adequate numbers of **specialised infection control staff**, receiving regular **training**, and with dedicated **time** for this work. Further, tailored basic infection prevention and control structures and practices in nursing homes and other long term care facilities should be reinforced and patient information on healthcare associated infections should be improved and patient involvement in compliance with infection prevention and control measures should be strengthened.
URL	http://ec.europa.eu/health/patient_safety/policy/index_en.htm

Journal articles

A Survey Of Primary Care Doctors In Ten Countries Shows Progress In Use Of Health Information Technology, Less In Other Areas
Schoen C, Osborn R, Squires D, Doty M, Rasmussen P, Pierson R, et al
Health Affairs 2012 [epub].

Notes	Each year the (US) Commonwealth Fund surveys a large number of health care users and/or providers in a number of countries, including Australia. This year's survey, as reported in this article in Health Affairs, focused on primary care doctors (GPs) and their use of health information technology and their perceptions of the health care systems they work within. Across most of the measures Australia tends to fall in the middling or more positive rates. However, there are exceptions, at both ends. Further, middling or even good comparative scores in some measures are actually not particularly reassuring as there could be substantial improvement.
URL / DOI	http://content.healthaffairs.org/content/early/2012/11/13/hlthaff.2012.0884 http://dx.doi.org/10.1377/hlthaff.2012.0884

Over 150 potentially low-value health care practices: an Australian study
Elshaug AG, Watt AM, Mundy L, Willis CD
Med J Aust 2012; 197 (10): 556-560

Notes	Another addition to the conversation on **low value services and unnecessary care**. This article gives the Australian perspective, following recent coverage of international low-value reduction campaigns from the UK and the US, and pressure from many angles to deploy limited health care resources more effectively. One major challenge in this is the **development of a transparent and systematic method to identify services for review**. In 2010 the Australian Government introduced a Medicare Benefits Schedule (MBS) Quality Framework, subsequently named the Comprehensive Management Framework for the MBS (CMF), to improve management and governance of the MBS and conduct ongoing reviews of MBS items. As part of the development of the CMF, the authors conducted this **systematic review to identify non-pharmaceutical, MBS-listed** health care services that were flagged as **potentially unsafe, ineffective or otherwise inappropriately applied**. They also used this review to develop and apply a new strategy for scanning sources to identify such services of 'questionable benefit' for further investigation. This article outlines their approach and methods, and gives the results of their strategy. Their review identified **156 potentially ineffective or unsafe services** which warrant consideration of removal from the MBS. These include arthroscopic surgery for knee osteoarthritis, imaging in cases of low back pain, and surgery for obstructive sleep apnoea.
DOI	http://dx.doi.org/10.5694/mja12.11083

Do Patients Feel Comfortable Asking Healthcare Workers to Wash Their Hands?
Ottum A, Sethi AK, Jacobs EA, Zerbel S, Gaines ME, Safdar N
Infection Control and Hospital Epidemiology 2012;33(12):1282-1284.

Notes	The short answer is "No". Hand hygiene is widely seen as a key component to reducing the incidence of healthcare associated infections (HAI). In an era of supposedly empowered and/or empowering patients and consumers there still appears to be a barrier to encouraging or even challenging the healthcare workers they interact with to ensure good hand hygiene. This US study surveyed 200 patients at risk for methicillin-resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile*, central line-associated bloodstream infection or surgical site infection. While almost all (99.5%) agreed that healthcare professionals should wash their hands, only 14 percent had actually asked a healthcare worker to do so. Further, the study reports that 64% said they would feel comfortable asking nurses to wash their hands, 54% would ask the same of doctors. Results of hand hygiene monitoring have shown that nurses tend to display higher hand hygiene compliance rates.
DOI	http://dx.doi.org/10.1086/668419

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

Disorganized care: the findings of an iterative, in-depth analysis of surgical morbidity and mortality
Anderson CI, Nelson CS, Graham CF, Mosher BD, Gohil KN, Morrison CA, et al
The Journal of surgical research 2012;177(1):43-48.

Sharing Lessons Learned to Prevent Incorrect Surgery
Neily J, Mills PD, Paull DE, Mazzia LM, Turner JR, Hemphill RR, et al
The American Surgeon 2012;78(11):1276-1280.

Notes	A pair of items on surgical error and ways of analysing and reducing them. The first paper reports on an analysis of 153 cases from three years' of one US teaching hospital's surgical M&M (morbidity and mortality) conferences. Using a form of root cause analysis (RCA) the project sought to identify common underlying issues. The authors classified the majority of preventable errors as resulting from 'disorganised care', these included diagnostic errors, failure to rescue, and lack of situational awareness. The second paper has similar aims in seeking to understand causes of 'incorrect surgery' and how to use such knowledge. In this instance the setting is the US Veterans Health Administration (VHA). The VHA implemented a process for sharing de-identified stories of surgical lessons learned. This paper's study surveyed Chiefs of Surgery in the VHA to understand the awareness and impact of the lessons learned. The types of examples of adverse events included wrong eye implants, incorrect nerve blocks, and wrong site excisions of lesions. These were accompanied by human factors recommendations and change concepts such as designing the system to prevent mistakes, using differentiation, minimising handovers, and standardising how information is communicated. The majority of the respondents to the survey (87%) reported they were valuable and 85% that they changed or reinforced patient safety behaviours in their facility as a result of surgical lessons learned. The authors assert that "Simply having a policy will not ensure patient safety. When reviewing adverse events, human factors must be considered as a cause for error and for the failure to follow policy without assigning blame. VHA surgeons reported that the surgery lessons learned were valuable and impacted practice." Much of the literature on high-performing systems notes that self-learning and self-improvements are key and common features of such systems.
DOI	Anderson et al http://dx.doi.org/10.1016/j.jss.2012.05.007 Neily et al http://www.ingentaconnect.com/content/sesc/tas/2012/00000078/00000011/art00038

How are drug regimen changes during hospitalisation handled after discharge: a cohort study
Viktil KK, Blix HS, Eek AK, Davies MN, Moger TA, Reikvam A
BMJ Open 2012 [epub]

Notes	A small Norwegian cohort study of 105 patients admitted to hospital between 2008 and 2009. Researchers looked at **patients' medication regimen changes** while in hospital and in the 4-5 months following discharge from hospital. They found that the **medication regimens of 90 of the 105 patients included had been changed following discharge**, yet only 68 of 105 discharge notes contained complete drug lists, and only 24 of the discharge notes were received by the patient's GP within 7 days. The key messages of the article are:

	• Extensive changes in patients' drug regimens were made during their hospital stays and almost equally extensive changes were undertaken after the patients were transferred back into the care of their GPs • Discharge notes from the hospital to GPs were received late and often included incomplete drug lists • Surveillance of drug regimens is particularly necessary in the period immediately after hospital discharge.
DOI	http://dx.doi.org/10.1136/bmjopen-2012-001461

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

Reduced emergency calls and improved weekend discharge after introduction of a new electronic handover system
Rao BS, Lowe GO, Hughes AJ
Med J Aust 2012; 197 (10): 569-573

Notes	This study of a new clinical handover system introduced to Geelong Hospital in May 2009 found significant improvements in a number of indicators following implementation. With the input of a group of interns, registrars and a physician, the 5 general medicine units at Geelong Hospital, comprising 69 beds in total, came up with a structured handover system that worked for their units, with the major aim of improving doctor-to-doctor weekend shift handovers. The handover system had the acronym "Blue BARRWUE" (Blue - Updated working diagnosis, Background, Alerts, Resuscitation status, Requests, Who/what/when, Updates, and Executable discharge plan). This **point-prevalence study** examined data from 12 months prior to and 12 months following implementation of Blue BARRWUE, and looked at the presence of any written handover notes or updated working diagnoses in the BOSSnet clinical information system, the content of handover notes, the frequency of weekend discharges and the number of medical emergency team (MET) calls. The authors found dramatic **improvements in the percentage of patients with a handover note in BOSSnet** (from 47.98% pre-implementation to 95.09% post-implementation), an **increase in the number of patients discharged on weekends** (RR = 1.44 for weekend discharge after implementation; 95% CI, 1.25–1.65), and a **decrease in the number of MET calls** (RR = 0.73 for MET calls after implementation; 95% CI, 0.57–0.940).
DOI	http://dx.doi.org/10.5694/mja11.11048

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

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Imprecision concerning the Global Trigger Tool (Ellen Tveter Deilkås) • Self-reported patient safety competence among new graduates in medicine, nursing and pharmacy (Liane R Ginsburg, Deborah Tregunno, P G Norton) • The relationship between commercial website ratings and traditional hospital performance measures in the USA (Naomi S Bardach, Renée Asteria-Peñaloza, W John Boscardin, R Adams Dudley)

	The patient satisfaction chasm: the gap between hospital management and frontline clinicians (Ronen Rozenblum, Marianne Lisby, Peter M Hockey, Osnat Levtzion-Korach, Claudia A Salzberg, Nechama Efrati, Stuart Lipsitz, David W Bates)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

	International Journal for Quality in Health Care has published a number of 'online first' articles, including: • Development of the Chinese **primary care assessment tool**: data quality and measurement properties (Hui Yang, Leiyu Shi, Lydie A. Lebrun, Xiaofei Zhou, Jiyang Liu, and Hao Wang) http://intqhc.oxfordjournals.org/content/early/2012/11/21/intqhc.mzs072.abstract.html?papetoc • Application of the analytic hierarchy process in the performance measurement of colorectal **cancer care** for the design of a **pay-for-performance** program in Taiwan (Kuo-Piao Chung, Li-Ju Chen, Yao-Jen Chang, Yun-Jau Chang, and Mei-Shu Lai) http://intqhc.oxfordjournals.org/content/early/2012/11/21/intqhc.mzs070.abstract.html?papetoc • From coordinated care trials to **medicare locals**: what difference does changing the policy driver from efficiency to quality make for coordinating care? (K Gardner, L Yen, M Banfield, J Gillespie, I Mcrae, and R Wells) http://intqhc.oxfordjournals.org/content/early/2012/11/21/intqhc.mzs069.abstract.html?papetoc • A qualitative exploration of patients' attitudes towards the 'Participate Inform Notice Know' (PINK) **patient safety video** (Anna Pinto, Charles Vincent, Ara Darzi, and Rachel Davis) http://intqhc.oxfordjournals.org/content/early/2012/11/21/intqhc.mzs073.abstract.html?papetoc • Developing **mental health-care quality indicators**: toward a common framework (Carl Erik Fisher, Brigitta Spaeth-Rublee, Harold Alan Pincus, and for the IIMHL Clinical Leaders Group http://intqhc.oxfordjournals.org/content/early/2012/11/21/intqhc.mzs074.abstract.html?papetoc
Notes	
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

BMJ Quality and Safety
December 2012, Vol 21, Issue 12

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: • Editorial: Anatomy of a successful multimodal **hand hygiene** campaign (Andrew Stewardson, Didier Pittet) • Editorial: Disciplining doctors for **misconduct**: character matters, but so does competence (Robert M Wachter) • Narrative synthesis of **health service accreditation** literature (Reece Hinchcliff, David Greenfield, Max Moldovan, Johanna Irene Westbrook, Marjorie Pawsey, Virginia Mumford, Jeffrey Braithwaite)

	- What's in a name generator? Choosing the right **name generators for social network** surveys in healthcare quality and safety research (Ronald S Burt, David O Meltzer, Michael Seid, Amy Borgert, Jeanette W Chung, Richard B Colletti, G Dellal, S A Kahn, H C Kaplan, L E Peterson, P Margolis) - Managing the **after effects of serious patient safety incidents** in the NHS: an online survey study (Anna Pinto, Omar Faiz, Charles Vincent) - Self-reported uptake of recommendations after dissemination of **medication incident alerts** (Ka-Chun Cheung, Michel Wensing, Marcel L Bouvy, Peter A G M De Smet, Patricia M L A van den Bemt) - Impact of a hospital-wide **hand hygiene** initiative on healthcare-associated infections: results of an interrupted time series (Kathryn B Kirkland, Karen A Homa, Rosalind A Lasky, Judy A Ptak, Eileen A Taylor, Mark E Splaine) - Removal of doctors from practice for **professional misconduct** in Australia and New Zealand (Katie Elkin, Matthew J Spittal, D Elkin, D M Studdert) - Reciprocal **peer review for quality improvement**: an ethnographic case study of the Improving Lung Cancer Outcomes Project (Emma-Louise Aveling, Graham Martin, Senai Jiménez García, Lisa Martin, Georgia Herbert, Natalie Armstrong, Mary Dixon-Woods, Ian Woolhouse) - Using **Six Sigma** to improve once daily gentamicin dosing and therapeutic drug **monitoring performance** (Sean Egan, Philip G Murphy, Jerome P Fennell, Sinead Kelly, Mary Hickey, Carolyn McLean, Muriel Pate, Ciara Kirke, Annette Whiriskey, Niall Wall, E McCullagh, J Murphy, T Delaney) - Case-mix adjusted **hospital mortality** is a poor proxy for **preventable mortality**: a modelling study (Alan J Girling, Timothy P Hofer, Jianhua Wu, Peter J Chilton, J P Nicholl, Mohammed A Mohammed, R J Lilford)
URL	http://qualitysafety.bmj.com/content/vol21/issue12/

BMJ Quality and Safety
December 2012, Vol 21, Issue 12 Supplement 1

Notes	With the current issue of *BMJ Quality and Safety* there is also a supplement on the Proceedings from the **European Handover Research Collaborative**. Articles in this supplement include: - Editorial: The European HANDOVER Project: a multi-nation program to improve transitions at the primary care—inpatient interface (Ingrid Philibert, Paul Barach) - Editorial: The European HANDOVER project: the role of nursing (Shirley M Moore) - The patient handover as an entrustable professional activity: adding meaning in teaching and practice (Olle ten Cate, John Q Young) - Fragmented care: a practicing surgeon's response (Peter J Fabri) - Fragmented care in the era of limited work hours: a plea for an explicit handover curriculum (Max Wohlauer) - Technology support of the handover: promoting observability, flexibility and efficiency (Emily S Patterson) - Conducting a multicentre and multinational qualitative study on patient transitions (Julie K Johnson, Paul Barach, Myrra Vernooij-Dassen on behalf of the HANDOVER Research Collaborative) - Evaluation of a predevelopment service delivery intervention: an application to improve clinical handovers (Guiqing Lily Yao, Nicola

		Novielli, Semira Manaseki-Holland, Yen-Fu Chen, Marcel van der Klink, Paul Barach, Peter J Chilton, Richard J Lilford on behalf of the European HANDOVER Research Collaborative) • 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) • Mapping and assessing clinical handover training interventions (Slavi Stoyanov, Henny Boshuizen, Oliver Groene, Marcel van der Klink, Wendy Kicken, Hendrik Drachsler, Paul Barach) • The collaborative communication model for patient handover at the interface between high-acuity and low-acuity care (Giulio Toccafondi, Sara Albolino, Riccardo Tartaglia, Stefano Guidi, Antonio Molisso, Francesco Venneri, Adriano Peris, Filippo Pieralli, Elisabetta Magnelli, Marco Librenti, Marco Morelli, Paul Barach) • "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) • Beliefs and experiences can influence patient participation in handover between primary and secondary care—a qualitative study of patient perspectives (Maria Flink, Gunnar Öhlén, Helen Hansagi, Paul Barach, Mariann Olsson) • Handover training: does one size fit all? The merits of mass customisation (Wendy Kicken, Marcel Van der Klink, Paul Barach, HPA Boshuizen) • The key actor: a qualitative study of patient participation in the handover process in Europe (Maria Flink, Gijs Hesselink, Loes Pijnenborg, Hub Wollersheim, Myrra Vernooij-Dassen, Ewa Dudzik-Urbaniak, Carola Orrego, Giulio Toccafondi, Lisette Schoonhoven, Petra J Gademan, Julie K Johnson, Gunnar Öhlén, Helen Hansagi, Mariann Olsson, Paul Barach, on behalf of the 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) • The Handover Toolbox: a knowledge exchange and training platform for improving patient care (Hendrik Drachsler, Wendy Kicken, Marcel van der Klink, Slavi Stoyanov, Henny P A Boshuizen, Paul Barach) • Context, culture and (non-verbal) communication affect handover quality (Richard M Frankel, Mindy Flanagan, Patricia Ebright, Alicia Bergman, Colleen M O'Brien, Zamal Franks, Andrew Allen, Angela Harris, Jason J Saleem)
	URL	http://qualitysafety.bmj.com/content/vol21/Suppl_1/

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

Australian Health Review
Vol 36, No. 4

Notes	A new issue of *Australian Health Review* has been published. Articles in this issue include:
	• Integration of **patient safety systems** in a suburban hospital (Peter Stride, Mostafa Seleem, Noleen Nath, Ami Horne and Christina Kapitsalas)
	• **Hand hygiene**: a way out of the deadlock (S C. Stevens and C L. M. Scott)
	• **Healthcare-associated infections**: getting the balance right in safety and quality v. public reporting (Brett G. Mitchell, Anne Gardner and Alistair McGregor)
	• Characteristics of **an educational publication** sourced from deaths investigated by the Coroner that is reported to have promoted practice change (Judith A. McInnes and Joseph E. Ibrahim)
	• What is the value of **hospital mortality indicators**, and are there ways to do better? (Anna Barker, Kerrie Mengersen and Anthony Morton)
	• Encouraging participation in health system reform: is **clinical engagement** a useful concept for policy and management? (Dimitra Bonias, Sandra G. Leggat and Timothy Bartram)
	• The Bundaberg **emergency response team** (Michael P. Daly, Michael I. Cleary and Linda J. McCormack)
	• **Orthopaedic podiatry triage**: process outcomes of a skill mix initiative (Lyndon J. Homeming, Pim Kuipers and Aneel Nihal)
	• Quality **allied health clinical supervision** policy in Australia: a literature review (Sue Fitzpatrick, Megan Smith and Clare Wilding)
	• An empirical investigation into beliefs about **collaborative practice among maternity care providers** (Bernadette M. Watson, Michelle L. Heatley, Sue G. Kruske and Cindy Gallois)
URL	http://www.publish.csiro.au/?nid=270

American Journal of Medical Quality
November 2012, Vol 27, No. 6

Notes	A new issue of *American Journal of Medical Quality* has been published. Articles in this issue include:
	• **Variation in Colorectal Cancer Screening** Steps in Primary Care: Basis for Practice Improvement (Mona Sarfaty, Ronald E Myers, Daniel M Harris, Amanda E Borsky, Randa Sifri, J Cocroft, B Stello, and M Johnson)
	• Using Theory and Evidence to Guide the Use of **Educational Outreach** to Improve Patient Care (Thomas J Van Hoof and Thomas P Meehan)
	• **Multiple Patient Safety Events** Within a Single Hospitalization: A National Profile in US Hospitals (Hao Yu, Michael D Greenberg, Amelia M Haviland, and Donna O Farley)
	• Vital Sign Abnormalities, **Rapid Response**, and Adverse Outcomes in Hospitalized Patients (K Fagan, A Sabel, P S Mehler, and T D MacKenzie)
	• Inappropriately Ordered **Echocardiograms** Are Related to Socioeconomic Status (Gabriel P. Silverman, Stuart Vyse, and David I. Silverman)

	- Establishing **Quality Review** of Cardiac and Respiratory Arrest in a **Pediatric Intensive Care Unit** (Jason M Kane, Laurely S Fusilero, Brian F Joy, and Eric Wald) - Evaluation of the B-SAFE Campaign to Reduce Clinically Significant **Warfarin–Drug Interactions** Among Fee-for-Service Medicare Beneficiaries (James C Mitchiner, Steven J Korzeniewski, David Betten, David Castle, L Halasyamani, S M Burns, C Callahan, and C Manthey)
URL	http://ajm.sagepub.com/content/vol27/issue6/?etoc

Online resources

[UK] TARGET Antibiotics toolkit
http://www.rcgp.org.uk/TARGETantibiotics
The TARGET antibiotics toolkit has been created to aid clinicians and commissioners use antibiotics responsibly and meet (UK) Care Quality Commission requirements.
It has been developed by the Royal College of General Practitioners, the (UK) Health Protection Agency and The Antimicrobial Stewardship in Primary Care collaboration of professional societies including GPs, pharmacists, microbiologists, clinicians, guidance developers and other stakeholders.

Pretty Darn Quick Evidence
http://www.pdq-evidence.org/
The Cochrane Collaboration have developed a new resource called *Pretty Darn Quick Evidence.* The site has been structured so as to present primary studies and references in a hierarchical format to enhance the usability and acceptability of the evidence.

Most popular items
The items that have been most popular in the past couple of months are:
1. *Safety and Quality Improvement Guides and Accreditation Workbooks,* ACSQHC http://www.safetyandquality.gov.au/our-work/accreditation/nsqhss/safety-and-quality-improvement-guides-and-accreditation-workbooks/
2. *Health Outcomes of Care: An Idea Whose Time Has Come,* Canadian Institute for Health Information https://secure.cihi.ca/free_products/HealthOutcomes2012_EN.pdf
3. *The Never Events Policy Framework: An update to the never events policy,* Department of Health (UK) https://www.wp.dh.gov.uk/publications/files/2012/10/never-events-policy-framework-update-to-policy.pdf
4. *Australian Commission on Safety and Quality in Health Care Annual Report 2011/12*, ACSQHC http://www.safetyandquality.gov.au/publications-resources/annual-reports/
5. *NHS Outcomes Framework 2013/14,* Department of Health (UK) https://www.wp.dh.gov.uk/publications/files/2012/11/121109-NHS-Outcomes-Framework-2013-14.pdf

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