AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Reports

Health Policy Brief: Reducing Waste in Health Care
Health Affairs, December 13, 2012.

Notes	The latest Health Policy Brief from *Health Affairs* is on 'Reducing waste in health care'. This follows on a couple of items that have been reported on earlier issues of *On the Radar*, particularly those by Don Berwick and Hackbarth who had estimated that "five categories of waste consumed \$476 to \$992 billion…in 2011" and Classen and colleagues who had reported that "adverse events occurred in one-third of hospital admissions". The Brief notes that: "A third or more of what the US spends annually may be wasteful. How much could be pared back—and how—is a key question. …A key target is eliminating waste—spending that could be eliminated without harming consumers or reducing the quality of care that people receive and that, according to some estimates, may constitute one-third to nearly one-half of all US health spending. Waste can include spending on services that lack evidence of producing better health outcomes compared to less-expensive alternatives; inefficiencies in the provision of health care goods and services; and costs incurred while treating avoidable medical injuries,"

	Among the major categories of waste the Brief discusses are: • Failures of care delivery • Failures of care coordination • Over-treatment • Administrative complexity • Pricing failures • Fraud and abuse. Some of the recommended improvements to health systems include: • Improving the collection and use of data • Involving patients • Using clinical practice guidelines and decision support tools • Promoting partnerships and coordination • Realigning financial incentive • Improving transparency in provider performance, including quality, price, cost and outcomes information.
URL	http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=82

Evidence: Using safety case in industry and healthcare
The Health Foundation
London: The Health Foundation, 2012.

Notes	From the Health Foundation website: "This report presents the results of a study that reviewed the use of safety cases in six safety-critical industries, as well as the emerging use of safety cases in healthcare. … The aims of the study were to describe safety case use in other industries, to make pragmatic recommendations for the adoption of safety cases in healthcare and to outline possible healthcare application scenarios. The core of a safety case is typically a risk-based argument and corresponding evidence to demonstrate that: • all risks associated with a particular system have been identified • appropriate risk controls have been put in place • there are appropriate processes in place to monitor the effectiveness of the risk controls and the safety performance of the system on an ongoing basis. The purpose of a safety case is to provide a structured argument, supported by a body of evidence, that provides a compelling, comprehensible and valid case that a system is acceptably safe for a given application in a given context. The use of safety cases is an accepted best practice in UK safety-critical industries and is adopted by companies as a means of providing rigour and structure to their safety management systems. The report highlights a number of potential benefits of using safety cases in healthcare, including: • promoting structured thinking about risk among clinicians and fostering multidisciplinary communication about safety • integrating evidence sources • aiding communication among stakeholders • making the implicit explicit. Risks and challenges identified include safety cases: • becoming a paper exercise • being removed from everyday practice • being produced by the wrong people."

URL	http://www.health.org.uk/publications/using-safety-cases-in-industry-and-healthcare/

Improving Patient and Worker Safety—Opportunities for Synergy, Collaboration and Innovation
Oakbrook Terrace, IL: Joint Commission; 2012.

Notes	Safe care should be care that is safe for both the patient and the provider. This report is designed to generate greater awareness of the potential synergies between patient and worker health and safety activities. The report uses case studies to describe a range of topic areas and settings in which opportunities to improve patient safety and worker health and safety activities may exist.
URL	http://www.jointcommission.org/improving_Patient_Worker_Safety/ http://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf

Journal articles

A stakeholder-driven agenda for advancing the science and practice of scale-up and spread in health
Norton WE, McCannon CJ, Schall MW, Mittman BS
Implementation Science 2012;7(1):118.

Notes	Paper recounting a conference held in Washington DC in July 2010 attended by 100 representatives from research, practice, policy, public health, healthcare, and international health communities that sought to develop recommendations for advancing scale-up and spread of effective health programs at the regional, national, or international level. The conference attendees identified and prioritised five recommendations (and sub-recommendations) for advancing scale-up and spread in health: increase **awareness**, facilitate **information exchange**, **develop new methods**, apply new approaches for **evaluation**, and expand **capacity**.
DOI	http://dx.doi.org/10.1186/1748-5908-7-118

Shared Decision Making to Improve Care and Reduce Costs
Oshima Lee E, Emanuel EJ
New England Journal of Medicine 2013;368(1):6-8

Notes	A concise summary of shared decision making (SDM) and decision aids and a thoughtful argument for investing serious energy and resources into advancing SDM in the face of the changing landscape of health care and medical practice in the US. The authors call on the Centers for Medicare and Medicaid Services (CMS) to begin **certifying and implementing patient decision aids**, with the aim of **promoting an ideal approach to clinician–patient decision making**, **improving the quality of medical decisions**, and **reducing costs**. They outline the benefits of SDM and decision aids on reducing unwarranted clinical variation, improving patient satisfaction with their treatment and increasing patients' adherence to treatment plans.
DOI	http://dx.doi.org/10.1056/NEJMp1209500

Tapping Front-Line Knowledge: Identifying Problems as They Occur Helps Enhance Patient Safety
Luther K, Resar RK
Healthcare Executive. 2013 Jan/Feb;28(1):84-87

Notes	This short piece from *Healthcare Executive*, the bi-monthly journal of the American College of Healthcare Executives, is reprinted and available free of charge through the Institute of Healthcare Improvement. From the abstract: "This article describes a methodology, developed and tested by IHI and Cedars-Sinai Medical Center, that helps front-line staff to 'see' patient safety problems in their systems and enables them to solve the problems and share that learning with others. The methodology is constructed around an informal unit visit and designed to be a 'conversation' about safety issues, versus an inspection or evaluation, with specific staff duties and desired outcomes also articulated."
URL	http://www.ihi.org/knowledge/pages/publications/tappingfrontlineknowledge.aspx

Measuring organizational and individual factors thought to influence the success of quality improvement in primary care: a systematic review of instruments
Brennan S, Bosch M, Buchan H, Green S
Implementation Science 2012, 7(1):121

Notes	The effectiveness and outcomes of continuous quality improvement (CQI) methods are influenced by contextual and other factors, but investigation of this relationship is limited by measurement. The authors aim to provide guidance to support the selection of **measurement instruments** by systematically collating, categorising, and reviewing **quantitative self-report instruments**. They identified 186 potentially relevant instruments, 152 of which were analysed to develop the taxonomy. The authors found that **development methods were often pragmatic**, **rather than systematic and theory-based**, and evidence supporting measurement properties was limited.
DOI	http://dx.doi.org/10.1186/1748-5908-7-121

The role of chief executive officers in a quality improvement: a qualitative study
Parand A, Dopson S, Vincent C
BMJ Open 2013;3(1)

Notes	Article reporting on a qualitative interview study of 20 organisations across the UK participating in the main phase of the Safer Patients Initiative (SPI) program. The objective of the study was to identify the critical dimensions of hospital CEOs involvement in quality and safety. The article also seeks to offer practical guidance to assist CEOs to fulfil their leadership role in quality improvement. The five dimensions identified were: **resource provision**; **staff motivation and engagement**; **commitment and support**; **monitoring progress**; and **embedding program elements**. These dimensions were confirmed in interviews with other staff members involved in the SPI program; however, the weighting of the dimensions differed.
DOI	http://dx.doi.org/10.1136/bmjopen-2012-001731

A cross-sectional study to identify organisational processes associated with nurse-reported quality and patient safety
Tvedt C, Sjetne IS, Helgeland J, Bukholm G
BMJ Open 2012;2:e001967

Notes	All registered nurses working in direct patient care in 31 Norwegian hospitals were invited to answer this survey, which aimed to identify organisational processes and structures that are associated with nurse-reported patient safety and quality of nursing. 3618 nurses from surgical and medical wards responded (response rate = 58.9%). The authors conclude that there is a considerable potential in addressing organisational design in improvement of patient safety and quality of care.
DOI	http://dx.doi.org/10.1136/bmjopen-2012-001967

Attitudes and beliefs about hand hygiene among paediatric residents: a qualitative study
Dixit D, Hagtvedt R, Reay T, Ballermann M, Forgie S
BMJ Open 2012;2:e002188

Notes	This small qualitative research project investigated the common beliefs and attitudes held by paediatric residents in one hospital in Edmonton, Canada, about hand hygiene. From interviews, four major themes that were identified: • the importance of **role modelling**, • balancing HH with **other competing factors** which may cause HH to be neglected, • **self-protection as a driving factor for HH**, and • **cues** as an important part of habit that stimulate HH.
DOI	http://dx.doi.org/10.1136/bmjopen-2012-002188

Assessing Preventable Hospitalisation InDicators (APHID): protocol for a data-linkage study using cohort study and administrative data
Jorm LR, Leyland AH, Blyth FM, Elliott RF, Douglas KMA, Redman S, on behalf of the APHID Investigators
BMJ Open 2012;2:e002344

Notes	This article sets out the protocol for the Assessing Preventable Hospitalisation InDicators (APHID) study, "the first large-scale study to **explore internationally longitudinal relationships between primary care and potentially preventable hospitalisations** using detailed person-level information about health risk factors, health status and health service use." The APHID study will **create a new data resource by linking together data** from a large-scale cohort study (the 45 and Up Study) and prospective administrative data relating to use of general practitioner (GP) services, dispensing of pharmaceuticals, emergency department presentations, hospital admissions and deaths. The APHID study aims to validate the potentially preventable hospitalisation indicator as a measure of health system performance in Australia and Scotland, and involves three partner agencies with key roles in using these measures to drive change in the Australian health system: the Australian Commission on Safety and Quality in Health Care, the Agency for Clinical Innovation and the NSW Bureau of Health Information.
DOI	http://dx.doi.org/10.1136/bmjopen-2012-002344

Disclosure-And-Resolution Programs That Include Generous Compensation Offers May Prompt A Complex Patient Response
Murtagh L, Gallagher TH, Andrew P, Mello MM
Health Affairs 2012;31(12):2681-2689.

Notes	This recent addition to the literature on disclosure and compensation suggests that separating the disclosure conversations and compensation offers and having clinicians not part of the compensation discussions may enhance the utility of the disclosure process by avoiding it being 'tainted' or perceived as being a way of minimising compensation and/or litigation.
DOI	http://dx.doi.org/10.1377/hlthaff.2012.0185

Disclosure, Apology, and Offer Programs: Stakeholders' Views of Barriers to and Strategies for Broad Implementation
Bell SK, Smulowitz PB, Woodward AC, Mello MM, Duva AM, Boothman RC, Sands K
Milbank Quarterly 2012;90(4):682-705

Notes	The Disclosure, Apology, and Offer (DA&O) model, a response to patient injuries caused by medical care, is an alternative model to the medical liability system in the US and is gaining attention and praise. This qualitative study focused on Massachusetts and investigated the potential for more widespread implementation of the DA&O model through **interviews with key stakeholders** such as liability insurers, patient advocacy groups, practicing physicians, and patient safety experts. Interviewees reported several appealing aspects of the DA&O model, including: • Ethical and professional considerations • Reduced legal risk and costs • Improved safety culture in hospital • Improved dispute resolution process • Serves patients' needs better Several barriers to implementation were also identified, such as: • Charitable immunity • Physicians' discomfort with disclosure • Attorneys' interest in maintaining the status quo • Coordination across insurers • Physicians' name–based reporting • Concern about increased liability • The need for supporting legislation The authors conclude that "there was a striking degree of **consensus among the stakeholders that the DA&O model holds great potential to improve medical liability and patient safety**" and "DA&O programs may prove not only to constrain liability costs but also to improve access to compensation, **strengthen linkages between the liability system and patient safety**, increase health care organizations' accountability and patient advocacy, and promote transparency in regard to medical error."
DOI	http://dx.doi.org/10.1111/j.1468-0009.2012.00679.x
TRIM	73424

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

Cross-sectional study of prescribing errors in patients admitted to nine hospitals across North West England
Seden K, Kirkham JJ, Kennedy T, Lloyd M, James S, Mcmanus A, Richings A, Simpson J, Thornton D, Gill A, Coleman C, Thorpe B, Khoo SH
BMJ Open 2013;3(1)

Notes	Prescribing errors are continually identified as a major threat to patient safety in hospital settings. In this large study across nine diverse hospitals in England, ward-based clinical pharmacists prospectively documented prescribing errors at the point of **clinically checking admission or discharge prescriptions**, and assigned error categories and severities. The objective was to evaluate the prevalence, type and severity of prescribing errors observed between grades of prescriber, ward area, admission or discharge and type of medication prescribed. The researchers found that of 4238 prescriptions evaluated, **one or more error was observed in** 1857 **(43.8%) prescriptions**, with a total of 3011 errors observed. Of these, 1264 (41.9%) were minor, 1629 (54.1%) were significant, **109 (3.6%) were serious** and **9 (0.30%) were potentially life threatening**. The majority of errors considered to be potentially lethal related to overdose (n=7). Multivariable analyses revealed the **strongest predictor of error was the number of items on a prescription**, with the risk of error increasing 14% for each additional item.
DOI	http://dx.doi.org/10.1136/bmjopen-2012-002036

Medication Reconciliation Accuracy and Patient Understanding of Intended Medication Changes on Hospital Discharge
Ziaeian B, Araujo KB, Ness P, Horwitz L
Journal of General Internal Medicine 2012;27(11):1513-1520.

Notes	This study examined medication reconciliation and patient comprehension., particularly in older patients on discharge from hospital. Studying 377 patients, all over 64 and admitted with heart failure, acute coronary syndrome or pneumonia and discharged to home, the study assessed medication reconciliation accuracy by comparing admission to discharge medication lists and reviewing charts to resolve discrepancies. Medication reconciliation changes that did not appear intentional were classified as suspected provider errors. Patient understanding of intended medication changes was assessed using post-discharge interviews. A total of 565/2534 (22.3 %) of admission medications were re-dosed or stopped at discharge. Of these, 137 (24.2 %) were classified as suspected provider errors. Excluding suspected errors, patients had no understanding of 142/205 (69.3 %) of re-dosed medications, 182/223 (81.6 %) of stopped medications, and 493 (62.0 %) of new medications. Altogether, 307 patients (**81.4 %**) either **experienced a provider error, or had no understanding of at least one intended medication change**. Providers were significantly more likely to make an error on a medication unrelated to the primary diagnosis than on a medication related to the primary diagnosis. Patients were also significantly more likely to misunderstand medication changes unrelated to the primary diagnosis. The authors consider that "Efforts to improve medication reconciliation and patient understanding should not be disease-specific, but should be focused on the whole patient."
DOI	http://dx.doi.org/10.1007/s11606-012-2168-4

Use of FMEA analysis to reduce risk of errors in prescribing and administering drugs in paediatric wards: a quality improvement report
Lago P, Bizzarri G, Scalzotto F, Parpaiola A, Amigoni A, Putoto G, Perilongo G
BMJ Open 2012;2:e001249

Notes	Failure mode and effect analysis (FMEA) is an analytic method for identifying potential failure modes and their causes before they happen, to grade their potential impact on the final outcome of a process and to guide the prioritisation of improvement changes. This study applied FMEA to the drug-delivery process of all five units of the paediatric department at Padua University Hospital in Italy. The analysis identified 37 higher-priority potential failure modes and 71 associated causes and effects. The **prescription and preparation of drugs emerged as the most vulnerable steps in the process**, particularly related to errors in calculating drug doses and concentrations. The project also included suggestions for improvement activities to address the high-risk failure modes.
DOI	http://dx.doi.org/10.1136/bmjopen-2012-001249

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

Appropriateness Criteria and Elective Procedures — Total Joint Arthroplasty
Ghomrawi HMK, Schackman BR, Mushlin AI
New England Journal of Medicine 2012;367(26):2467-2469

Notes	The authors of this article put forward the case for appropriateness criteria to be applied to elective total joint arthroplasty procedures, in order to tackle the rising frequency and cost of these in the face of an ageing population, the growing obesity epidemic, and, in the United States, increasing health insurance coverage provided under the Affordable Care Act reforms. They argue that "evidence-based criteria, if applied wisely and fairly, may be the most powerful tool for controlling the cost and enhancing the quality of elective procedures." More than 1 million elective total hip and knee arthroplasties for the treatment of advanced osteoarthritis were performed in 2009 in the US, and this demand is estimated to quadruple by 2030. The authors explore the **potential applications of appropriateness criteria to decrease this demand**, through insurance coverage and reimbursements, and also the possible challenges and downsides, such as consensus about the criteria themselves, variable application, and loopholes.
DOI	http://dx.doi.org/10.1056/NEJMp1209998

The Patient Experience and Health Outcomes
Manary MP, Boulding W, Staelin R, Glickman SW
New England Journal of Medicine 26 December 2012 [epub]

Notes	This article explores the use of patient experience surveys and patient experience data and their correlation to patient outcomes. It refutes the three main concerns about patient-reported measures (1. patient feedback is not credible because patients lack formal medical training, 2. patient-experience measures could be confounded by factors not directly associated with the quality of processes, 3. patient-experience measures may reflect fulfillment of patients' a priori desires), articularly those assessing 'patient satisfaction', and attempts to explain the inconsistent results concerning patient-experience measures and health outcomes.
DOI	http://dx.doi.org/10.1056/NEJMp1211775

A systematic review of evidence on the links between patient experience and clinical safety and effectiveness
Doyle C, Lennox L, Bell D
BMJ Open 2013;3(1)

Notes	This broad systematic review summarised evidence from 55 studies to explore the links between patient experience and clinical safety and effectiveness outcomes. From the abstract: the results "indicate **consistent positive associations between patient experience, patient safety and clinical effectiveness** for a wide range of disease areas, settings, outcome measures and study designs. There is some evidence of positive associations between patient experience and measures of the technical quality of care and adverse events. Overall, it was more common to find positive associations between patient experience and patient safety and clinical effectiveness than no associations."
DOI	http://dx.doi.org/10.1136/bmjopen-2012-001570

For 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/

Strategies to enhance venous thromboprophylaxis in hospitalized medical patients (SENTRY): a pilot cluster randomized trial
Pai M, Lloyd NS, Cheng J, Thabane L, Spencer FA, Cook DJ, Haynes RB, Schünemann HJ, Douketis JD
Implementation Science 2013;8(1):1

Notes	Results of a 16-week pilot cluster RCT to examine the efficacy of a multicomponent knowledge-translation intervention to increase the rate of medical inpatients appropriately managed for thromboprophylaxis. The intervention comprised **clinician education**, a **paper-based VTE risk assessment algorithm**, printed physicians' orders, and audit and feedback sessions. 2,611 patients (1,154 in the intervention and 1,457 in the control group) from medical wards at six hospitals (representing clusters) in Ontario, Canada were eligible and included in the analysis. **The study did not find a significant difference in appropriate VTE prophylaxis rates between intervention and control hospitals**. The study did identify major barriers to effective knowledge translation, such as poor attendance by clinical staff at education and feedback sessions, difficulty locating preprinted orders, and lack of involvement by clinical and administrative leaders, as well as several factors that may increase uptake of a VTE prophylaxis strategy, including local champions, support from clinical and administrative leaders, mandatory use, and a simple, clinically relevant risk assessment tool.
DOI	http://dx.doi.org/10.1186/1748-5908-8-1

High-Fidelity Simulation and Safety: An Integrative Review
Shearer JE
Journal of Nursing Education 2012:1-7.

Notes	The potential for high-fidelity simulation training to impart safety and quality learnings is an area that has been attracting interest. This paper presents a thematic review of recent (since 2007) literature that suggests such training may improve trainees' knowledge and attitudes toward patient safety, perhaps particularly so with medication safety and errors. However, it also notes that any impact upon clinical outcomes is yet to be seen.

DOI	http://dx.doi.org/10.3928/01484834-20121121-01

BMJ Quality and Safety
January 2013, Vol 22, Issue 11

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: **Safety climate research**: taking stock and looking forward (Sara J Singer, Timothy J Vogus) • Editorial: Improving performance through **human-centred reconfiguration** of existing designs (Ken Catchpole) • Editorial: Patient safety and **junior doctors**: are we missing the obvious? (Claire Lemer, Fiona Moss) • Strategies for improving **patient safety culture** in hospitals: a systematic review (Renata Teresa Morello, Judy A Lowthian, Anna Lucia Barker, Rosemary McGinnes, David Dunt, Caroline Brand) • Determinants of success of **quality improvement collaboratives**: what does the literature show? (Marlies E J L Hulscher, Loes M T Schouten, Richard P T M Grol, Heather Buchan) • Variation in **safety culture** dimensions within and between US and Swiss Hospital Units: an exploratory study (René Schwendimann, Natalie Zimmermann, Kaspar Küng, Dietmar Ausserhofer, Bryan Sexton) • Using Healthcare Failure Mode and Effect Analysis to reduce **medication errors** in the process of drug prescription, validation and dispensing in hospitalised patients (Manuel Vélez-Díaz-Pallarés, Eva Delgado-Silveira, María Emilia Carretero-Accame, Teresa Bermejo-Vicedo) • Recorded quality of **primary care** for patients with diabetes in England before and after the introduction of a financial incentive scheme: a longitudinal observational study (Evangelos Kontopantelis, David Reeves, Jose M Valderas, Stephen Campbell, Tim Doran) • **Junior doctors** and patient safety: evaluating knowledge, attitudes and perception of safety climate (Piyush Durani, Joseph Dias, Harvinder P Singh, Nicholas Taub) • Use of in situ **simulation** and human factors engineering to assess and improve emergency department clinical systems for timely telemetry-based detection of life-threatening arrhythmias (Leo Kobayashi, Ramakrishna Parchuri, F G Gardiner, G A Paolucci, N M Tomaselli, R S Al-Rasheed, K S Bertsch, J Devine, R M Boss, F J Gibbs, E Goldlust, J E Monti, B O'Hearn, D C Portelli, N A Siegel, D Hemendinger, G D Jay) • Honouring **patient's resuscitation wishes**: a multiphased effort to improve identification and documentation (Nicola Schiebel, Sarah Henrickson Parker, Richard R Bessette, Eric J Cleveland, J Paul Neeley, Karen T Warfield, Mellissa M Barth, Kim A Gaines, James M Naessens)
URL	http://qualitysafety.bmj.com/content/vol22/issue1/

American Journal of Medical Quality
January 2013; Vol. 28, No. 1

Notes	A new issue of *American Journal of Medical Quality* has been published. Articles in this issue of *American Journal of Medical Quality* include:

	• Editorial: **Empathy** and Health Care Quality (Mohammadreza Hojat, Daniel Z Louis, Vittorio Maio, and Joseph S. Gonnella) • Minimizing **Geriatric Rehospitalizations**: A Successful Model (Daniel J Oates, David Kornetsky, Michael R Winter, Rebecca A Silliman, Lisa B Caruso, Matthew E Sharbaugh, Eric J Hardt, and Victoria A Parker) • **Medication Safety** in Primary Care Practice: Results From a PPRNet Quality Improvement Intervention (Andrea M Wessell, Steven M Ornstein, Ruth G Jenkins, Lynne S Nemeth, C B Litvin, and P J Nietert) • The Hybrid Progress Note: Semiautomating Daily Progress Notes to Achieve High-Quality **Documentation** and Improve Provider Efficiency (G J Kargul, S M Wright, A M Knight, M T McNichol, and J M Riggio) • An Assessment of **Clinical Performance Measures** for Pediatric Emergency Physicians (M K Mittal, J Zorc, J Garcia-Espana, and K Shaw) • Positive Recognition Program Increases Compliance With **Medication Reconciliation** by Resident Physicians in an Outpatient Clinic (Nathan J Neufeld, Marlís González Fernández, Paul J Christo, and K A Williams) • Examination of Hospital Characteristics and **Patient Quality Outcomes** Using Four Inpatient **Quality Indicators** and 30-Day All-Cause Mortality (Henry J. Carretta, Askar Chukmaitov, Anqi Tang, and Jihyung Shin) • Detecting **Medical Device Complications**: Lessons From an Indwelling Pleural Catheter Clinic (Roberto F Casal, Lara Bashoura, David Ost, Hsienchang T Chiu, S A Faiz, C A Jimenez, R C Morice, and G A Eapen) • Commentary: **Making Hospital Care Patient-Centered**: The Three Patient Questions Framework (Hanan Aboumatar and Peter Pronovost)
URL	http://ajm.sagepub.com/content/vol28/issue1/?etoc

Healthcare Quarterly
Vol. 15 Special Issue, Toward Performance and Quality

Notes	The current issue of the Canadian journal *Healthcare Quarterly* is a special issue with the theme *Towards Performance and Quality*. This special issue includes the following articles: • The Journey toward High Performance and Excellent Quality (Adalsteinn Brown, G. Ross Baker, Tom Closson and Terrence Sullivan) • Patient-and Family-Centredness: Growing a Sustainable Culture (Barbara Balik) • A Relentless Commitment to Improvement: The Guelph General Hospital Experience (Esther Green and Richard Ernst) • Public Engagement in Ontario's Hospitals – Opportunities and Challenges (Karen Born and Andreas Laupacis) • Organization Culture and Managerial Discipline Key to Quality Improvement: The Mount Sinai Hospital Experience (Esther Green and Joe Mapa) • A Ten-Year History: The Cancer Quality Council of Ontario (Rebecca Anas, Robert Bell, Adalsteinn Brown, William Evans and Carol Sawka) • Aligning and Pursuing Quality Goals: The Role of Health Quality Ontario (Anthony Dale and Ben Chan) • It's about the Relationships: Reflections from a Provincial Quality Council on Building a Better Healthcare System (Bonnie Brossart)

	• The Crucial Role of Clinician Engagement in System-Wide Quality Improvement: The Cancer Care Ontario Experience (Carol Sawka, Jillian Ross, John Srigley and Jonathan Irish) • Engaging Clinicians through Intrinsic Incentives (Chris Carruthers and Wendy Levinson) • Governance for Quality and Patient Safety: The Impact of the Ontario Excellent Care for All Act, 2010 (G. Ross Baker and Anu MacIntosh-Murray) • Improving Care for British Columbians: The Critical Role of Physician Engagement (Julian Marsden, Marlies van Dijk, Peter Doris, Christina Krause and Doug Cochrane) • Clinicians as Designers and Leaders of Quality Improvement (Chris Carruthers and Ward Flemons) • Supporting the Use of Research Evidence in the Canadian Health Sector (Michael Wilson, John Lavis and Jeremy Grimshaw) • Bringing Evidence to Healthcare Decision Making (Charles Wright and Brian O'Rourke) • Evidence and Quality, Practicalities and Judgments: Some Experience from NICE (Anthony Culyer and Michael Rawlins) • Stronger Policy through Evidence (Charles Wright and Les Levin) • Building Better Healthcare Facilities through Evidence-Based Design: Breaking New Ground at Vancouver Island Health Authority (Howard Waldner, Bart Johnson and Blair Sadler)
DOI	http://www.longwoods.com/publications/healthcare-quarterly/23120
TRIM	73874

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of ‘online first’ articles, including: • In situ **simulation**: detection of safety threats and teamwork training in a high risk emergency department (Mary D Patterson, Gary Lee Geis, Richard A Falcone, Thomas LeMaster, Robert L Wears) • Impact of multidisciplinary **simulation**-based training on patient safety in a paediatric emergency department (Mary D Patterson, Gary L Geis, Thomas LeMaster, Robert L Wears) • Characterising physician listening behaviour during hospitalist handoffs using the HEAR **checklist** (Elizabeth A Greenstein, Vineet M Arora, Paul G Staisiunas, Stacy S Banerjee, Jeanne M Farnan) • Leaders’ and followers’ individual experiences during the early phase of **simulation-based team training**: an exploratory study (Lisbet Meurling, Leif Hedman, Li Felländer-Tsai, Carl-Johan Wallin) • Errors as allies: **error management training** in health professions education (Aimee King, Michael G Holder, Jr, Rami A Ahmed) • **Interprofessional education in team communication**: working together to improve patient safety (Douglas Brock, Erin Abu-Rish, Chia-Ru Chiu, D Hammer, S Wilson, L Vorvick, K Blondon, D Schaad, D Liner, B Zierler) • Changes in **adverse event rates in hospitals** over time: a longitudinal retrospective patient record review study (Rebecca J Baines, Maaike Langelaan, Martine C de Bruijne, Henk Asscheman, Peter Spreeuwenberg, Lotte van de Steeg, K M Siemerink, F van Rosse, M Broekens, C Wagner)

	• Identifying optimal **postmarket surveillance** strategies for medical and surgical devices: implications for policy, practice and research (Anna R Gagliardi, Muriah Umoquit, P Lehoux, S Ross, A Ducey, D R Urbach) • A novel approach to improving **emergency department consultant** response times (Christine Soong, Sasha High, M W Morgan, H Ovens) • Methodological variations and their effects on reported **medication administration error rates** (Monsey C McLeod, N Barber, B D Franklin)
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: • The incidence of **adverse events among home care** patients (Nancy Sears, G. Ross Baker, Jan Barnsley, and Sam Shortt) • **Human factors in clinical handover**: development and testing of a 'handover performance tool' for doctors' shift handovers (Cinzia Pezzolesi, Tanja Manser, Fabrizio Schifano, Andrzej Kostrzewski, John Pickles, Nicholls Harriet, Iain Warren, and Soraya Dhillon) • Reduction in **catheter-associated urinary tract infections** by bundling interventions (Karen Clarke, David Tong, Yi Pan, Kirk A. Easley, Bonnie Norrick, Christin Ko, Alan Wang, Behzad Razavi, and Jason Stein) • The effect of a workflow-based response system on hospital-wide voluntary **incident reporting rates** (Szu-Chang Wang, Ying-Chun Li, and Hung-Chi Huang)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

[UK] Shared Decision Making
http://sdm.rightcare.nhs.uk/
The aim of the Right Care Shared Decision Making Programme is to embed Shared Decision Making in NHS care. This is part of the wider ambition to promote patient centred care, to increase patient choice, autonomy and involvement in clinical decision making and make "no decision about me, without me" a reality. As part of this, the Right Care Shared Decision Making Programme has launched 14 Patient Decision Aids. The available decision aids are:

- Abdominal aortic aneurysm (AAA) repair
- Abdominal aortic aneurysm (AAA) screening
- Cataracts
- Chronic obstructive pulmonary disease (COPD)
- Established kidney failure
- Established kidney failure (kidney dialysis)
- Established kidney failure (kidney transplant)
- Localised prostate cancer
- Lower urinary tract symptoms
- Lung cancer
- Osteoarthritis of the hip
- Osteoarthritis of the knee
- Prostate specific antigen (PSA) testing
- Stable angina

[UK] Action plan for improving use of medicines and reducing waste
http://www.dh.gov.uk/health/files/2012/12/Improving-the-use-of-medicines-for-better-outcomes-and-reduced-waste-An-action-plan.pdf
The NHS has published this Action plan to identify how people can be better supported in taking their medicines as prescribed, thus improving health outcomes, reducing waste and ensuring better value for the NHS. It is stated that "The pragmatic and practical Action Plan will identify:

- Ways of optimising the use of medicines by NHS patients
- How the improved use of medicines can be better incorporated into care pathways and self-management plans, as a fundamental contribution to the QIPP work programme
- How optimising the use of medicines through full patient participation and shared decision-making might be embedded in the education of health and social care professionals in the future
- Synergies with the work programme on Care Homes being led by the Royal Colleges of Physicians and Psychiatry and the Academy of Medical Royal Colleges
- Policy implications for the Department of Health, and implications for NHS contracting arrangements
- Whether a communications campaign might raise awareness of the issues of improved medicine taking and reducing waste and contribute to behavioural change, building on current knowledge of patient and public views.
- The cultural, diversity, health literacy and other barriers or challenges in taking forward any of the suggested initiatives, and recommend actions to mitigate them."

[USA] The Dartmouth Atlas of Health Care
http://www.dartmouthatlas.org/
The Dartmouth Atlas of Health Care uses US Medicare data to document variations in how medical resources are distributed and used in the United States. Based at The Dartmouth Institute for Health Policy and Clinical Practice, the project is supported by a coalition of funders led by the Robert Wood Johnson Foundation.
The project has just released a new series of **nine regional reports** analysing care provided across the country, specifically focusing on trends in elective, or 'preference-sensitive,' procedures. The report series, titled ***Improving Patient Decision-Making in Health Care*** emphasises "the importance of patients working with their health care team to make a **shared decision** based on the best evidence and their values" and presents data on how Medicare patients differ in receiving treatments for early-stage breast cancer, stable angina, low back pain, arthritis of the knee or hip, carotid artery disease, gallstones, enlarged prostate, and early-stage prostate cancer.

[USA] *TeamSTEPPS® Training Module for Primary Care Teams*
http://www.ahrq.gov/teamsteppstools/primarycare/
A new TeamSTEPPS® training module for primary care practices is now available in draft form. Primary care practices can use this training curriculum to improve patient safety by teaching health care providers and staff how to communicate better, work more effectively, and make a greater commitment to teamwork. This new module applies the four TeamSTEPPS core competencies: team leadership, situation monitoring, mutual support, and communication to the primary care setting. It also includes case studies and videos relevant to primary care to illustrate these evidence-based concepts.

Health Workforce Innovation in Australia: a National Inventory
http://www.hwainventory.net.au/
Health Workforce Australia has established this website to allow the sharing of work already being undertaken by individuals and organisations to encourage and change across the Australian health, higher education and training sectors. There are already more than 250 examples of innovations that have been submitted. Visitors can post, browse or search for information about innovations.

[USA] Health Care Innovations Exchange – Patient-centred hospital design
http://www.innovations.ahrq.gov/
The [US] Agency for Healthcare Research and Quality (AHRQ) has uploaded the January 16 issue of the Health Care Innovations Exchange with a focus on patient-centred hospital design.
The featured Innovations showcase efforts to implement patient-centred hospital design, leading to improved patient care and satisfaction.
The featured QualityTools provide guidance and the rationale for designing patient-centred hospitals and tools to help improve patient-centred care.

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