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On the Radar

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On the Radar
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Journal articles

Improving patient safety through the systematic evaluation of patient outcomes
Forster AJ, Dervin G, Martin C, Papp S
Canadian Journal of Surgery 2012;55(6):418-425.

Notes	The authors of this paper suggest that the apparent lack of progress in reducing harm to patients is related to a "failure to systematically measure patient safety". The authors of their review of reporting and detection systems, how patient safety can be assessed and the consequences of the absence of systematic measurement. The paper concludes with the assertion that a **disciplined approach to measurement** is required, along with **clinician leadership** and a move away from 'one size fits all' and 'top-down' to more **local/contextualised solutions**. One area where the evaluation of outcomes is considered to have great potential is that of the local or unit level – allowing clinicians to understand and reflect on their practice, including that relative to their peers. Obviously this would require timely, granular and accurate information.
DOI / URL	http://dx.doi.org/10.1503/cjs.007811 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3506692/

Enhancing patient safety and quality of care by improving the usability of electronic health record systems: recommendations from AMIA
Middleton B, Bloomrosen M, Dente MA, Hashmat B, Koppel R, Overhage JM, et al
Journal of the American Medical Informatics Association 2013 [epub].

Notes	A set of recommendations from the American Medical Informatics Association (AMIA) intended to maximise the safety and quality value of electronic health records (EHR). The AMIA Board of Directors convened a Task Force on Usability to examine evidence from the literature and make recommendations. The recommendations are intended to "stimulate informed debate, provide a plan to increase understanding of the impact of usability on the effective use of health IT, and lead to safer and higher quality care with the adoption of useful and usable EHR systems." The recommendations are: 1. Usability and human factors research agenda in health IT a. Prioritize standardized use cases b. Develop a core set of measures for adverse events related to health IT use c. Research and promote best practices for safe implementation of HER 2. Policy recommendations a. Standardization and interoperability across EHR systems should take account of usability concerns b. Establish an adverse event reporting system for health IT and voluntary health IT event reporting c. Develop and disseminate an educational campaign on the safe and effective use of EHR 3. Industry recommendations a. Develop a common user interface style guide for select EHR functionalities b. Perform formal usability assessments on patient-safety sensitive EHR functionalities 4. Clinical end-user recommendations a. Adopt best practices for EHR system implementation and ongoing management b. Monitor how IT systems are used and report IT-related adverse events.
DOI / URL	http://dx.doi.org/10.1136/amiajnl-2012-001458 http://jamia.bmj.com/content/early/2013/01/24/amiajnl-2012-001458.full

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

A Systematic Review of Simulation for Multidisciplinary Team Training in Operating Rooms
Cumin D, Boyd MJ, Webster CS, Weller JM
Simul Healthc 2013 [epub].

Notes	The potential of simulation to enhance the safety and quality of care has been suggested by a number of authors in recent years. Simulation training has rather tended to "occur in uniprofessional silos and do little to integrate different disciplines working in the operating room (OR)." This systematic review sought to examine what work was being done on **simulation for full OR multidisciplinary teams** and to identify barriers and the factors contributing to successful courses. The review tends to be fairly positive about simulation training.

	The authors report on 18 articles and note that "training sessions were generally perceived as **realistic** and **beneficial** by participants despite rudimentary integration of surgical and anesthetic models" Challenges included recruitment, model fidelity or realism, and financial costs. The authors suggest a focus on "how to overcome the barriers to implementation of team training interventions for full OR teams, particularly on how to engage senior staff to aid recruitment."
DOI	http://dx.doi.org/10.1097/SIH.0b013e31827e2f4c

Can incident reporting improve safety? Healthcare practitioners' views of the effectiveness of incident reporting
Anderson JE, Kodate N, Walters R, Dodds A
International Journal for Quality in Health Care 2013 [epub].

Notes	Incident reporting has been widely adopted, but this has not always been universally welcomed and, as noted by the authors here, "critiques of incident reporting suggest that its role in managing safety has been over emphasized". This paper reports on the views of 62 healthcare practitioners at two large teaching hospitals in London (one providing acute care, the other mental healthcare). The participants all had experience with reporting and analysing incidents. The study sought to examine the perceived effectiveness of incident reporting in improving safety by asking staff about their perceptions and experiences. The authors report that "**incident reporting** was perceived as having a **positive effect on safety**, not only by leading to changes in care processes but also by changing staff attitudes and knowledge." They conclude that "reporting can be a powerful tool for developing and maintaining an awareness of risks in healthcare practice". They also noted that "using incident reports to improve care is challenging and the study highlighted the **complexities** involved and the **difficulties** faced by staff in learning from incident data."
DOI	http://dx.doi.org/10.1093/intqhc/mzs081

International Journal for Quality in Health Care online first articles

Notes	The *International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • How to achieve optimal organization of **primary care service delivery** at system level: lessons from Europe (Ferruccio Pelone, Dionne S. Kringos, Peter Spreeuwenberg, Antonio G. De Belvis, and Peter P. Groenewegen) • Treatment compliance under physician–industry relationship: a framework of **health-care coordination** in the USA (J Chen and A Vargas-Bustamante) • **Accreditation of hospitals** in Lebanon: is it a worthy investment? (Shadi S. Saleh, Jihane Bou Sleiman, Diana Dagher, Hanaa Sbeit, and Nabil Natafgi) • Wait watchers: the application of a **waiting list active management** program in ambulatory care (Antonio Giulio De Belvis, Marta Marino, M Avolio, F Pelone, D Basso, G A Dei Tos, S Cinquetti, and W Ricciardi) • **Adverse event reporting** in Czech long-term care facilities (Zdeněk Hřib, Pavel Vychytil, and David Marx) • Assessment of **patient safety culture** in Palestinian public hospitals (Motasem Hamdan and Abed Alra'oof Saleem)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Systematic **simulation-based team training** in a Swedish intensive care unit: a diverse response among critical care professions (Lisbet Meurling, Leif Hedman, Christer Sandahl, Li Felländer-Tsai, Carl-Johan Wallin) • Development and reliability of the explicit professional oral communication observation tool to quantify the **use of non-technical skills in healthcare** (Peter F Kemper, Inge van Noord, Martine de Bruijne, Dirk L Knol, Cordula Wagner, Cathy van Dyck)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[USA] Care About Your Care
http://www.rwjf.org/en/about-rwjf/program-areas/quality-equality/care-about-your-care.html
Some new resources are available from the *Care About Your Care* program, including a **discharge preparation checklist and care transition plan** for leaving hospital, and a **fact sheet 'How to avoid being readmitted to hospital'**, which recommends six steps patients should take to improve their experience post-discharge:

- Ask and ask again
- Say it back
- Have a discharge plan
- Manage your medications
- Keep appointments
- Know what to do if you don't feel well

The *Care About Your Care* initiative from the Robert Wood Johnson Foundation seeks to focus attention on what people can do to provide and receive better health care. In 2013 the focus is on strategies to improve care transitions and reduce hospital readmissions.