AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

Issue 116
25 February 2013

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.

Access to particular documents may depend on whether they are Open Access or not, and/or your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

On the Radar is available online, via email or as a PDF document from http://www.safetyandquality.gov.au/publications-resources/on-the-radar/

If you would like to receive *On the Radar* via email, you can subscribe on our website http://www.safetyandquality.gov.au/ or by emailing us at mail@safetyandquality.gov.au. You can also send feedback and comments to mail@safetyandquality.gov.au.

For information about the Commission and its programs and publications, please visit http://www.safetyandquality.gov.au/ You can also follow us on Twitter @ACSQHC.

On the Radar
Editor: Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

Reports

Acting on Concerns: Your Professional Responsibility
Royal College of Surgeons of England
London. Royal College of Surgeons of England, 2013.

Notes	The Royal College of Surgeons of England has published this guidance to advise clinicians on how to act if they consider patients are receiving poor care. It guides surgeons on how best to collaborate with colleagues to monitor performance and quality of care, deal with problems, raise concerns and support others. The guidance offers practical advice on how to develop an open culture where there is a willingness to address issues. It urges individuals not to wait for things to go wrong before personally attending to the quality of clinical governance in a team or department. Key recommendations include: • Don't wait for things to go wrong • Don't 'explain away' dissonant or worrying data • Be aware of the avenues open to you to raise concerns • Understand the legal protection in place for whistleblowers.
URL	http://www.rcseng.ac.uk/publications/docs/acting-on-concerns/
TRIM	75430

There and Home Again, Safely: Five Responsibilities of Ambulatory Practices in High Quality Care Transitions
Sokol PE, Wynia MK, writing for the AMA Expert Panel on Care Transitions
Chicago IL. American Medical Association, 2013:77.

Notes	Report from an American Medical Association expert panel that presents the consensus views of a set of experts on how ambulatory practices should be optimally engaged in ensuring safe care transitions for patients entering and leaving the inpatient setting. The panel agreed on 5 tasks that need to be accomplished for safe care transitions and articulated 5 principles to help guide ambulatory practices in these tasks. 5 Responsibilities • Assessment • Goal-Setting • Supporting Self-Management • Medication Management • Care Coordination. 5 Principles • Person-centred • Collaborative • Structured • Iterative • Flexible.
URL	http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/patient-safety/ambulatory-safety.page http://www.ama-assn.org/resources/doc/patient-safety/ambulatory-practices.pdf
TRIM	75540

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

Journal articles

A Closer Look at Associations Between Hospital Leadership Walkrounds and Patient Safety Climate and Risk Reduction: A Cross-Sectional Study
Schwendimann R, Milne J, Frush K, Ausserhofer D, Frankel A, Sexton JB
American Journal of Medical Quality 2013 [epub].

Notes	Paper reporting on a retrospective, cross-sectional study evaluated the association between executive walkrounds and caregiver assessments of patient safety climate and patient safety risk reduction across from 706 units across 49 hospitals in a non-profit health care system. The authors report that leadership walkround participation was strongly associated with positive safety climates and greater risk reductions. The application of walkrounds varied from institution to institution, but the project used a standardised strategy, including monthly hospital executive visits and scripted, open-ended questions meant to engage staff in patient safety discussions, in what could again be seen as a form of flexible standardisation. This approach allows for an approach to amended to better suit the given context or setting while retaining the overall aims and methods.
DOI	http://dx.doi.org/10.1177/1062860612473635

The use of a standard design medication room to promote medication safety: organizational implications
Rozenbaum H, Gordon L, Brezis M, Porat N.
International Journal for Quality in Health Care 2013 [epub].

Design for patient safety: A guide to the design of the dispensing environment
National Patient Safety Agency
London: The National Patient Safety Agency, 2007.

Notes	Rozenbaum et al report on the development and implementation of guidelines for planning and designing standardised medication rooms in an Israeli hospital. The authors report that indicators that were design dependent and design and behaviour dependent improved and led the authors to claim that a "standard design [medication room] can improve environmental aspects of safety medication administration." The former UK National Patient Safety Agency published its *Design for patient safety: A guide to the design of the dispensing environment* which was perhaps slightly less proscriptive, but certainly identified design and process elements to enhance safety. Such an approach is somewhat akin to a **flexible standardisation** approach. There is also an argument that standardised designs, procedures and processes can mitigate against errors, particularly by temporary/agency staff, locums, etc.
DOI / URL	Rozenbaum et al. http://dx.doi.org/10.1093/intqhc/mzt005 NPSA http://www.nrls.npsa.nhs.uk/resources/collections/design-for-patient-safety/

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

Reduction in medication errors in hospitals due to adoption of computerized provider order entry systems
Radley DC, Wasserman MR, Olsho LE, Shoemaker SJ, Spranca MD, Bradshaw B
Journal of the American Medical Informatics Association 2013.

Notes	Medication errors are a substantial source of patient harm. This paper reports on a study that sought to estimate the reduction in medication error in hospitals that could be attributed electronic prescribing through computerised provider order entry (CPOE) systems. The study combined a systematic literature review and random-effects meta-analytic techniques to derive a summary estimate of the effect of CPOE on medication errors which was then combined with data from the 2006 American Society of Health-System Pharmacists Annual Survey, the 2007 American Hospital Association Annual Survey, and the AHA 2008 Electronic Health Record Adoption Database supplement to estimate the percentage and absolute reduction in medication errors attributable to CPOE. The study results suggest that by **processing a prescription drug order through a CPOE system decreases the likelihood of error on that order by 48%**. Using this effect size, and the degree of CPOE adoption and use in US hospitals in 2008, the authors estimate a 12.5% reduction in medication errors, or 17.4 million medication errors averted in the USA in 1 year. The authors argue that **CPOE can substantially reduce the frequency of medication errors in inpatient acute-care settings**. But they do also note that **it is unclear whether this translates into reduced harm for patients**.

	When implementing new systems and processes it is also important to be aware that such changes can introduce new risks and/or unintended consequences.
DOI	http://dx.doi.org/10.1136/amiajnl-2012-001241

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

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

BMJ Quality and Safety
March 2013, Vol 22, Issue 3

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: **Patient-centred healthcare**, social media and the internet: the perfect storm? (Ronen Rozenblum, David W Bates) • Overarching goals: a **strategy for improving healthcare quality and safety**? (Karen C Nanji, Timothy G Ferris, David F Torchiana, G S Meyer) • 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) • 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) • 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) • Matching identifiers in **electronic health records**: implications for duplicate records and patient safety (Allison B McCoy, Adam Wright, Michael G Kahn, Jason S Shapiro, Elmer Victor Bernstam, Dean F Sittig) • Identifying attributes required by Foundation Year 1 doctors in multidisciplinary teams: a tool for **performance evaluation** (Patricia McGettigan, Jean McKendree, N Reed, S Holborow, C D Walsh, T Mace) • Process evaluation of a tailored multifaceted feedback program to improve the quality of **intensive care** by using quality indicators (Maartje L G de Vos, Sabine N van der Veer, Wilco C Graafmans, Nicolette F de Keizer, Kitty J Jager, Gert P Westert, Peter H J van der Voort) • The **patient satisfaction** chasm: the gap between hospital management and frontline clinicians (Ronen Rozenblum, Marianne Lisby, Peter M Hockey, Osnat Levtzion-Korach, C A Salzberg, N Efrati, S Lipsitz, D W Bates) • Harnessing the cloud of **patient experience**: using social media to detect poor quality healthcare (Felix Greaves, Daniel Ramirez-Cano, Christopher Millett, Ara Darzi, Liam Donaldson) • Personalised **performance feedback** reduces narcotic prescription errors in a NICU (Kevin M Sullivan, Sanghee Suh, Heather Monk, John Chuo) • Why traditional statistical **process control charts** for attribute data should be viewed alongside an xmr-chart (M A Mohammed, P Worthington)
URL	http://qualitysafety.bmj.com/content/vol22/issue3/

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Women's safety alerts in **maternity care**: is speaking up enough? (S Rance, C McCourt, J Rayment, N Mackintosh, W Carter, K Watson, J Sandall) • Competition in collaborative clothing: a qualitative case study of influences on **collaborative quality improvement** in the ICU (Katie N Dainty, Damon C Scales, Tasnim Sinuff, Merrick Zwarenstein) • **Staff perceptions of quality of care**: an observational study of the NHS Staff Survey in hospitals in England (Richard J Pinder, Felix E Greaves, Paul P Aylin, Brian Jarman, Alex Bottle)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[USA] Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care
http://www.ahrq.gov/research/ltc/fallpxtoolkit/index.html
The US Agency for Healthcare Research and Quality (AHRQ) has released a toolkit focuses on overcoming the challenges associated with developing, implementing, and sustaining a fall prevention program.

For information about the Commission's work on falls prevention, including the falls prevention guidelines, *Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals, Residential Aged Care Facilities and Community Care 2009*, see http://www.safetyandquality.gov.au/our-work/falls-prevention/