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On the Radar

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On the Radar
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Reports

Workbase. Literature review of health literacy education, training tools and resources for health providers
Wellington: Health Quality and Safety Commission New Zealand, 2013.

Notes	This literature review is part of the Health Quality and Safety Commission New Zealand's Health Literacy Medication Safety project. The review provides a high level overview of evidence-based education, training tools and resources for health professionals which help address health literacy issues within the pharmacy environment.
URL	http://www.hqsc.govt.nz/our-programmes/consumer-engagement/publications-and-resources/publication/835/

Bring it on – 40 ways to support patient leadership guide
Centre for Patient Leadership, 2013.

Notes	The UK's Centre for Patient Leadership has published this short guide explaining what patient leadership means, as well as the role and purpose of patient leaders. It aims to help (NHS) organisations foster patient leadership by providing descriptions of key concepts, examples, case studies, tools (such as self-assessment frameworks and checklists), top tips and useful background material.
URL	http://centreforpatientleadership.com/resources/links/
TRIM	78046

Healthy Communities: Australians' experiences with primary health care in 2010-11
Sydney: National Health Performance Authority, 2013.

Notes	The National Health Performance Authority has started publishing its *Healthy Communities* series of reports. This report on consumers' use, experience and views on various primary health care, mostly at the Medicare Local level. The more recent report, on child immunisation rates has garnered much media coverage and is also available.
URL	http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/Healthy-communities

Journal articles

Parent perceptions of children's hospital safety climate
Cox ED, Carayon P, Hansen KW, Rajamanickam VP, Brown RL, Rathouz PJ, et al
BMJ Quality & Safety 2013 [epub].

Notes	The role that patients and carers can have in experiencing and contributing to reporting on and maintaining or enhancing the safety culture has been discussed previously. This paper reports on a study surveying 172 parents of hospitalised children in the USA. The parents were asked about their perceptions of hospital safety climate (14 items representing four domains—overall perceptions of safety, openness of staff and parent communication, and handoffs and transitions) and perceived need to watch over their child's care. The authors report that 39 % of the surveyed parents agreed or strongly agreed they needed to watch over care. They also report that the perceived need to watch over care was significantly related to overall perceptions of safety and to handovers and transitions, but not to openness of staff or parent communication. The authors conclude that "Findings suggest **parents can provide valuable data on specific safety climate domains**. Opportunities exist to improve our safety climate's impact on parent burden to watch over their child's care, such as targeting overall perceptions of safety as well as handoffs and transitions."
DOI	http://dx.doi.org/10.1136/bmjqs-2012-001727

Hospital staff nurses' shift length associated with safety and quality of care
Stimpfel AW, Aiken LH
Journal of Nursing Care Quality 2013;28(2):122-129.

Notes	Questions of staffing numbers and length of shift and their relationship with safety and quality are perennial. This is a recent addition to the literature. This US study sought to examine hospital staff nurses' shift length, scheduling characteristics, and nurse-reported safety and quality by using more than 22 000 registered nurses' reports of shift length. The authors report that "**Extended shift lengths were associated with higher odds of reporting poor quality and safety**. Policies aimed at reducing the use of extended shifts may be advisable." The authors also report that nurses who worked shifts of 10 hours or longer were more likely to report a poor safety level compared with nurses working 8- to 9-hour shifts. The measure of safety and quality of care being a self-reported one may be questioned by some as lacking objectivity, validity or rigour.
DOI	http://dx.doi.org/10.1097/NCQ.0b013e3182725f09

Interruptions during nurses' work: A state-of-the-science review
Hopkinson SG, Jennings BM
Research in Nursing & Health 2013;36(1):38-53.

Notes	Another aspect of nursing care that has generated speculation for its impact on care has been that of interruption. This paper describes a review of the area. In reviewing articles published in 2001–2011, 31 were selected from the initial 791 identified. The authors report that "the current findings suggest that **beliefs about the ill effects of interruptions remain more conjecture than evidence-based**." As tends to be the way with reviews, the 'need for further research' theme is one conclusion.
DOI	http://dx.doi.org/10.1002/nur.21515

Complications of Mechanical Ventilation — The CDC's New Surveillance Paradigm
Klompas M
N Engl J Med 2013; 368:1472-1475

Notes	This perspective piece outlines the CDC's new surveillance definitions for patients receiving mechanical ventilation. The new definitions feature a broadening of the focus of surveillance beyond ventilator-associated pneumonia (VAP), which Klompas argues is not a valuable nor reliable metric, with the aim to make surveillance more objective.
DOI	http://dx.doi.org/10.1056/NEJMp1300633

Reducing the risk of adverse drug events in older adults
Pretorius RW, Gataric G, Swedlund SK, Miller JR
American Family Physician 2013;87(5):331-336.

Notes	Medication errors are one of the most common forms of error and can have consequences that range from the trivial to the fatal. This commentary piece commentary outlines types of adverse drug events that occur with elderly patients and recommends various prevention strategies. The authors suggest that as many as **50% of adverse drug events are potentially preventable**. They note that the more common "serious manifestations include falls, orthostatic hypotension, heart failure, and delirium" and that the "most common causes of death are gastrointestinal or intracranial bleeding and renal failure. Antithrombotic and antidiabetic medications, diuretics, and nonsteroidal anti-inflammatory drugs cause most of the preventable hospital admissions due to adverse drug events". They go on to discuss and recommend **strategies to reduce the risk of adverse drug events** including "**discontinuing medications**, prescribing **new medications sparingly**, **reducing the number of prescribers**, and frequently **reconciling medications**". They also note that approaches such as Beers, STOPP (screening tool of older persons' potentially inappropriate prescriptions), and START (screening tool to alert doctors to right treatment) criteria can help identify medications causing adverse drug events. They also claim that clinicians should **involve patients in shared decision making** and **individualise prescribing decisions** based on medical, functional, and social conditions; quality of life; and prognosis.
URL	http://www.aafp.org/afp/2013/0301/p331.html Information for patients: http://www.aafp.org/afp/2013/0301/p331-s1.html

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

Chemotherapy Medication Errors in a Pediatric Cancer Treatment Center: Prospective Characterization of Error Types and Frequency and Development of a Quality Improvement Initiative to Lower the Error Rate
Watts RG, Parsons K
Pediatric Blood & Cancer 2013 [epub].

Notes	Chemotherapy is a common treatment option for cancer patients. However chemotherapy medications can be extremely dangerous and errors in this area can be very serious. This study sought to understand chemotherapy medication errors in paediatric cancer by examining more than 20,000 chemotherapy orders in 2008–2011 at paediatric cancer treatment program. The paper describes how a multi-disciplinary team developed and implemented a prospective pharmacy surveillance system of chemotherapy prescribing and administration errors. Every chemotherapy order was prospectively reviewed for errors at the time of order submission. The authors report that error rates were low (6/1,000 patient encounters and 3.9/1,000 medications dispensed) at the start of the project and reduced by 50% to 3/1,000 patient encounters and 1.8/1,000 medications dispensed during the initiative. Error types included chemotherapy dosing or prescribing errors (42% of errors), treatment roadmap errors (26%), supportive care errors (15%), timing errors (12%), and pharmacy dispensing errors (4%). Ninety-two percent of errors were intercepted before reaching the patient. No error caused identified patient harm. Efforts to lower rates were successful but have not succeeded in preventing all errors. The authors argue that while "chemotherapy medication errors are possibly unavoidable" they "can be minimized by thoughtful, multispecialty review of current policies and procedures."
DOI	http://dx.doi.org/10.1002/pbc.24514

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • The science of **human factors**: separating fact from fiction (Alissa L Russ, Rollin J Fairbanks, Ben-Tzion Karsh, L G Militello, J J Saleem, R L Wears) • Editorial: Spreading **human factors** expertise in healthcare: untangling the knots in people and systems (Ken Catchpole)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl