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On the Radar

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On the Radar
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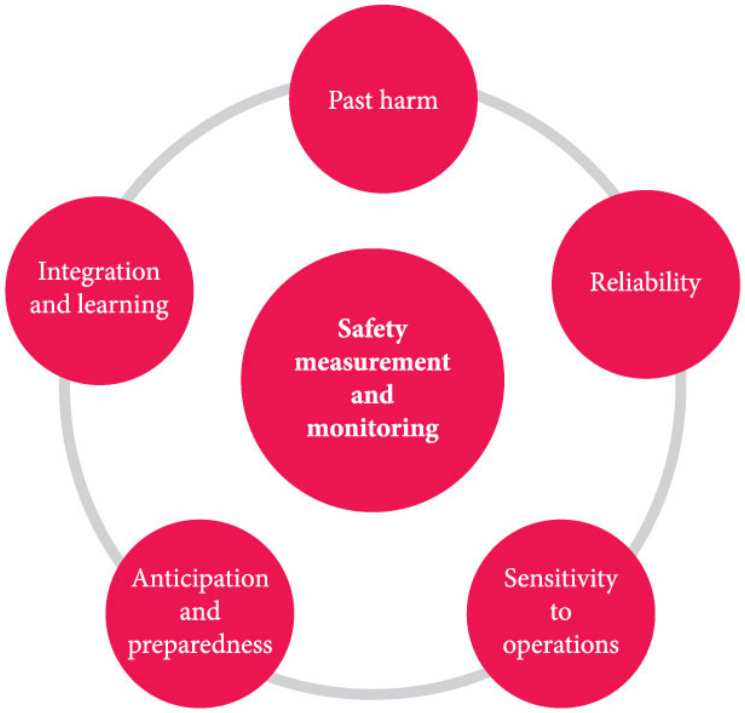
Reports

Quality governance: How does a board know that its organisation is working effectively to improve patient care? Guidance for boards of NHS provider organisations
Monitor. London. Monitor, 2013:47.

Notes	The UK regulator Monitor has produced this brief guidance document primarily for members of boards of NHS organisations to enable them to perform their role in improving health services for patients. This guidance has been developed to support the Quality Governance Framework, and is designed to support NHS foundation trusts in making the Corporate Governance Statement that is now required. Trusts need to assess themselves against the Framework so as to satisfy themselves, patients and Monitor that effective arrangements are in place to continuously monitor and improve the quality of health care provided and that areas highlighted through the process as requiring further work are effectively addressed. However, Monitor is aware that not all NHS foundation trusts realise the amount of work required to achieve this and this guidance document addresses this.
URL	http://www.monitor.gov.uk/sites/default/files/publications/ToPublishQualityGovGuide22April13FINAL.pdf
TRIM	78817

The measurement and monitoring of safety: Drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring
Vincent C, Burnett S, Carthey J
London: The Health Foundation, 2013.

Notes	The UK Health Foundation commissioned Professor Charles Vincent and his colleagues from Imperial College London to bring together evidence from a range of sources (published research, public data, case studies and interviews), both from within healthcare settings and from other safety critical industries. The authors have synthesised this evidence and have proposed a framework that brings together a number of conceptual and technical facets of safety. This framework highlights the following five dimensions, which the authors believe should be included in any safety and monitoring approach in order to give a comprehensive and rounded picture of an organisation's safety: • **Past harm**: this encompasses both psychological and physical measures. • **Reliability**: this is defined as 'failure free operation over time' and applies to measures of behaviour, processes and systems. • **Sensitivity to operations**: the information and capacity to monitor safety on an hourly or daily basis. • **Anticipation and preparedness**: the ability to anticipate, and be prepared for, problems. • **Integration and learning**: the ability to respond to, and improve from, safety information.  The Health Foundation is seeking the thoughts and insights of a wide range of interested parties and have a deadline for responses of 1 July 2013.
URL	http://www.health.org.uk/publications/the-measurement-and-monitoring-of-safety/ http://www.health.org.uk/public/cms/75/76/313/4209/The%20measurement%20and%20monitoring%20of%20safety.pdf?realName=haK11Q.pdf
TRIM	78819

People Power Health: Health for people, by people and with people
Horne M, Khan H, Corrigan P
London. NESTA, 2013:56.

The Business Care for People Powered Health
NESTA
London. NESTA, 2013:46.

Doctor Know: A Knowledge Commons in Health
Loder J, Brunt L, Wyatt JC
London. NESTA, 2013.

Notes	This latest report form the UK charity NESTA, calls for changes to three aspects of Britain's healthcare: **doctor-patient consultations**, **service design and focus**, and **patient pathway design**. The authors argue for a **more patient-centred approach that focuses on long-term outcomes, recovery and prevention**, and is applied in the context of behaviour change, improved wellbeing and social support. The People Powered Health approach advocates: • **Changing consultations** to create purposeful, structured conversations that combine clinical expertise with patient-driven goals of well-being and which connect to interventions that change behaviour and build networks of support. • **Commissioning new services** that provide 'more than medicine' to complement clinical care by supporting long term behaviour change, improving well-being and building social networks of support. Services are co-designed to configure and commission services around patients' needs. • **Co-designing pathways** between patients and professionals to focus on long-term outcomes, recovery and prevention. These pathways include services commissioned from a range of providers including the voluntary and community sector. NESTA has also produced an accompanying paper titled *The Business Case for People Powered Health*. This report follows another NESTA report — *Doctor Know: A Knowledge Commons in Health* — that garnered a degree of interest. It's argument of a more distributed and shared knowledge, a reduction in the information asymmetry of healthcare, can also be seen as a way of increasing patient involvement and making care more patient-centred
URL	http://www.nesta.org.uk/publications/reports/assets/features/health_by_the_people_for_the_people_and_with_the_people *The Business Case for People Powered Health*: http://www.nesta.org.uk/publications/reports/assets/features/the_business_case_for_people_powered_health *Doctor Know: A Knowledge Commons in Health* http://www.nesta.org.uk/publications/assets/features/doctor_know_a_knowledge_commons_in_health
TRIM	78822

For more information on the Commission's work on patient and consumer centred care, see http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Implementing shared decision making. Clinical teams' experiences of implementing shared decision making as part of the MAGIC programme
Health Foundation
London. Health Foundation, 2013.

Notes	This 40-page report from the Health Foundation in the UK compiled improvement narratives developed for the UK's MAGIC (Making good decisions in collaboration) program to help clinical teams embed shared decision-making in daily practice. The narratives explore the experience of implementing shared decision-making in seven different UK settings in both primary care and hospital-based teams. In each clinical setting, participants are working to: • change professional attitudes and practice and the culture of the health service, and to inspire staff to work closely with patients • demonstrate the benefits of shared decision making to health professionals and patients • help teams and patients build the skills they need to do more and better shared decision making consultations • show how clinical teams can use a standard, simple but robust approach to develop their own simple decision aids for use during consultations • explore how shared decision making can fit into the existing health system, overcoming time and resource limitations. The stories explore the participants' experiences of the MAGIC programme, and of implementing shared decision making in practice. Each story explains why the team wanted to take part in the programme, what they did, what improvements they saw as a result, the challenges they encountered, and how they dealt with them. Each ends with a short section on useful tips drawn from the teams' experiences.
URL	http://www.health.org.uk/publications/implementing-shared-decision-making/

Making the case for continuous learning from routinely collected data
Okun S, McGraw D, Strang P, Larson E, Goldmann D, Kupersmith J, et al.
Washington D.C. Institute of Medicine, 2013.

Notes	This short (15 page) discussion paper from the (US) Institute of Medicine argues that to achieve better health, patients and clinicians need to view every health care encounter as an opportunity to improve outcomes. It cites examples of how routinely collected digital health data are already being applied to: • improve disease monitoring and tracking • better target medical services for improved health outcomes and cost savings • help inform both patients and clinicians to improve how they make decisions during clinical visits • avoid harm to patients and unnecessary costs associated with repeat testing and delivery of unsuccessful treatments • and accelerate and improve the use of research in routine medical care to answer medical questions more effectively and efficiently.
URL	http://www.iom.edu/makingthecase http://www.iom.edu/~/media/Files/Perspectives-Files/2013/Discussion-Papers/VSRT-MakingtheCase.pdf

Exploring the Dynamics of Physician Engagement and Leadership for Health System Improvement Prospects for Canadian Healthcare Systems. Final Report
Denis J-L, Baker GR, Black C, Langley A, Lawless B, Leblanc D, et al.
Montréal. École nationale d'administration publique 2013.

Are We There Yet? Models of Medical Leadership and their effectiveness: An Exploratory Study. Final report
Dickinson H, Ham C, Snelling I, Spurgeon P
NIHR Service Delivery and Organisation programme. London. National Institute for Health Research, 2013:230.

Possibilities and Pitfalls for Clinical Leadership in Improving Service Quality, Innovation and Productivity, Final report
Storey J, Holti R
NIHR Service Delivery and Organisation programme. London. National Institute for Health Research, 2013:172.

Notes	A literature review led by Quebec's École nationale d'administration publique (ENAP) that synthesizes knowledge on how to foster physician engagement and leadership to improve organizational and health system performance. Among the authors' findings: a full range of physicians rather than only individual physicians must be targeted to produce meaningful engagement, and it is not enough to simply place physicians in managerial and administrative positions. Other key messages include: • Physician leadership and physician engagement are essential elements of high-performing healthcare systems. Likewise, physician participation in hospital governance can improve quality and safety. • Physician leadership is important at the apex of the organization, but leadership occurs at all levels of the system. Increasing attention is being paid to high-performing clinical microsystems as well as new leadership modalities that are fostering what some refer to as "organized professionalism." • Physician engagement does not happen on its own. Organizations must use diverse strategies and initiatives to strengthen physician engagement and leadership. • A key variable for success in these approaches to physician involvement is trust between physicians and organizations, which can develop around these elements: open communication, willingness to share relevant data, creating a shared vision and accumulating evidence of successful collaboration. • True physician engagement and leadership begins with understanding and addressing the underlying characteristics and values of the engaged physicians. • Organizationally, physician engagement depends on a mosaic of factors and can therefore be difficult to achieve. Physician leaders may experience obstacles in assuming leadership roles in organizations and systems. • Successful strategies to engage physicians need to go beyond, but not ignore, appeals to their economic motives.. The main challenge is to bridge and integrate cultures, not buy commitment. • Developing physicians' skills and competencies to support improvements in health systems means targeting a full range of physicians rather than only individual physicians. Key core competencies for engaging and fostering

	physician leadership include leadership, strategic planning, "systems thinking," change management, project management, persuasive communication and team building. A longer examination of medical leadership (and not just relating to system improvement) in the NHS is provided by the final report produced for the NHS National Institute for Health Research (NIHR). The author's conclude that "it is clear that medical leaders face many challenges and occupy a relatively precarious middle ground between senior managers and their medical colleagues. There are many barriers to involving doctors effectively in leadership roles, and in most organisations a step change is needed to overcome these barriers. This includes increasing the time commitment of medical leaders and the proportion of doctors in formal leadership roles and developing the culture of engagement we found in those trusts that had progressed furthest on this journey." In various ways this report complements a slightly earlier report from the NIHR that looked at clinical leadership, including its role in service quality.
URL	Denis et al http://www.getoss.enap.ca/GETOSS/Publications/Lists/Publications/Attachments/438/Expedited_Synthesis_CIHR_2013-04-10-Final.pdf Dickinson et al http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1808-236_V07.pdf Storey and Holti http://www.netscc.ac.uk/hsdr/projdetails.php?ref=09-1001-22
TRIM	78816

Something to teach, something to learn: global perspectives on healthcare
KMPG International
KPMG International, 2013.

Notes	This KPMG report looks at challenges facing international health systems by drawing on the perspective of leading practitioners across 22 countries who participated in KPMG's 2012 Global Healthcare summit. The report suggests that the next five to ten years will be critical for health systems around the world as they look for strategies to cope with rapidly growing and ageing populations. Despite the differences between the various international systems examined, it reveals a number of striking similarities in the strategies that are beginning to emerge. Five major trends were identified: • "Payers – whether governments, public sector bodies or insurers – are becoming '**activist payers**' by focusing on value, contracting more selectively, reshaping patient behavior and moving care upstream to focus more on prevention. • Providers need to rethink their approach as it is becoming clear that major **transformational change** can no longer be delayed. Some hospitals have the opportunity to transform themselves into 'health systems', providing new forms of much more extensive and integrated care and taking more risk and accountability for outcomes from payers. Others need equally radical approaches to reshape their operating models. • There is an imperative to **engage patients** in new ways so that they become **active partners** in their care, rather than passive recipients. This requires new systems and ways of working – as one physician put it, clinicians need to change their role from 'God to guide'.

	• The rise of the '**high-growth health systems**', from rapidly developing countries in Asia, Africa and South America, is changing global outlooks. Unencumbered by traditional healthcare doctrines, they are innovating fast. It is a global phenomenon offering extensive learning, and opportunities for all. • **Sustainable change** and **better value** are increasingly being seen as a direct result of new approaches to **integration**. A survey of our delegates revealed that 90 percent of payers, providers and professionals believed integration would produce better patient outcomes, while three-quarters were confident that it would cut costs.
URL	http://www.kpmg.com/global/en/issuesandinsights/articlespublications/something-to-teach-something-to-learn/Pages/default.aspx

Journal articles

Safety leadership: A meta-analytic review of transformational and transactional leadership styles as antecedents of safety behaviours
Clarke S
Journal of Occupational and Organizational Psychology 2013;86(1):22-49.

Notes	Another item on leadership, this time a journal article that describes a meta-analytic review of two leadership approaches. The authors report that their "final model showed that transformational leadership had a positive association with both perceived safety climate and safety participation" and that "Active transactional leadership had a positive association with perceived safety climate, safety participation and safety compliance." They argue that their "findings suggest that active transactional leadership is important in ensuring compliance with rules and regulations, whereas transformational leadership is primarily associated with encouraging employee participation in safety" and that "a combination of both transformational (where leaders inspire and motivate subordinates to achieve the goals through their personal development) and transactional (where leaders identify tasks for their subordinates and set clear expectations and goals) styles appeared to be most beneficial for safety."
DOI	http://dx.doi.org/10.1111/j.2044-8325.2012.02064.x

The Relationship between Patients' Perceptions of Team Effectiveness and their Care Experience in the Emergency Department
Kipnis A, Rhodes KV, Burchill CN, Datner E
The Journal of Emergency Medicine 2013 [epub].

Notes	Patient's may be well-placed to make observations on their care and when they make a favourable summation it can contribute to their care. In this case it emerged that those patients who perceived high levels of teamwork among clinicians reported greater satisfaction with their care and were more likely to adhere to the recommended plan of care. For this study 1010 patients at University of Pennsylvania ED in the autumn of 2011 were surveyed.
DOI	http://dx.doi.org/10.1016/j.jemermed.2012.11.052

25-Year summary of US malpractice claims for diagnostic errors 1986–2010: an analysis from the National Practitioner Data Bank
Saber Tehrani AS, Lee H, Mathews SC, Shore A, Makary MA, Pronovost PJ, et al.
BMJ Quality & Safety 2013 [epub].

Cognitive diagnostic error in internal medicine
van den Berge K, Mamede S
European Journal of Internal Medicine 2013 [epub].

Notes	The issue of errors in diagnosis has been gathering interest in recent years. This study offers a longer perspective by using 25 years of data on malpractice claims was undertaken in order to understand the frequency, health outcomes and economic consequences of diagnostic errors by examining closed, paid malpractice claims. The study analysed 350,706 claims from the USA's National Practitioner Data Bank (1986–2010) to determine error type, outcome severity and payments (in 2011 US dollars), when comparing diagnostic errors to other malpractice allegation groups and inpatient to outpatient within diagnostic errors. The authors report that **diagnostic errors** (n=100,249) were the leading type (**28.6%**) and accounted for the highest proportion of total payments (35.2%). The most frequent **outcomes** were **death**, significant **permanent injury**, major permanent injury and minor permanent injury. **Diagnostic errors more often resulted in death than other allegation groups** (40.9% vs 23.9%, p<0.001) and were the leading cause of claims-associated death and disability. More diagnostic error claims were outpatient than inpatient (68.8% vs 31.2%), but inpatient diagnostic errors were more likely to be lethal (48.4% vs 36.9%). The inflation-adjusted, 25-year sum of diagnosis-related payments was US$38.8 billion (mean per-claim payout US$386,849; median US$213,250). These findings led the authors to claims that "Among malpractice claims, **diagnostic errors appear to be the most common, most costly and most dangerous of medical mistakes**. We found roughly equal numbers of lethal and non-lethal errors in our analysis, suggesting that the public health burden of diagnostic errors could be twice that previously estimated." Such a study is likely to attract many questions. Thee may include: Are such data representative? Are they the more extreme end of errors and do they tend to capture those errors that are more clearly attributable to specific individuals? Van den Berge asserts that diagnostic error accounts for a substantial fraction of all medical mistakes and that most **diagnostic errors** have been associated with **flaws in clinical reasoning**. The article reviews recent experimental studies of the relationship between cognitive factors and diagnostic mistakes. The authors consider that these studies "have explored the role of cognitive biases, such as confirmation and availability bias, in diagnostic mistakes. They have suggested that confirmation bias and availability bias may indeed cause diagnostic errors. The latter bias seems to be associated with non-analytical reasoning, and was neutralized by analytical, or reflective, reasoning. Although non-analytical reasoning is a hallmark of clinical expertise, reflective reasoning was shown to improve diagnoses when cases are complex."
DOI	http://dx.doi.org/10.1136/bmjqs-2012-001550 van den Berge and Mamede http://dx.doi.org/10.1016/j.ejim.2013.03.006

Relationship between occurrence of surgical complications and hospital finances
Eappen S, Lane BH, Rosenberg B, Lipsitz SA, Sadoff D, Matheson D, et al.
Journal of the American Medical Association 2013;309(15):1599-1606.

Economic Measurement of Medical Errors Using a Hospital Claims Database
David G, Gunnarsson CL, Waters HC, Horblyuk R, Kaplan HS.
Value in health : the journal of the International Society for Pharmacoeconomics and Outcomes Research 2013;16(2):305-310.

Notes	Eappen et al. offer a paper that offers some confirmation of the claims that current funding models can provide a perverse (financial) incentive. In this case showing that in the US hospitals can financially benefit from sub-optimal care. The study's authors sought to determine the relationship between major surgical complications and per-encounter hospital costs and revenues by payer type by undertaking a retrospective analysis of administrative data for all inpatient surgical discharges during 2010 from a non-profit 12-hospital system in the southern United States. Of 34 256 surgical discharges, 1820 patients (5.3%) experienced 1 or more postsurgical complications. Compared with absence of complications, complications were associated with a mean $39 017 higher contribution margin per patient with private insurance ($55 953 vs $16 936) and a mean $1749 higher contribution margin per patient with US Medicare ($3629 vs $1880). Conversely , David et al present an actuarial study that suggests errors cost (US) hospitals money. In this paper they argue that there were an estimated 161,655 medical errors in 2008 and 170,201 medical errors in 2009 in their dataset and that extrapolated to the entire US population, there were more than 4 million unique injury visits containing more than 1 million unique medical errors each year. This analysis estimated that the total annual cost of measurable medical errors in the United States was $985 million in 2008 and just over $1 billion in 2009. The median cost per error to hospitals was $892 for 2008 and rose to $939 in 2009. The authors concluded that "Medical errors directly impact patient outcomes and hospitals' profitability, especially since 2008 when [US] Medicare stopped reimbursing [US] hospitals for care related to certain preventable medical errors."
DOI	Eappen et al. http://dx.doi.org/10.1001/jama.2013.2773 David et al. http://dx.doi.org/10.1016/j.jval.2012.11.010

On higher ground: ethical reasoning and its relationship with error disclosure
Cole AP, Block L, Wu AW
BMJ Quality & Safety 2013.

Notes	Transparency and candour are often cited when it comes to positive safety cultures and as key elements of open disclosure of events. This study – from a relatively small survey of house officers in internal medicine at Johns Hopkins Hospital. – suggests that training in ethical reasoning can be a useful support in engendering a culture in which disclosure can occur more readily.
DOI	http://dx.doi.org/10.1136/bmjqs-2012-001496

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

Reported medication errors after introducing an electronic medication management system
Redley B, Botti M
Journal of Clinical Nursing 2013;22(3-4):579-589.

Notes	Paper reporting on the impact of an electronic medication management system in two sites of a Melbourne not-for-profit hospital by conducting a retrospective analysis of 359 incident reports from 1 May 2005–30 April 2006.. Site A used a conventional pen and paper system for medication management, and Site B had introduced a computerised medication management system. The authors report that most **medication errors occurred** at the **nurse administration** (71·5%) and **prescribing** (16·4%) stages of delivery. The most common medication error type reported at Site A was omission (33%), and at Site B was wrong documentation (24·2%). A higher proportion of errors at the prescribing phase, and less nurse administration errors, were detected at Site B where the medication management system was in use. The incidence of other, less frequent errors was similar across the two hospital sites. The authors suggest that there are differences in the types of medication errors that are reported in association with the introduction of electronic medication management system.
DOI	http://dx.doi.org/10.1111/j.1365-2702.2012.04326.x

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

An organizational assessment of disruptive clinician behavior: findings and implications
Walrath JM, Dang D, Nyberg D
Journal of Nursing Care Quality 2013;28(2):110-121.

Notes	This article reports on a survey conducted in a large US academic medical centre that investigated registered nurses' (RNs) and physicians' (MD) experiences with disruptive behaviour, triggers, responses, and impacts on clinicians, patients, and the organization. The authors report that RNs experienced a significantly higher frequency of disruptive behaviours and triggers than MDs. The most frequently occurring trigger was "pressure from high census, volume, and patient flow". There were 189 incidences of harm to patients as a result of disruptive behaviour reported.
DOI	http://dx.doi.org/10.1097/NCQ.0b013e318270d2ba

Surgical safety checklist: implementation in an ambulatory surgical facility
Morgan P, Cunningham L, Mitra S, Wong N, Wu W, Noguera V, et al.
Canadian Journal of Anesthesia/Journal canadien d'anesthésie 2013:1-11.

Notes	The literature on the value of checklists has been developing for sometime. This paper is something of a contradiction to much of that as it reports on an unsuccessful attempt at instituting the World Health Organization's surgical safety checklist in an ambulatory surgery setting. The authors suggest that this may be due to staff perceptions that the checklist was overly long and had been imposed without a clear rationale. This example may again put out the need to understand the local context prior and as part of an intervention.
DOI	http://dx.doi.org/10.1007/s12630-013-9916-8

A Framework for Patient Safety: A Defense Nuclear Industry Based High-Reliability Model
Birnbach DJ, Rosen LF, Williams L, Fitzpatrick M, Lubarsky DA, Menna JD.
Joint Commission Journal on Quality and Patient Safety;39(5):233-240.

Notes	It is not that uncommon for healthcare to be encouraged to borrow concepts from other industries. In the areas of safety and quality this tends to be from 'high reliability industries' such as airlines and nuclear power generation. This most recent comes via the (US) Joint Commission journal and describes how a seven-point high reliability framework used by the United States Department of Energy can be applied to health care delivery. The seven principles are: **1. Leadership Commitment Is Essential for Creating a Culture of Safety** **2. Everyone Is Responsible for Safety** **3. Empower Governing Bodies to Create and Enforce Safety Policies** **4. Eliminate Preventable Harm** **5. Establish a Universal, Uniform Approach for Safety Management** **6. Mandate Reporting of Safety Issues, Errors, and Near Misses** 7. **Cultivate Learning as Part of the Organizational Mentality.**
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2013/00000039/00000005/art00006

BMJ Quality and Safety
May 2013, Vol 22, Issue 5

Notes	A new issue of *BMJ Quality and Safety* has been published and is a special issue on **teamwork**. 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: • Building **high reliability teams**: progress and some reflections on teamwork training (Eduardo Salas, Michael A Rosen) • Building collaborative **teams in neonatal intensive care** (Dara Brodsky, Munish Gupta, Mary Quinn, Jane Smallcomb, Wenyang Mao, Nina Koyama, Virginia May, Karen Waldo, Susan Young, DeWayne M Pursley) • 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) • A theory-driven, longitudinal evaluation of the impact of **team training on safety culture** in 24 hospitals (Katherine J Jones, Anne M Skinner, Robin High, Roni Reiter-Palmon) • High performance **teamwork training** and systems redesign in outpatient **oncology** (CA Bunnell, A H Gross, S N Weingart, M J Kalfin, A Partridge, S Lane, H J Burstein, B Fine, N A Hilton, C Sullivan, E E Hagemeister, A E Kelly, L Colicchio, A H Szabatura, E P Winer, M Salisbury, S Mann) • Interprofessional **education in team communication**: working together to improve patient safety (Douglas Brock, Erin Abu-Rish, C Chiu, D Hammer, S Wilson, L Vorvick, K Blondon, D Schaad, D Liner, B Zierler) • Building a **culture of safety** through team training and engagement (Lily Thomas, Catherine Galla) • Going DEEP: **guidelines for building simulation-based team assessments** (James A Grand, Marina Pearce, Tara A Rench, Georgia T Chao, Rosemarie Fernandez, Steve W J Kozlowski)
URL	http://qualitysafety.bmj.com/content/vol22/issue5/

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Patterns in the recording of vital signs and early warning scores: compliance with a **clinical escalation** protocol (Chris Hands, Eleanor Reid, Paul Meredith, Gary B Smith, D R Prytherch, P E Schmidt, P I Featherstone) • Speaking the same language? International variations in the **safety information** accompanying top-selling **prescription drugs** (Aaron S Kesselheim, Jessica M Franklin, Jerry Avorn, Jon D Duke) • **Labelling of diathermy consoles** when multiple systems are used: should this be part of the WHO checklist? (Nadine Hachach-Haram, Samer Saour, Reza Alamouti, Joannis Constantinides, Pari-Naz Mohanna)
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: • Approaches for improving continuity of care in **medication management**: a systematic review (Anne Spinewine, Coraline Claeys, Veerle Foulon, and Pierre Chevalier) • Using clinical indicators to facilitate quality improvement via the **accreditation** process: an adaptive study into the control relationship (Sheuwen Chuang, Peter P. Howley, and Stephen Hancock)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

[UK} What to expect from your doctor: a guide for patients
http://www.gmc-uk.org/static/documents/content/What_to_expect_from_your_doctor_-_a_guide_for_patients_-_English_0413.pdf
This guide from the UK General Medical Council explains how patients can help to create a partnership with their doctor. It is based on the standards the General Medical Council sets for doctors. The guide states that:
Doctors must:

- **provide good care**
- **put patients' safety first and make sure that the care they provide is safe and effective**
- **treat patients as individuals**
- **be honest and trustworthy.**
