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On the Radar
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Reports

The Listening Organisation: Ensuring care is person-centred in NHS Wales. Improving Healthcare White Paper Series – No.11
Williams A
Cardiff. 1000 Lives Plus, 2013:24.

Notes	This new white paper from 1000 Lives Plus explains how **listening to patients and understanding what it feels like to experience care is** a **key** way for NHS Wales can improve its services. The Welsh Government"s Framework for Assuring Service User Experience identified three domains of patient experience: 1. First and lasting impressions, including dignity and respect. 2. Receiving care in a safe, supportive, healing environment. 3. Understanding of and involvement in care. The white paper uses these domains as a basis for exploring how Boards, senior managers, and all those working in NHS Wales can practically gather information from patients and use those insights to inform service planning and delivery and report back to their citizens.
URL	http://www.1000livesplus.wales.nhs.uk/news/27557

Changing care, improving quality: Reframing the debate on reconfiguration
The Academy of Medical Royal Colleges, The NHS Confederation, and National Voices
London. NHS Confederation, 2013:44.

Notes	Extracted from the Executive Summary: "One of the greatest challenges facing the health service today is the need to redesign services to meet the needs of patients, improve the quality of care and achieve better value for society. There is growing support among patient groups, clinicians and managers for the potential benefits of 'reconfiguration' in health services, which focuses on making large-scale changes to provide care in the right place at the right time. The Academy of Medical Royal Colleges, the NHS Confederation and National Voices have come together to examine the case for radical, far-reaching change across the NHS. This report outlines what we learned … and aims to support those engaged locally in making a decision on whether to reconfigure services and, if so, how to make change happen. We have identified **six key principles** to consider as a foundation for most reconfiguration plans: **1. Healthcare is constantly changing** **2. There are significant benefits to delivering new models of care** **3. 'Reconfiguration' is a catch-all term** **4. Patients can co-produce better services** **5. A 'whole-system' approach is essential** **6. Change requires consistency of leadership**." The report provides further detail on these principles and examples. Recommendations for **local leaders** include: **1. Co-produce any change with patients** **2. Create a clinically-driven case for change, to motivate clinical leaders** **3. Make the case for value** **4. Provide a forum to consider access** **5. Develop plans openly with staff.** Recommendations for **national leaders** include: **1. Provide more slack for change** **2. Communicate a national vision on community services** **3. Be clear about the rules of engagement for crisis-driven change** **4. Let change be driven locally and regionally** **5. Establish a political consensus.**
URL	http://www.nhsconfed.org/Publications/Documents/Changing-care-improving-quality.pdf

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/

Journal articles

Handoff checklists improve the reliability of patient handoffs in the operating room and postanesthesia care unit
Boat AC, Spaeth JP
Pediatric Anesthesia 2013;23(7):647-654.

Development of a checklist for documenting team and collaborative behaviors during multidisciplinary bedside rounds
Henneman EA, Kleppel R, Hinchey KT
J Nurs Adm 2013;43(5):280-285.

Notes	A pair of articles adding to the literature on checklists, in slightly different hospital settings. These articles discuss the development and use of checklists in the operating room and post-anaesthesia care unit and in documenting team and collaborative behaviours during rounds. Boat and Spaeth report on how a need for a mechanism to support and improve handover/handoffs in perioperative and post-anaesthesia care was recognised (particularly due to the large number of handovers that can occur in a short period in these settings). The project saw two quality improvement teams examining intraoperative and post-anaesthesia handover. Key driver diagrams and 'smart aims' were developed for each process based on feedback from anaesthesia and nursing staff, and checklists were developed and revised using multiple plan-do-study-act cycles. Data on the reliability of the handoff processes were obtained at baseline and over the 6-month project period. The authors report that the **reliability** of intraoperative anaesthesia handovers **improved from 20% to 100%** with use of the intraoperative handover checklist. PACU handover reliability improved from 59% to greater than 90%. The authors note that that "**Acceptance of and adherence to** the standardized handoff **protocols** dramatically **increased the quality and reliability** of our handoff process." Henneman and colleagues also report on their experience in developing and refining a reliable and valid checklist tool for documenting team and collaborative behaviours during multidisciplinary bedside rounds. This was undertaken as while teamwork and collaboration are considered key elements of quality care, they lacked an **objective means of evaluating the occurrence of team and collaborative behaviours during rounds**. The authors encourage others to use and/or modify this checklist for use in their setting.
DOI	Boat & Spaeth http://dx.doi.org/10.1111/pan.12199 Henneman et al http://dx.doi.org/10.1097/NNA.0b013e31828eebfb

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

Quality improvement through implementation of discharge order reconciliation
Lu Y, Clifford P, Bjorneby A, Thompson B, VanNorman S, Won K, et al
American Journal of Health-System Pharmacy 2013;70(9):815-820.

Notes	Reconciliation of medications on admission and discharge is considered good practice in reducing medication errors and potential for harm. This article looks at reconciliation at the point of discharge by reporting how a US medical centre undertook a two-phase quality-improvement project.. Phase one entailed "a three-month failure modes and effects analysis of existing procedures discharge, followed by the development and pilot testing of a multidisciplinary, closed-loop workflow process involving staff and resident physicians, clinical nurse coordinators, and clinical pharmacists. During pilot testing of the new workflow process, the rate of discharge medication errors involving skilled-nursing facilities(SNF) patients was tracked, and data on medication-related readmissions in a designated intervention group (n = 87) and a control group of patients (n = 1893) discharged to SNFs via standard procedures during a nine-month period were collected, with the data stratified using severity of illness (SOI) classification. Analysis of the collected data indicated a cumulative 30-day medication-related readmission rate for study group patients in the minor, moderate, and major SOI categories of 5.4% (4 of 74 patients), compared with a rate of 9.5% (169 of 1780 patients) in the control group. In phase 2 of the project, the revised SNF discharge medication reconciliation procedure was implemented throughout the hospital; since hospitalwide implementation of the new workflow, the readmission rate for SNF patients has been maintained at about 6.7%." The authors conclude "**Implementing** a standardized **discharge order reconciliation** process that includes pharmacists led to **decreased readmission rates** and improved care for patients discharged to SNFs."
DOI	http://dx.doi.org/10.2146/ajhp120050

The safety of electronic prescribing: manifestations, mechanisms, and rates of system-related errors associated with two commercial systems in hospitals
Westbrook JI, Baysari MT, Li L, Burke R, Richardson KL, Day RO
Journal of the American Medical Informatics Association 2013 [epub].

Notes	As computerised prescribing systems have become more widespread there has been some concern that such systems may be a source of new medication errors. This study reports on the experience in two Sydney hospitals by auditing 629 inpatient admissions where two different electronic prescribing systems. The study analysed and categorised errors but found that both **systems prevented significantly more errors than they generated**. Systems-related errors were found to be frequent, comprising 42% of all prescribing errors, although only 2.2% were serious errors. The authors conclude that "System-related errors are frequent, yet few are detected. [electronic prescribing systems] require new tasks of prescribers, creating additional cognitive load and error opportunities. Dual classification, by manifestation and mechanism, allowed identification of design features which increase risk and potential solutions. [Electronic prescribing systems] designs with fewer drop-down menu selections may reduce error risk."
DOI	http://dx.doi.org/10.1136/amiajnl-2013-001745

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

PCA Safety Data Review After Clinical Decision Support and Smart Pump Technology Implementation
Prewitt J, Schneider S, Horvath M, Hammond J, Jackson J, Ginsberg B.
Journal of Patient Safety 2013;9(2):103-109.

Notes	Technologies and devices can greatly enhance care. They can, however, also bring their own risks and concerns. Pumps of various kinds have been identified as such an area of concern. In an effort to decrease medication errors, Duke University Hospital implemented clinical decision support via computer provider order entry (CPOE) and "smart pump" technology with the goal to decrease patient-controlled analgesia (PCA) adverse events. This paper report on the project that evaluated PCA safety events, reviewing voluntary report system and adverse drug events via surveillance (ADE-S), on intermediate and step-down units pre-implementation and post-implementation of clinical decision support via CPOE and PCA smart pumps for the prescribing and administration of opioids therapy in the adult patient requiring analgesia for acute pain. The paper details various **reductions in rates** and the authors argued that a decrease in PCA events between time periods in both the ADE-S and voluntary report system data was demonstrated, and this supports the **recommendation of clinical decision support** via CPOE **and PCA smart pump technology**.
DOI	http://dx.doi.org/10.1097/PTS.0b013e318281b866

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Involvement of **patients with cancer in patient safety**: a qualitative study of current practices, potentials and barriers (Helle Max Martin, Laura Emdal Navne, Henriette Lipczak) • Educational agenda for **diagnostic error** reduction (Robert L Trowbridge, Gurpreet Dhaliwal, Karen S Cosby) • Implementing an interprofessional **patient safety learning** initiative: insights from participants, project leads and steering committee members (Lianne Jeffs, Ilona Alex Abramovich, Chris Hayes, Orla Smith, Deborah Tregunno, Wai-Hin Chan, Scott Reeves) • Narrative review: The incidence of **diagnostic error** in medicine (Mark L Graber)
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: • **Innovation spread**: lessons from HIV (Kristina Talbert-Slagle, David Berg, and Elizabeth H. Bradley) • **Missed medication doses** in hospitalised patients: a descriptive account of quality improvement measures and time series analysis (Jamie J. Coleman, James Hodson, Hannah L. Brooks, and David Rosser)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

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