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On the Radar

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On the Radar
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Reports

Making the Case for Information: The evidence for investing in high quality health information for patients and the public
Patient Information Forum
London. Patient Information Forum, 2013:83.

Notes	The UK Patient Information Forum (PiF) has published a research report that highlights how providing **information to patients and their carers improves outcomes, reduces costs and gives people a better experience of care**. From the PiF website: "PiF commissioned research to identify the benefits of investing in health information. The project, which looked at over 300 studies, found that there are good business reasons to justify the investment of more time, money and training in health information provision and support. These include positive impacts on service use and costs, substantial capacity savings, and significant returns on investment by increasing shared decision-making, self-care and the self-management of long-term conditions." The report is available, along with an executive summary and three separate 2-page summaries for specific audiences (Health professionals, Health Information Specialists, and Policy makers and Commissioners).
URL	http://www.pifonline.org.uk/the-case-for-information-investment-in-patient-information-improves-outcomes-and-reduces-costs/
TRIM	81872

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

The incidence of diagnostic error in medicine
Graber ML
BMJ Quality & Safety 2013 [epub].

Notes	In this narrative review, Mark Graber describes how it is estimated that **diagnoses may be wrong as much as 10–15% of the time**. Diagnostic error is gathering increasing attention but apparently the lack of a measure of diagnostic errors is hampering research and activity to address this issue. Graber reviews the various existing methods of estimating diagnostic errors in this piece and nominates three approaches that he considers most promising: "(1) using 'trigger tools' to identify from electronic health records cases at high risk for diagnostic error; (2) using standardised patients (secret shoppers) to study the rate of error in practice; (3) encouraging both patients and physicians to voluntarily report errors they encounter, and facilitating this process."
DOI	http://dx.doi.org/10.1136/bmjqs-2012-001615

Nurses' workarounds in acute healthcare settings: a scoping review
Debono DS, Greenfield D, Travaglia JF, Long JC, Black D, Johnson J, et al.
BMC Health Services Research 2013;13:175.

Notes	Workarounds are something many of us create and use. Sometimes they can improve efficiency, sometimes they can have unforeseen consequences. This paper describes a scoping review undertaken on the topic of nurses' workarounds and sought to assess the "peer reviewed empirical evidence available on the use, proliferation, conceptualisation, rationalisation and perceived impact of nurses' use of workarounds in acute care settings." The authors note that "Behaviours fitting the definition of workarounds often include violations, deviations, problem solving, improvisations, procedural failures and shortcuts." The review covered 58 studies, mostly published since 2008 and mostly conducted in the USA, and found that workarounds can be used individual or by groups and that organisational, work process, patient-related, individual, social and professional factors contribute to the proliferation of workarounds. The review also found that group norms, local and organisational culture, 'being competent', and collegiality influence the implementation of workarounds.
DOI	http://dx.doi.org/10.1186/1472-6963-13-175

BMJ Quality and Safety
July 2013, Vol 22, Issue 7

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: **Physicians with multiple patient complaints**: ending our silence (Thomas H Gallagher, Wendy Levinson) • Editorial: Not so random: **patient complaints** and 'frequent flier' doctors (Ron Paterson) • Editorial: **'Bad apples'**: time to redefine as a type of systems problem? (Kaveh G Shojania, Mary Dixon-Woods) • Identification of **doctors at risk of recurrent complaints**: a national study of healthcare complaints in Australia (Marie M Bismark, Matthew J Spittal, Lyle C Gurrin, Michael Ward, David M Studdert) • TeamGAINS: a tool for structured debriefings for **simulation-based team trainings** (Michaela Kolbe, Mona Weiss, Gudela Grote, Axel Knauth, Micha Dambach, Donat R Spahn, Bastian Grande) • Developing a **patient measure of safety** (PMOS) (Sally J Giles, Rebecca J Lawton, Ikhlaq Din, Rosemary R C McEachan) • **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) • Assessment of the **global trigger tool** to measure, monitor and evaluate patient safety in cancer patients: reliability concerns are raised (Thea Otto Mattsson, Janne Lehmann Knudsen, Jens Lauritsen, K Brixen, J Herrstedt) • On higher ground: ethical reasoning and its relationship with **error disclosure** (Alexander Putnam Cole, Lauren Block, Albert W Wu) • 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) • Co-ACT—a framework for **observing coordination behaviour** in acute care teams (Michaela Kolbe, Michael Josef Burtscher, Tanja Manser) • PostScript: To what extent are **inpatient deaths preventable**? (Robert Nash, James Quinn) • To what extent are **inpatient deaths preventable**? The author's reply (Helen Hogan, Frances Healey, Graham Neale, Richard Thomson, Charles Vincent, Nick Black)
URL	http://qualitysafety.bmj.com/content/vol22/issue7/

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, Laura G Militello, Jason J Saleem, Robert L Wears)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[UK] Care Quality Commission consultation
Consultation on changes to the way we inspect, regulate and monitor care services
http://www.cqc.org.uk/public/sharing-your-experience/consultations/consultation-changes-way-we-inspect-regulate-and-monito
The UK's Care Quality Commission is undertaking a consultation on a new way of assessing hospital quality and safety. This is part of the UK government's response to recommendations in the public inquiry report into failings at the Mid Staffordshire NHS Foundation Trust.
The CQC seeks feedback on the plans to:

- inspect all care services, NHS trusts and foundation trusts and independent acute hospitals
- develop clear standards of care that health and social care services must meet
- make better use of information and evidence we receive to decide when, where and what to expect
- introduce Chief Inspectors to lead national teams of expert inspectors which will include people who receive care, clinical experts and others
- develop a ratings system to help people choose between services and to encourage services to make improvements
- make sure that directors or leaders of organisations have made legal commitments to provide safe and high-quality care, and are personally held to account for it.

A Consultation document, *Consultation: A new start*, has been developed and is available from the website, along with further information.

[USA] Pressure Ulcer Risk Assessment and Prevention: Comparative Effectiveness
http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displaytopic&topicid=309
The US Agency for the Healthcare Research and Quality (AHRQ) has published this report that sought to review the comparative clinical utility and diagnostic accuracy of risk-assessment instruments for evaluating risk of pressure ulcers and to evaluate the benefits and harms of preventive interventions for pressure ulcers in different settings and patient populations.
This report focuses on the comparative effectiveness of various pressure ulcer risk-assessment and prevention approaches; the treatment of pressure ulcers is addressed in a separate review (available at http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1491

[USA] Barriers to patient safety still exist
http://www.healthcarefinancenews.com/news/barriers-patient-safety-still-exist?topic=05,19
Media report on a study commissioned American International Group (AIG), an international insurance company, that reported significant barriers to patient safety still exist in healthcare.
The study surveyed 250 hospital administrators and 100 risk managers in hospitals across the USA/
A majority of respondents said the **largest barrier to patient safety is lack of teamwork, negative culture and poor communication** (42 percent C-suite; 55 percent risk managers).

[USA] The Worst Time to Have Surgery: By the month, day, and hour
http://www.theatlantic.com/magazine/archive/2013/07/the-worst-time-to-have-surgery/309393/
The US magazine/website *The Atlantic* has this story compiling various studies into how time can apparently influence one's care. Perhaps not quite a systematic review though!

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