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On the Radar

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On the Radar
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Reports

A promise to learn – a commitment to act: Improving the Safety of Patients in England
National Advisory Group on the Safety of Patients in England
London. Department of Health, 2013:46.

Notes	The UK government commissioned the renowned Don Berwick to report on how the NHS could be safer for patients following the Francis Report into the failing in Mid-Staffordshire. The key findings in this report include: • The **quality of patient care**, especially **patient safety**, should be **paramount** • **Patients and carers must be empowered, engaged and heard** • **Staff should be supported** to develop themselves and improve what they do • There should be **complete transparency of data** to improve care. Berwick's recommendations include: • The NHS needs to adopt a **culture of learning** • **Staffing levels must be adequate**, based on evidence

	• **Complaints systems** need to be **continuously reviewed** and improved • **Transparency** must be complete, timely and unequivocal • **Supervisory and regulatory systems should be clear** • New **criminal offences** should be created around recklessness or wilful neglect or mistreatment by organisations or individuals and for healthcare organisations which withhold or obstruct relevant information.
URL	https://www.gov.uk/government/publications/berwick-review-into-patient-safety Video of Don Berwick discussing the report is available at http://www.kingsfund.org.uk/audio-video/don-berwick-improving-safety-patients-england
TRIM	85039

Journal articles

Root Cause Analysis Reports Help Identify Common Factors In Delayed Diagnosis And Treatment Of Outpatients
Davis Giardina T, King BJ, Ignaczak AP, Paull DE, Hoeksema L, Mills PD, et al
Health Affairs 2013;32(8):1368-1375.

Notes	This papers reports on how root cause analysis (RCA) was applied to investigate the factors that contribute to delays for outpatients that might result in patient harm. The study examined 111 RCA reports that investigated such delays and were submitted to the Veterans Affairs National Center for Patient Safety in 2005–2012. The study found that "the most common contributing factors included co-ordination problems resulting from inadequate follow-up planning, delayed scheduling for unspecified reasons, inadequate tracking of test results, and the absence of a system to track patients in need of short-term follow-up. Other contributing factors were team-level decision-making problems resulting from miscommunication of urgency between providers and providers' lack of awareness of or knowledge about a patient's situation; and communication failures among providers, patients, and other health care team members." The authors suggest there is a need for "more rigorous interprofessional **teamwork principles to improve outpatient communication and coordination**."
DOI	http://dx.doi.org/10.1377/hlthaff.2013.0130

Surgical checklists: a systematic review of impacts and implementation
Treadwell JR, Lucas S, Tsou AY
BMJ Quality & Safety 2013 [epub].

Notes	Checklists have been a major trend in recent years. This paper provides a systematic review of surgical checklists focusing on experiences with checklist use and their efficacy for improving patient safety. The authors found 33 studies and a variety of outcomes reported including avoidance of adverse events, facilitators and barriers to implementation. They also note that "Checklists have been adopted in a wide variety of settings and represent a promising strategy for improving the culture of patient safety and perioperative care in a wide variety of settings". **Surgical checklists** were associated with **increased detection of potential safety hazards**, **decreased surgical complications** and **improved communication** among OR staff.

	Strategies for **successful checklist implementation** included "enlisting institutional leaders as **local champions**, incorporating **staff feedback** for checklist adaptation and **avoiding redundancies** with existing systems for collecting information." However, it seems that they is remains a lack of studies to as yet "evaluate to what degree checklists improve clinical outcomes and whether improvements may be more pronounced in particular settings".
DOI	http://dx.doi.org/10.1136/bmjqs-2012-001797

Prescribing errors on admission to hospital and their potential impact: a mixed-methods study
Basey AJ, Krska J, Kennedy TD, Mackridge AJ
BMJ Quality & Safety 2013 [epub].

Notes	This UK study examined how doctors obtain the information necessary to prescribe on admission to hospital, and the number and potential impact of any errors. Nineteen doctors were observed undertaking the patient admission process in four separate week-long periods .The study found discrepancies between perceived practice stated in interviews and actual practice observed. These included using a single source of information, non-confirmation of medications with patients, and so on. Of. 688 medication charts reviewed, 318 (46.2%) had errors. A total of 851 errors were identified; 737/851 (86.6%) involved omission of a medicine; 94/737 (12.8%) of these were potentially significant. The authors remark that "Although **doctors know the importance of obtaining an accurate medication history** and checking prescriptions with patients, **they often fail** to put this into practice, resulting in prescribing errors."
DOI	http://dx.doi.org/10.1136/bmjqs-2013-001978

The Commission has just released a video training tool that guides clinicians on how to obtain an accurate and complete Best Possible Medication History.
Get it right! Taking a Best Possible Medication History can be accessed via the Commission's YouTube channel http://www.youtube.com/watch?v=dc5jFuba6CI
For more information on the Commission's work on medication safety, including medication reconciliation, see http://www.safetyandquality.gov.au/our-work/medication-safety/

Australian Journal of Primary Health
Vol. 19, No. 3

Notes	A new issue of the *Australian Journal of Primary Health* has been published. Articles in this issue include: • The **Teamwork Study**: enhancing the role of non-GP staff in chronic disease management in general practice (D. A. Black, J. Taggart, U. W. Jayasinghe, J. Proudfoot, P. Crookes, J. Beilby, G. Powell-Davis, L. A. Wilson, M. F. Harris and the Teamwork Research Team) • **Multidisciplinary collaboration** in primary care: through the eyes of patients (Lynn H. Cheong, Carol L. Armour and S Z. Bosnic-Anticevich) • **Activating patients** with chronic disease for self-management: comparison of self-managing patients with those managing by frequent readmissions to hospital (Sue E. Kirby, Sarah M. Dennis, Pat Bazeley and Mark F. Harris) • The state of **risk prevention** in a sample of Australian hospitals, medical centres and allied health services (Deon V. Canyon)
URL	http://www.publish.csiro.au/nid/261.htm

Health Affairs
August 2013; Volume 32, Issue 8

Notes	A new issue of *Health Affairs* has been published. Articles in this issue include: • **Electronic Communication Improves Access**, But Barriers To Its Widespread Adoption Remain (Tara F Bishop, Matthew J Press, Jayme L Mendelsohn, and Lawrence P Casalino) • Physician Office Practice: Independent Practice Associations And Physician-Hospital Organizations Can **Improve Care Management For Smaller Practices** (Lawrence P Casalino, Frances M Wu, Andrew M Ryan, Kennon Copeland, D R Rittenhouse, PP Ramsay, and S M Shortell) • Physician Office Practice: High Physician Concern About **Malpractice Risk** Predicts More **Aggressive Diagnostic Testing** In Office-Based Practice (Emily R Carrier, J D Reschovsky, D A Katz, and M M Mello) • Hospitals & Vulnerable Populations: **Transitional Care Cut Hospital Readmissions** For North Carolina Medicaid Patients With Complex Chronic Conditions (Carlos T Jackson, Troy K Trygstad, Darren A DeWalt, and C Annette DuBard • Measuring Quality: **Provider Performance Measures** In Private And Public Programs: Achieving Meaningful Alignment With Flexibility To Innovate (Aparna Higgins, German Veselovskiy, and Lauren McKown)
URL	http://content.healthaffairs.org/content/32/8.toc?etoc

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Editorial: Redefining the clinical gaze (Peter Lachman) • **Hospital performance** based on treatment delays: comparison of ranking methods (Henri Leleu, Frédéric Capuano, Gérard Nitenberg, Lydie Travental, Etienne Minvielle) • The incidence of **diagnostic error** in medicine (Mark L Graber) • The patient is in: patient involvement strategies for **diagnostic error** mitigation (Kathryn M McDonald, Cindy L Bryce, Mark L Graber) • Educational agenda for **diagnostic error reduction** (Robert L Trowbridge, Gurpreet Dhaliwal, Karen S Cosby) • Use of health information technology to reduce **diagnostic errors** (Robert El-Kareh, Omar Hasan, Gordon D Schiff) • The pursuit of **better diagnostic performance**: a human factors perspective (Kerm Henriksen, Jeff Brady) • **Cognitive debiasing** 1: origins of bias and theory of debiasing (Pat Croskerry, Geeta Singhal, Sílvia Mamede)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

Notes	The *International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Benchmarking French regions according to their prevalence of **healthcare-associated infections** (Y T Chen, M Rabilloud, J M Thiolet, B Coignard, and M H Metzger) • Impact evaluation of a quality improvement intervention on **maternal and child health** outcomes in Northern Ghana: early assessment of a national

	scale-up project (Kavita Singh, Ilene Speizer, Sudhanshu Handa, Richard O. Boadu, Solomon Atinbire, Pierre M. Barker, and Nana A.Y. Twum-Danso) • What is known about **adverse events** in older medical hospital inpatients? A systematic review of the literature (Susannah Jane Long, Katrina Fiona Brown, Diane Ames, and Charles Vincent)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

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