AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

Issue 142
2 September 2013

On the Radar is a summary of some of the recent publications in the areas of safety and quality in health care. Inclusion in this document is not an endorsement or recommendation of any publication or provider.

Access to particular documents may depend on whether they are Open Access or not, and/or your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

On the Radar is available online, via email or as a PDF document from
http://www.safetyandquality.gov.au/publications-resources/on-the-radar/

If you would like to receive *On the Radar* via email, you can subscribe on our website http://www.safetyandquality.gov.au/ or by emailing us at mail@safetyandquality.gov.au.
You can also send feedback and comments to mail@safetyandquality.gov.au.

For information about the Commission and its programs and publications, please visit
http://www.safetyandquality.gov.au
You can also follow us on Twitter @ACSQHC.

On the Radar
Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

Journal articles

Progress in Patient Safety: A Glass Fuller Than It Seems
Pronovost PJ, Wachter RM
American Journal of Medical Quality 2013 [epub].

Notes	At times, reading the safety and quality literature can make one wonder if we are making as much progress as we should or would like? So it is useful to be reminded at times that there has been progress, in some areas substantial progress, and our efforts are not in vain. This commentary piece by two of the leaders in patient safety, Peter Pronovost and Robert Wachter, to be published in the *American Journal of Medical Quality* reminds us of some of the progress we have seen. They go on to discuss the utility of the Global Trigger Tool and the importance of measurement.
DOI	http://dx.doi.org/10.1177/1062860613495554

The Effect of an Organizational Network for Patient Safety on Safety Event Reporting
Jeffs L, Hayes C, Smith O, Mamdani M, Nisenbaum R, Bell CM, et al
Evaluation & the Health Professions 2013 [epub].

Notes	One of the steps an organisation can take in developing a better understanding of what is occurring is to try and develop a more open reporting culture. This paper reports on the experiences of an organisation that implemented an organization-wide patient safety network approach, with particular focus (in this paper) on the impact on patient safety event reporting. Undertaking time-series analysis with reported rates of adverse events (major and moderate), near misses, sentinel events, and incidents from 2 years prior through 13 months following implementation revealed that there was a **significant increase in reporting of patient safety events** (approximately 50% increase in overall reporting of safety events), especially near misses (approximately 100% increase). The authors suggest that "a multifaceted networked approach does contribute to improving patient safety event reporting."
DOI	http://dx.doi.org/10.1177/0163278713491267

Setting Quality and Safety Priorities in a Target-Rich Environment: An Academic Medical Center's Challenge
Mort EA, Demehin AA, Marple KB, McCullough KY, Meyer GS
Academic Medicine 2013;88(8):1099-1104.

Notes	Another activity that is commonly undertaken is that of goal setting. This paper describes how 'academic medical centers' (teaching hospitals) may determine appropriate goals. The paper provides a step-by-step framework for prioritising and setting effective annual quality and safety goals in such settings. The framework is based on the approach the authors at Massachusetts General Hospital. The process involves collecting and analysing data, identifying the most pressing quality issues, review and goal setting. Specific tactical initiatives and executive owners are assigned to each goal, and metrics are selected to track performance. A reporting tool based on these tactics and metrics is used to deliver progress updates to senior hospital leadership. The authors report that the "hospital has experienced excellent results and strong organizational buy-in using this effective, low-cost, and replicable goal-setting process. It has led to improvements in structural, process, and outcomes aspects of quality."
DOI	http://dx.doi.org/10.1097/ACM.0b013e31829a3ee8

"Excuse Me:" Teaching Interns to Speak Up
O'Connor P, Byrne D, O'Dea A, McVeigh TP, Kerin MJ
Joint Commission Journal on Quality and Patient Safety 2013;39(9):426-431.

Notes	A key lesson for healthcare workers (and others) is learning when and how to speak up. One group this can be particularly relevant for (and difficult) is junior doctors. This article describes an educational program for interns that successfully improved their knowledge and attitudes regarding speaking up. The program was undertaken by 110 interns at University Hospital Galway in Ireland in 2012 and 2013.
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2013/00000039/00000009/art00005

Risk Factors for Hospital Admissions Associated with Adverse Drug Events
Kongkaew C, Hann M, Mandal J, Williams SD, Metcalfe D, Noyce PR, et al
Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy 2013;33(8):827-837.

Notes	One of the larger areas of risk and error is that of medications, with admissions for adverse drug events making a substantial proportion of all hospital admissions. This paper describes some of the specific predictors associated with preventable adverse drug event (ADE) admissions. Based on the observation of 3,904 adult patients in medical admission units at two British National Health Service hospitals June 2006 and November 2007, clinical pharmacists identified hospital admissions associated with drug-related problems by using medical record review, supplemented by patient interview for those identified as having an ADE. The authors report that of the 3904 patients, 439 (**11.2%**) were judged by the review panel to have **experienced ADEs**. Of these, 209 patients (**47.6%**) experienced **preventable** ADEs. Four independent variables were found to have significant relationships with ADE admissions and preventability of ADEs: **patient age**, **length of time since starting new drug**, **total number of prescription drugs**, and **hospital site**. Drug classes most commonly associated with preventable ADEs were antiplatelet drugs, anticoagulants, diuretics (loop and thiazide diuretics), angiotensin-converting enzyme inhibitors, and antiepileptic drugs. The authors conclude that "Better systems for health care practitioners to identify patients at high risk of preventable hospital admissions associated with ADEs (e.g., age > 65 years old, receiving more than five drugs, and starting new high-risk drugs) should be implemented in order to minimize the risks to patients and the burden on the health care system."
DOI	http://dx.doi.org/10.1002/phar.1287

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

Using Six Sigma to improve patient safety in the perioperative process
Galli BJ, Riebling N, Paraso C, Lehmann G, Yule M
Patient Safety & Quality Healthcare, 2013:36-41.

Notes	Magazine article recounting how a safety intervention was developed using Six Sigma methods to enhance compliance with time outs and measures to improve surgical safety in a US hospital. The Six Sigma method uses a structured approach –Define, Measure, Analyse, Improve, and Control (DMIAC) – that can be used to organise improvement/control projects.
URL	http://www.psqh.com/julyaugust-2013/1716-using-six-sigma-to-improve-patient-safety-in-the-perioperative-process.html

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Are interventions to reduce interruptions and errors **during medication administration** effective?: a systematic review (Magdalena Z Raban, Johanna I Westbrook)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[USA] Health Care Innovations Exchange – Shared decision-making and decision aids
http://www.innovations.ahrq.gov
The 28 August edition of the US Agency for Healthcare Research and Quality (AHRQ)'s Health Care Innovations Exchange focuses on shared decision-making and decision aids.
The featured Innovations describe two programs that promoted shared decision-making through the use of decision aids, and legislative efforts in the state of Washington that support its routine use in care delivery.
The featured QualityTools include decision aids for patients on particular health topics and resources for providers on the process, use, and evaluation of decision aids in shared decision making.
