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On the Radar

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On the Radar
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150 issues

This is the 150th edition of *On the Radar*. From its inception as an internal resource to its current global audience, *On the Radar*'s purpose has remained that of keeping its readers abreast of current publications and activities in the domain of safety and quality of health care. We enjoy bringing *On the Radar* to you each week and hope that you enjoy reading it and find it useful. As always, we welcome your comments and suggestions and thank you for your support.

Listening to a Radio National program (via podcast) on the relative importance of culture and strategy in business, including the health business, led me to thinking about how these influence the delivery of care. We do know how to deliver excellent health care, and yet it is just not done every time and everywhere. The challenge is to make excellence the norm.
It is said that culture is that which you deem acceptable. As the saying has it, 'what you walk past is what you accept'. How do we make it everyone's business to not keep walking? To stop – and to act. How do we go from "It's someone else's job" to "It ***is*** *my job" How do we allow and empower people in a system that we are always told is hectic and over-loaded?*
Niall Johnson (editor)

Reports

Closing the NHS funding gap: how to get better value health care for patients
Monitor.
London. Monitor, 2013.

Notes	The UK health sector regulator, Monitor, has published this brief (26 page) report outlining some opportunities to deliver better care and close the financial gap. In the report they note that they "hope the findings from this review of the evidence will encourage everyone in the NHS to look for radically different ways to serve patients better at lower cost so everyone in England can enjoy excellent health care, free at the point of delivery. The rest of this review details the four types of opportunity for making recurrent improvements in health care productivity indicated by the evidence, and actions that could realise those opportunities." The opportunities they identify come in four groups: • **Improving productivity** within existing services • Delivering the **right care in the right setting** • Developing **new ways of delivering care** • Allocating **spending more rationally**.
URL	http://www.monitor.gov.uk/sites/default/files/publications/ClosingTheGap091013.pdf

Delivering better services for people with long-term conditions: Building the house of care
Coulter A, Roberts S, Dixon A
London. The King's Fund, 2013:28.

Notes	The latest report from The King's Fund describes a **co-ordinated service delivery model** – the 'house of care' – that aims to deliver proactive, encompassing and patient-centred care for people with long-term conditions. It incorporates learning from a number of sites in England that are working to achieve these goals, and makes recommendations on how key stakeholders can work together to improve care for people with long-term conditions. The model encompasses all people with long-term conditions (not just those with a single disease or in high-risk groups) and it assumes an active role for patients, with **collaborative personalised care planning** at its heart.
URL	http://www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions
TRIM	89434

Journal articles

Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study
Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, et al
BMJ Quality & Safety 2013 [epub].

Notes	Getting the culture right is seen as a critical step in creating a high performing health unit/facility. This paper reports on a large research programme to examine culture and behaviour in the English National Health Service (NHS). The authors report that there is "an almost universal desire to provide the best quality of care" and that there are many instances of excellent caring and practice and high-quality innovation, but they also report finding considerable inconsistency.

	The authors conclude that their findings "highlight the importance of clear, challenging goals for high-quality care. **Organisations need to put the patient at the centre** of all they do, **get smart** intelligence, focus on **improving organisational systems**, and **nurture caring cultures** by ensuring that staff feel valued, respected, engaged and supported."
DOI	http://dx.doi.org/10.1136/bmjqs-2013-001947

Informal learning from error in hospitals: what do we learn, how do we learn and how can informal learning be enhanced? A narrative review
Feijter J, Grave W, Koopmans R, Scherpbier AJA
Advances in Health Sciences Education 2013;18(4):787-805.

Notes	The importance of learning, being a learning organisation, etc, is frequently raised in the safety and quality literature. This piece points out that such learning does not have to be formal and provides a narrative review focussing on "five learning opportunities": **morbidity and mortality conferences**, **incident reporting systems**, **patient claims and complaints**, **chart review** and **prospective risk analysis**. The authors note that "informal learning occurred **mostly through reflection and action** and was often linked to the learning of others. Most important to enhance informal learning from these learning opportunities was the realisation of a **climate of collaboration and trust.**"
DOI	http://dx.doi.org/10.1007/s10459-012-9400-1

Measuring the incidence of hospital-acquired complications and their effect on length of stay using CHADx
Trentino KM, Swain SG, Burrows SA, Sprivulis PC, Daly FFS.
Medical Journal of Australia 2013;199 (8):543-547.

Patient safety in hospitals — can we measure it?
Board N
Medical Journal of Australia 2013;199(8):521-522.

Notes	Trentino et al describe the use of a relatively new classification for monitoring adverse outcomes of healthcare. The **Classification of Hospital Acquired Diagnoses** (**CHADx**) was used by a West Australian Health Service to identify the incidence of hospital-acquired complications and to investigate their impact on length of stay (LOS). In a 2 year period, around **7% of** 430,000 **patient separations** were associated with a **complication**, with a **mean LOS approximately four times greater** than those which were not (after adjustment for confounders). CHADx was developed to enable the use of routinely collected administrative data for monitoring complications such as hospital-acquired infections, adverse drug events, and post-surgical complications. Accurate comparisons using hospital data may be limited, partially due to the measurement error resulting from variable clinical documentation and coding into the correct ICD codes—as pointed out in the accompanying editorial. Variation in hospitals may be difficult to interpret without a good understanding of demographic and other differences. Nonetheless, the editorial found that "the study reaffirms the need to ensure sustainable systems of safety measurement are in place to help clinicians and managers understand the breadth and types of harm in an institution, drive improvement and prioritise safety programs."

	CHADx might be used as one tool in a range of safety improvement reporting and monitoring methods, which is described by the study authors as a useful "hospital business intelligence tool" allowing users to "analyse CHADx rates by specialty, DRG, ward and other clinically meaningful factors."
DOI	Trentino et al http://dx.doi.org/10.5694/mja12.11640 Board http://dx.doi.org/10.5694/mja13.10626

For information about the Commission's work with the Classification of Hospital Acquired Diagnoses (CHADx), see http://www.safetyandquality.gov.au/our-work/information-strategy/health-information-standards/classification-of-hospital-acquired-diagnoses-chadx/

Positive Deviance: A New Tool for Infection Prevention and Patient Safety
Marra A, Pavão dos Santos O, Cendoroglo Neto M, Edmond M
Current Infectious Disease Reports 2013 [epub].

Notes	Deviance is generally perceived as a negative, but it is not always the case. This article examines 'positive deviance' (PD) in terms how it may be used to reduce hospital-acquired infections. The authors assert the PD can promote "dialogue among leaders, managers and healthcare workers, which is a key factor in establishing a safety culture. It also enables cultural changes aimed at empowering frontline workers (the positive deviants) to innovate and improve compliance". They also argue that the "structure and the process of PD, and its ability to offer a space for experience discussions, changing ideas and making plans that emerge from team participation will also be discussed." Clearly PD can be applied in areas other than infection control.
DOI / URL	http://dx.doi.org/10.1007/s11908-013-0372-y http://www.positivedeviance.org/

Incidence of adverse drug events in an academic hospital: a prospective cohort study
Aljadhey H, Mahmoud MA, Mayet A, Alshaikh M, Ahmed Y, Murray MD, et al
International Journal for Quality in Health Care 2013 [epub]

Notes	This Saudi Arabian study adds to the knowledge on the incidence of medication events. Here the medical records of 977 patients admitted to two medical, one surgical and two intensive care units over four months were reviewed to determine the incidence of adverse drug events (ADEs) and assess their severity and preventability. The authors report that pharmacists identified 361 incidents, of which 281 (78%) were considered to be an ADE, potential ADE or medication error by reviewers. The **incidence of ADEs was 8.5 per 100 admissions**, with the highest rate found in the **intensive care unit (21.1 per 100 admissions**) Of all ADEs, 59% were rated as significant, 35% as serious and 6% as life threatening. **Thirty percent** of ADEs were **preventable** and 96% of these occurred in the **ordering stage**. The incidence of potential ADEs was 13.8 per 100 admissions. Overall, 223 medication errors were identified, 66 (30%) were harmless, 132 (59%) had the potential to cause harm and 25 (11%) resulted in harm.
DOI	http://dx.doi.org/10.1093/intqhc/mzt075

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

The effects of improving hospital physicians working conditions on patient care: a prospective, controlled intervention study
Weigl M, Hornung S, Angerer P, Siegrist J, Glaser J
BMC Health Services Research 2013;13(1):401.

Notes	German study adding to the literature on working environments/conditions and their possible relationship with safety and quality of care. The authors contend that there is a link between physicians' psychosocial work environment and the quality of the work they deliver. The study sought to explore whether a participatory work-design intervention involving hospital physicians is effective in improving working conditions and quality of patient care. The study was conducted in two surgical and two internal departments with 57 hospital physicians and 1581 inpatients. The intervention was a structured, participatory intervention based on continuous group meetings. Physicians analysed "problematic working conditions, developed solutions, and initiated their implementation". Physicians' working conditions and patients' perceived quality of care were outcome criteria as assessed by questionnaires. Post-intervention, **physicians** in the intervention departments **reported substantially less conflicting demands** and **enhanced quality of cooperation** with patients' relatives. Patient reports of **quality of care**, and **patient ratings** of physicians organization of care all **improved** for physicians in the intervention group.
URL	http://www.biomedcentral.com/1472-6963/13/401

SBAR improves nurse–physician communication and reduces unexpected death: A pre and post intervention study
De Meester K, Verspuy M, Monsieurs KG, Van Bogaert P
Resuscitation 2013;84(9):1192-1196.

Notes	Communication is a fundamental factor in safe care. This Belgian study, conducted across 16 hospital wards covering 37,239 admissions and surveyed 425 nurses, sought to examine the impact of a standardised communication tool (SBAR – situation, background, assessment, recommendation) used to communicate with physicians in cases of deteriorating patients on the incidence of serious adverse events (SAEs). Over the 37,239 admissions 207 SAEs were detected. Post-intervention all four SBAR elements were notated more frequently in patient records in case of a SAE, the number of unplanned intensive care unit (**ICU) admissions increased** (from 13.1/1000 to 14.8/1000 admissions) and **unexpected deaths decreased** (from 0.99/1000 to 0.34/1000 admissions). There was no difference in the number of cardiac arrest team calls. The authors conclude that there was "increased perception of effective communication and collaboration in nurses, an increase in unplanned ICU admissions and a decrease in unexpected deaths."
DOI	http://dx.doi.org/10.1016/j.resuscitation.2013.03.016

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

Safety in home care: a mapping review of the international literature
Harrison MB, Keeping-Burke L, Godfrey CM, Ross-White A, McVeety J, Donaldson V, et al
International Journal of Evidence-Based Healthcare 2013;11(3):148-160.

Notes	Much of the literature on safety and quality of care focuses on acute care. Yet much of the care we receive takes place in other settings. This review reflects that focus by reporting that while there is an "emerging evidence base" it lacks conceptual clarity, there is a "paucity of research on the occurrence of AEs", prevalence estimates/incidence rates, and that research to evaluate risk reduction strategies was very limited. They also note that the grey literature may be some of the more useful material as it was there that innovative strategies/tools appear. This is one of the reasons *On the Radar* has included grey literature within its scope from inception.
DOI	http://dx.doi.org/10.1111/1744-1609.12027

Impact of contact isolation for multidrug-resistant organisms on the occurrence of medical errors and adverse events
Zahar JR, Garrouste-Orgeas M, Vesin A, Schwebel C, Bonadona A, Philippart F, et al
Intensive Care Medicine 2013 [epub].

Notes	Contact isolation – where health care workers wear gown, gloves, and mask before entering a patient's room – is implemented to disrupt transmission of various pathogens, particularly multi-drug resistant organisms. This study looks at how these methods can impact the patient by examining whether more adverse events occur for patients in intensive care units who are placed on contact isolation compared with those not on contact isolation. The authors report an increased incidence of hypoglycemia, hyperglycemia, anticoagulant prescription errors, and ventilator-associated pneumonia among patients in contact isolation. These findings indicate that a benefit analysis between disruption of transmission and patient safety should be done.
DOI	http://dx.doi.org/10.1007/s00134-013-3071-0

For information about the Commission's work on healthcare associated infections, see http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Healthcare Infection
Volume 18(4) 2013

Notes	A new issue of *Healthcare Infection* has been published. Articles in this issue include: • **Antibiotic resistance and prescribing in Australia**: current attitudes and practice of GPs (Rachel Hardy-Holbrook, Svetlana Aristidi, Vandana Chandnani, Daisy DeWindt and Kathryn Dinh) • The search for an evidence-based intervention to improve **hand hygiene compliance in a residential aged care facility** (Gail Abernethy and Wendy Smyth) • The use of **point prevalence surveys** of healthcare-associated infection to identify risk factors and facilitate **infection prevention and control planning** (Maura P. Smiddy and Olive M. Murphy)
URL	http://www.publish.csiro.au/nid/241/issue/6681.htm

Currents Problems in Pediatric and Adolescent Health Care
Volume 43(9) 2013

Notes	This issue of *Currents Problems in Pediatric and Adolescent Health Care* focuses on "Diagnostic Errors and Strategies to Minimize Them". Articles in this issue include: • **Diagnosing Diagnostic Error** (Satid Thammasitboon, Supat Thammasitboon, Geeta Singhal) • **Diagnostic Decision-Making** and Strategies to Improve Diagnosis (Satid Thammasitboon, William B. Cutrer) • **System-Related Factors** Contributing to Diagnostic Errors (Satid Thammasitboon, Supat Thammasitboon, Geeta Singhal) • **Educational Strategies** for Improving Clinical Reasoning (William B. Cutrer, William M. Sullivan, Amy E. Fleming)
URL	http://www.cppah.com/issues?issue_key=S1538-5442(13)X0009-4

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Managing competing demands through **task-switching** and **multitasking**: a multi-setting observational study of 200 clinicians over 1000 hours (Scott R Walter, Ling Li, William T M Dunsmuir, Johanna I Westbrook) • Increases in **HIV screening** in primary care clinics through an electronic reminder: an interrupted time series (Ann K Avery, Michelle Del Toro, Aleece Caron)
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: • Bridging the ivory towers and the swampy lowlands; increasing the impact of **health services research** on **quality improvement** (Martin N. Marshall) • Benchmarks for **acute stroke care delivery** (Ruth E. Hall, Ferhana Khan, Mark T. Bayley, Eriola Asllani, Patrice Lindsay, Michael D. Hill, Christina O'Callaghan, Frank L. Silver, and Moira K. Kapral) • The **Global Trigger Tool** shows that one out of seven patients suffers harm in Palestinian hospitals: challenges for launching a strategic safety plan (Shahenaz Najjar, Motasem Hamdan, Martin C Euwema, Arthur Vleugels, Walter Sermeus, Rashad Massoud, and Kris Vanhaecht) • Self-efficacy in **diabetic care** and occurrence of adverse events in an ambulatory setting (Benjamas Sirikamonsathian, Jiruth Sriratanaban, Narin Hiransuthikul, and Somrat Lertmaharit) • Impact of electronic chemotherapy order forms on **prescribing errors** at an urban medical center: results from an interrupted time-series analysis (K. Elsaid, T. Truong, M. Monckeberg, H. McCarthy, J. Butera, and C. Collins)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

Sir Muir Gray: The third healthcare revolution
http://www.safetyandquality.gov.au/our-work/medical-practice-variation/presentations/
Video (including PowerPoint presentation slides) of Professor Sir Muir Gray's recent public lecture in Sydney focusing on health reform and medical practice variation. Sir Muir believes we are in the midst of a Third Healthcare Revolution driven by citizens, knowledge and the internet.
Despite the significant clinical advances of the last 50 years, health services are faced with the same persistent problems: patient harm, waste, unwarranted variation, inequity, and failure to prevent the preventable. Health services are also faced with the new challenges of rising demand and resource constraints.

Professor France Légaré: Shared decision making
http://www.safetyandquality.gov.au/our-work/shared-decision-making/
Video (including PowerPoint presentation slides) of Professor France Légaré's (chair in Implementation of Shared Decision Making in Primary Care, Université Laval Québec) public lecture on shared decision making.

International Consortium for Health Outcomes Measurement
http://ichom.org/
The International Consortium for Health Outcomes Measurement grew out of a conviction that the universal development and reporting of patient outcomes by medical condition is the single greatest enabler of delivery system transformation. The vision was an organisation with international scope to bring together the best outcomes measurement efforts, foster standardization of measurement by medical condition, and encourage comprehensive measurement that would capture all the aspects of health that matter to patients.

[UK] QualityWatch
http://www.qualitywatch.org.uk/
Billed as "independent scrutiny into how the quality of health and social care is changing over time", QualityWatch has been established by the Nuffield Trust and the Health Foundation. QualityWatch aims to provide an independent picture of the quality of care and, in so doing, both augment and inform the work of other statutory national bodies and initiatives. It is hoped to:

- provide an authoritative resource on the overall quality of health and social care [in the UK];
- monitor and comment on changes over time, independently of government and the statutory bodies;
- highlight where there are clear and compelling gaps between what is being achieved and what is possible in order to incite action and improvement; and
- contribute to improving measures of quality.

[USA] Leading Improvement Across the Continuum: Skills, Tools and Teams for Success
http://www.hpoe.org/resources/guides/1455
From the Hospitals in Pursuit of Excellence (HPOE) this guide provides two frameworks, the Improvement Continuum and the Leadership Action Model, for conceptualizing and planning improvement activities
The Improvement Continuum describes four categories of improvement activities: topic or microsystem, care co-ordination, defined population and community health. For each of these categories, the framework describes the skills, tools and teams that lead to successful improvement efforts.
The Leadership Action Model is a framework for how to use the Improvement Continuum.

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