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On the Radar

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On the Radar
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Reports

Supporting doctors in raising concerns
BMA discussion paper and member consultation
London: British Medical Association, 2013

Examining professionalism
BMA discussion paper and member consultation
London: British Medical Association, 2013

Notes	The British Medical Association has started publishing a series of discussion papers examining issues of culture, particularly in the National Health Service. The first two discussions papers — *Supporting doctors in raising concerns* and *Examining professionalism* — are now available. In places these may strike some readers as having both a somewhat defensive or angry tone. As these are discussion papers intended to prompt reflection and comment, it may be that the final output of these processes is somewhat different.
URL	http://bma.org.uk/nhsculture

Polypharmacy and medicines optimisation: Making it safe and sound
Duerden M, Avery T, Payne R
London: The King's Fund, 2013.

Notes	This report from the (UK) King's Fund looks at phenomena of polypharmacy, including so me of the risks and how to make best and safest use of multiple medications. The key findings include: • Appropriate **polypharmacy can extend life expectancy** and **improve quality of life**. Medicines use needs to be optimised and prescribed according to best evidence. • There can be an **increased risk of drug interactions and adverse drug reactions**, together with **impaired adherence and quality of life**. • Clinical trials and practice guidelines often do not consider polypharmacy in the context of multi-morbidity. • Multi-morbidity and polypharmacy **increase clinical workload**, so clinicians need to work as a team with a balanced clinical skill-mix. • People often do not take medicines as they are intended. • Prescribers should consider if treatment should be stopped and 'end-of-life' care be offered for certain chronic conditions or cancer-related illness,. • **Patients may struggle** with complex drug regimens; their perspective on medicine-taking must be taken into account when prescribing.
URL	http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation

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

Journal articles

Patients do not always complain when they are dissatisfied: implications for service quality and patient safety
Howard M, Fleming ML, Parker E
Journal of Patient Safety 2013;9(4):224-231.

Notes	The premise of this paper may strike us as self-evident, but there is utility in understanding how prevalent this issue is — and thus how significant a step it is for (some) patients to express dissatisfaction or to complain. Based on in-depth interviews with 16 patients who had been admitted to an acute care Queensland hospital and experienced dissatisfaction with service delivery, the researchers found that the vast majority of patients "did not voice their complaint at the time of the event, but after the event, they stated they wished that they had reacted differently and complained at the actual point in time that they were dissatisfied. The themes that emerged that reflected potential **lost opportunities** included issues with **ineffective communication**, being treated with **disrespect**, **inconsistent standards of care**, perceptions of **negligence**, and **lack of information** about how to make a complaint." The authors suggest that "health-care professionals should take a more active role in identifying and responding to patients who are experiencing dissatisfaction but are not actively complaining. This level of vigilance and responsiveness will ensure opportunities to improve health service delivery, and patient safety are not lost."
DOI	http://dx.doi.org/10.1097/PTS.0b013e3182913837

For information about the Commission's work on patient and consumer centred care, see http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

The effects of safety checklists in medicine: a systematic review
Thomassen Ø, Storesund A, SØFteland E, BrattebØ G
Acta Anaesthesiologica Scandinavica 2013 [epub].

Notes	Checklists have become a commonplace way of addressing safety and quality concerns. This paper reviews—and confirms— the effectiveness of safety checklists in various clinical settings, including intensive care units, emergency departments, operating rooms, and wards. From an initial selection of 7408 items, 34 studies were included in the review. The authors conclude that "checklists appear to be **effective tools for improving patient safety** in various clinical settings by **strengthening compliance** with guidelines, **improving human factors**, **reducing the incidence of adverse events**, and **decreasing mortality and morbidity**. None of the included studies reported negative effects on safety."
DOI	http://dx.doi.org/10.1111/aas.12207

Development of the just culture assessment tool: measuring the perceptions of health-care professionals in hospitals
Petschonek S, Burlison J, Cross C, Martin K, Laver J, Landis RS, et al.
Journal of Patient Safety 2013;9(4):190-197.

Notes	For many, the prevailing culture is the most important feature in influencing the safety and quality of a facility or unit. This paper discusses the development of develop a survey to sure individual perceptions of just culture in a hospital setting. The research team has developed a 27-item survey, which displayed a theoretical structure and internal reliability when administered to 998 members of a health-care staff in a US paediatric research hospital as part of that hospital's ongoing patient safety culture assessment process.
DOI	http://dx.doi.org/10.1097/PTS.0b013e31828fff34

Global Research Priorities to Better Understand the Burden of Iatrogenic Harm in Primary Care: An International Delphi Exercise
Cresswell KM, Panesar SS, Salvilla SA, Carson-Stevens A, Larizgoitia I, Donaldson LJ, et al.
PLoS Med 2013;10(11):e1001554.

Notes	The scope and scale of patient harms in primary care has proven difficult to estimate with a range of estimates being produced. This paper reports on a three-phase Delphi survey engaging a group of 40 experts from across the world that sought to establish the priority areas for investigation. As the authors conclude: "**Family practice** and **pharmacy** were identified as important contexts across all income categories. Particular areas identified as warranting further investigation included **communication** between health care professionals and with patients, **teamwork** within the health care team, laboratory and diagnostic imaging **investigations**, issues relating to **data management**, **transitions** between different care settings, and **chart/patient record completeness**."
DOI	http://dx.doi.org/10.1371/journal.pmed.1001554

For information about the Commission's work on patient safety in primary health care, see http://www.safetyandquality.gov.au/our-work/patient-safety-in-primary-health-care/

Demonstrating High Reliability on Accountability Measures at The Johns Hopkins Hospital
Pronovost PJ, Demski R, Callender T, Winner L, Miller MR, Austin JM, et al.
Joint Commission Journal on Quality and Patient Safety 2013;39(12).

Notes	Paper reporting on how one US hospital developed and implemented methods for measuring and driving high performance and reliability on nine accountability and process measures. The [US] Joint Commission has created accountability measures, evidence-based practices that produce positive impacts on patient outcomes. In the hospital their team developed a conceptual model to addresses the challenges accompanying quality and safety interventions and then employed the Lean framework of define-measure-analyse-improve-control to systematically create improvement plans. A monthly performance dashboard was used to provide transparency and accountability. The hospital was able to reach a compliance goal of 96% or higher on 95% of the core measures in 2012. The authors note that "With support from **leadership** and a **conceptual model** to **communicate goals**, use **robust improvement methods**, and ensure **accountability**, The Johns Hopkins Hospital achieved high reliability for The Joint Commission accountability measures."
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2013/00000039/00000012/art00001

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • It's not you, it's me: time to narrow the gap in **weekend care** (Lauren Lapointe-Shaw, Chaim M Bell) • Integrating **patient safety** into health professionals' **curricula**: a qualitative study of medical, nursing and pharmacy faculty perspectives (Deborah Tregunno, Liane Ginsburg, Beth Clarke, Peter Norton) • Using data and quality monitoring to enhance **maternity outcomes**: a qualitative study of risk managers' perspectives (Rebecca A Simms, Andrew Yelland, Helen Ping, Antonia J Beringer, T J Draycott, R Fox)
URL	http://qualitysafety.bmj.com/content/early/recent

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: • How can we recognize **continuous quality improvement**? (Lisa Rubenstein, Dmitry Khodyakov, Susanne Hempel, Margie Danz, Susanne Salem-Schatz, Robbie Foy, Sean O'Neill, Siddhartha Dalal, and P Shekelle) • What impedes and what facilitates a **quality improvement** project for **older hospitalized patients**? (Roelie Ijkema, Maaike Langelaan, Lotte van de Steeg, and Cordula Wagner)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

[UK] Person-centred care resource centre
Health Foundation UK
http://personcentredcare.health.org.uk/
The Health Foundation has recently updated its person-centred care resource centre, which now contains reports, policies, practical tools and resources on shared decision making and self-management support.
From the website: "The resource centre is designed to help healthcare professionals implement a more person-centred healthcare service, where people are supported to more effectively manage and make informed decisions about their own health and care."

[Sweden] Empowered patients contribute to healthcare improvement
Health Consumer Powerhouse
http://healthpowerhouse.com/index.php?option=com_content&archive=news&view=article&id=362:&itemid=50&menu=yes
Following the release of the *Euro Health Consumer Index 2013* (www.healthpowerhouse.com/), this is one of a series of items drawing on that report. Apparently "the gap between patients and professionals is diminishing: patient rights legislation and involvement in policy-making has become standard in Europe. Year by year healthcare systems …open for patient engagement, as second opinion, access to own medical record etc become tools for empowerment.
The demand for choice in healthcare as well as in other parts of modern society is gradually implemented as web-services invite patients to compare the quality of medical services and pharmaceuticals, making healthcare navigation much easier than before."
