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On the Radar

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This is the last issue of *On the Radar* for 2013. The next issue will appear in mid-January 2014.

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.

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On the Radar
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Reports

The Dartmouth Atlas of Children's Health Care in Northern New England
Goodman DC, Morden NE, Ralston SL, Chang C-HC, Parker DM, Weinstein SJW
Lebanon, NH: The Dartmouth Institute for Health Policy & Clinical Practice, 2013.

Notes	The Dartmouth Atlas project has published its first atlas of children's health care, focusing on the northern New England region of the US. The report looks at ambulatory physician services, hospitalisation, common surgery, imaging, and outpatient prescription fills. The findings from this report show **marked variation in children's care** across the region. These raise questions about whether the medical practice patterns reflect the care that infants and children need and that their families want.
URL	http://www.dartmouthatlas.org/ http://www.dartmouthatlas.org/downloads/atlases/NNE_Pediatric_Atlas_121113.pdf
TRIM	92429

Patient Stories 2013: Time for Change
Harrow, Middlesex, UK
The Patients Association; 2013.

Notes	UK NGO the Patients Association has published its fifth annual *Patient Stories* report. This year's report again presents a series of stories or case studies illustrating some important issues, but also comes in the wake of the Mid-Staffordshire enquiry and the various reports and responses to that.
URL	http://www.patients-association.com/Portals/0/Patient%20Stories%202013.pdf

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/

Avoiding unhappy returns
Cardiff
Royal Voluntary Service: 2013

Notes	This very short pamphlet from the UK Royal Voluntary Service describes how Leicestershire County Council launched a Royal Voluntary Service Hospital 2 Home scheme in hospitals in six districts, including 3 university hospitals, in 2012 and how that has led to a marked reduction in readmission rates. The Hospital 2 Home scheme provides low level practical support for people returning home from hospital after illness, surgery or accident. The emphasis is strongly placed on people achieving full rehabilitation and regaining independence whilst also enabling quicker discharge from hospital. The service aims to: • Provide practical help and support following discharge • Help users to regain confidence and reduce anxiety • Reduce social isolation • Promote independent living and choice • Help users to maintain day to day activities • Provide information/signpost to other organisations • Help prevent readmissions to hospital.
URL	http://www.royalvoluntaryservice.org.uk/Uploads/Documents/Get%20involved/avoiding_unhappy_returns.pdf

Journal articles

Rates of medical errors and preventable adverse events among hospitalized children following implementation of a resident handoff bundle
Starmer AJ, Sectish TC, Simon DW, Keohane C, McSweeney ME, Chung EY, et al
JAMA 2013;310(21):2262-2270.

Developing a Medical Emergency Team Running Sheet to Improve Clinical Handoff and Documentation
Mardegan K, Heland M, Whitelock T, Millar R, Jones D
Joint Commission Journal on Quality and Patient Safety 2013;39(12).

Creating a safe, reliable hospital at night handover: a case study in implementation science
McQuillan A, Carthey J, Catchpole K, McCulloch P, Ridout DA, Goldman AP
BMJ Quality & Safety 2013 [epub].

Notes	A number of items on handoff/handover. Starmer at al describe the implementation of an **inpatient handover bundle** for paediatric resident physicians in a US hospital. The intervention included team training, standardised communication tools, electronic documentation, and new team structures. The study examined 1255 patient admissions (642 before and 613 after the intervention) involving 84 resident physicians (42 before and 42 after the intervention) from July-September 2009 and November 2009-January 2010. The authors report that **medical errors and preventable adverse events decreased** substantially and that the intervention did not adversely affect resident workflow. Residents were found to spend more time in direct contact with patients post-intervention. The second is interesting in that it describes the development and use of a handover tool in what can be more difficult context, that of a MET (Medical Emergency Team) call. This tool has been developed to assist the ward staff prepare appropriate and necessary information for the arriving team. In the project, a novel **MET running sheet** was developed to document events and therapies administered during MET calls. Key characteristics of the form were improved form layout, increased space for event documentation, and prompts to assist handover to the arriving MET using the Identity, Situation, Background, Assessment, Request (ISBAR) format. Ward nurses commonly involved in MET activation were surveyed to assess their perceptions of the new MET running sheet and 87 (84.5%) of the 103 respondents agreed or strongly agreed that the new MET running sheet was better than the previous form for documenting MET management, and 58 (57.4%) of 101 respondents agreed or strongly agreed that it assisted handoff. The third paper also looks at another context which may be more error-prone, that of night handover. This particular item reports on the development of protocols to handover patients from day to hospital at night (H@N) teams in a UK paediatric specialist hospital. For the study four handover protocols (baseline, Phases 1, 2 and 3) were observed over 2 years. A mixed-method study (observation, interviews, task analysis, prospective risk assessment, document and case note review) explored the impact of different protocols on performance. A handover protocol was introduced in Phase 1 to resolve problems with the baseline H@N handover. Two further revisions to the handover occurred, driven by staff feedback (Phases 2 and 3). The study identified variations in performance between handover protocols on three process measures, start time efficiency, total length of handover, and number of distractions and interruptions. Phase 1 and 2 handover protocols were effective at identifying patients whose clinical condition warranted review overnight. Performance on both surrogate outcome measures, length of handover and distractions, deteriorated in Phase 3. In their conclusion the authors note how difficult introducing and sustaining change and improvement can be: “A carefully designed prioritisation process within the H@N handover can be effective at flagging acutely unwell patients. However, the protocol we introduced was unsustainable. In a complex healthcare system, **sustainable implementation of new processes may be threatened by conflicting goals**.” This is an example of how an imperfect result can be informative and instructive.

DOI / URL	Starmer et al http://dx.doi.org/10.1001/jama.2013.281961 Mardegan et al http://www.ingentaconnect.com/content/jcaho/jcjqs/2013/00000039/00000012/art00005 McQuillan et al http://dx.doi.org/10.1136/bmjqs-2013-002146

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

Why Do Doctors Make Mistakes? A Study of the Role of Salient Distracting Clinical Features
Mamede S, van Gog T, van den Berge K, van Saase JL, Schmidt HG
Academic Medicine 2013 [epub].

Notes	There has been a volume of work done on the role of distraction in the safety of care delivery. This piece, looking at how doctors make errors, sought to examine what are the salient or important aspects of distraction. This is based on the premise that not all distractions are the same – perhaps it is the nature or timing of the distraction that is more important than being distracted per se. The authors sought to investigate whether salient distracting features (SDFs) (case findings that tend to grab physicians' attention because they are strongly associated with a particular disease, but are indeed unrelated to the problem) contribute to faulty diagnostic reasoning, causing errors. According to this Dutch study involving 72 internal medicine residents, when the SDFs appear early in a case they are apparently an important source of diagnostic errors. The residents made **more diagnostic errors** during complex clinical cases when a SDF appeared **near the beginning of the case description**, but not when presented toward the end.
DOI	http://dx.doi.org/10.1097/ACM.0000000000000077

Telemedicine Consultations and Medication Errors in Rural Emergency Departments
Dharmar M, Kuppermann N, Romano PS, Yang NH, Nesbitt TS, Phan J, et al.
Pediatrics 2013;132(6):1090-1097.

Notes	The use of technology in health care can bring risks and benefits. This retrospective study reported that telemedicine consultations for paediatric critical care were associated with fewer physician-related medication errors among seriously ill children in rural EDs. Among the 234 patients in the study, 73 received telemedicine consultations, 85 received telephone consultations, and 76 received no specialist consultations. Medications for patients who received **telemedicine consultations** had **significantly fewer physician-related medication errors** than medications for patients who received telephone consultations or no consultations (3.4% vs 10.8% and 12.5%, respectively. Such results suggest that telemedicine may provide valuable support for isolated clinicians and in improving the care of remote and rural patients.
DOI	http://dx.doi.org/10.1542/peds.2013-1374

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

Predictors of Completeness of Patients' Self-reported Personal Medication Lists and Discrepancies With Clinic Medication Lists
Lee KP, Nishimura K, Ngu B, Tieu L, Auerbach AD
Annals of Pharmacotherapy 2013.

Notes	Medication reconciliation is recommended during transitions in care so as to aid in preventing medication errors. This study sought to assess completeness of personal medication lists and identify factors associated with incomplete personal lists and discrepancies between personal and clinic medication lists. The study examined patients' personal medication lists at a US academic hospital preoperative clinic from January 2010 to October 2010 with 94 patients included. The authors report that patients' **personal medication lists are often incomplete**, and nearly all of them examined in this study had at least one discrepancy from their clinic medication list.
DOI	http://aop.sagepub.com/content/early/2013/11/13/1060028013512109

BMJ Quality and Safety
January 2014, Vol 23, Issue 11

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: **Diagnosis and diagnostic errors**: time for a new paradigm (Gordon D Schiff) • Viewpoint: **Making improvement interventions happen**—the work before the work: four leaders speak (Paul Batalden) • **Electronic health record-based triggers** to detect potential delays in cancer diagnosis (Daniel R Murphy, Archana Laxmisan, Brian A Reis, Eric J Thomas, Adol Esquivel, S N Forjuoh, R Parikh, M M Khan, H Singh) • **Prescribing errors** on admission to hospital and their potential impact: a mixed-methods study (Avril Janette Basey, Janet Krska, Thomas Duncan Kennedy, Adam John Mackridge) • Value of a modified **early obstetric warning system** (MEOWS) in managing maternal complications in the peripartum period: an ethnographic study (Nicola Mackintosh, Kylie Watson, Susanna Rance, Jane Sandall) • Effects of a team-based assessment and intervention on **patient safety culture in general practice**: an open randomised controlled trial (B Hoffmann, V Müller, J Rochon, M Gondan, B Müller, Z Albay, K Weppler, M Leifermann, C Mießner, C Güthlin, D Parker, G Hofinger, F M Gerlach) • A system-wide approach to explaining variation in **potentially avoidable emergency admissions**: national ecological study (Alicia O'Cathain, Emma Knowles, Ravi Maheswaran, Tim Pearson, Janette Turner, Enid Hirst, Steve Goodacre, Jon Nicholl) • Characterising the complexity of **medication safety** using a human factors approach: an observational study in two intensive care units (Pascale Carayon, Tosha B Wetterneck, Randi Cartmill, Mary Ann Blosky, Roger Brown, Robert Kim, S Kukreja, M Johnson, B Paris, K E Wood, J Walker)

	• **Sign-out snapshot**: cross-sectional evaluation of written sign-outs among specialties (Amy R Schoenfeld, Mohammed S Al-Damluji, L I Horwitz) • **Hospital performance** based on treatment delays: comparison of ranking methods (Henri Leleu, Frédéric Capuano, Gérard Nitenberg, Lydie Travental, Etienne Minvielle) • Building a safer foundation: the **Lessons Learnt patient safety training** programme (Maria Ahmed, Sonal Arora, Stephenie Tiew, Jacky Hayden, Nick Sevdalis, Charles Vincent, Paul Baker
URL	http://qualitysafety.bmj.com/content/23/1

BMC Medical Informatics and Decision Making 2013, **13**(Suppl 2):S2 (29 November 2013)

Notes	*BMC Medical Informatics and Decision Making* has published a special supplement celebrating 10 years of the International Patient Decision Aid Standards (IPDAS) Collaboration. A total of 102 authors from 10 countries contributed to this supplement. In 2003, the IPDAS Collaboration was established to enhance the quality and effectiveness of patient decision aids by establishing an evidence-informed framework for improving their content, development, implementation, and evaluation. • **Ten years of the International Patient Decision Aid Standards Collaboration: evolution of the core dimensions for assessing the quality of patient decision aids** (Robert J Volk, Hilary Llewellyn-Thomas, Dawn Stacey, Glyn Elwyn) • **A systematic development process for patient decision aids** (Angela Coulter, Diana Stilwell, Jennifer Kryworuchko, Patricia Mullen, Chirk Ng, Trudy van der Weijden) • **Disclosing conflicts of interest in patient decision aids** (Michael J Barry, Evelyn Chan, Benjamin Moulton, Sunita Sah, Magenta B Simmons, Clarence Braddock) • **Providing information about options in patient decision aids** (Deb Feldman-Stewart, Mary Ann O'Brien, Marla L Clayman, B Davison, Masahito Jimbo, Michel Labrecque, Richard W Martin, Heather Shepherd) • **Basing information on comprehensive, critically appraised, and up-to-date syntheses of the scientific evidence: a quality dimension of the International Patient Decision Aid Standards** (Victor M Montori, Annie LeBlanc, Angela Buchholz, Diana L Stilwell, Apostolos Tsapas) • **Balancing the presentation of information and options in patient decision aids: an updated review** (Purva Abhyankar, Robert J Volk, Jennifer Blumenthal-Barby, Paulina Bravo, Angela Buchholz, Elissa Ozanne, Dale Vidal, Nananda Col, Peep Stalmeier) • **Presenting quantitative information about decision outcomes: a risk communication primer for patient decision aid developers** (Lyndal J Trevena, Brian J Zikmund-Fisher, Adrian Edwards, Wolfgang Gaissmaier, Mirta Galesic, Paul KJ Han, John King, Margaret L Lawson, Suzanne K Linder, Isaac Lipkus, Elissa Ozanne, Ellen Peters, Danielle Timmermans, Steven Woloshin) • **Clarifying values: an updated review** (Angela Fagerlin, Michael Pignone, Purva Abhyankar, Nananda Col, Deb Feldman-Stewart, Teresa Gavaruzzi, Jennifer Kryworuchko, Carrie A Levin, Arwen H Pieterse,

	Valerie Reyna, Anne Stiggelbout, Laura D Scherer, Celia Wills, Holly O Witteman) • **Do personal stories make patient decision aids more effective? A critical review of theory and evidence** (Hilary L Bekker, Anna E Winterbottom, Phyllis Butow, Amanda J Dillard, Deb Feldman-Stewart, Floyd J Fowler, Maria L Jibaja-Weiss, Victoria A Shaffer, Robert J Volk) • **Addressing health literacy in patient decision aids** (Kirsten J McCaffery, Margaret Holmes-Rovner, Sian K Smith, David Rovner, Don Nutbeam, Marla L Clayman, Karen Kelly-Blake, Michael S Wolf, Stacey L Sheridan) • **Coaching and guidance with patient decision aids: A review of theoretical and empirical evidence** (Dawn Stacey, Jennifer Kryworuchko, Jeff Belkora, B Davison, Marie-Anne Durand, Karen B Eden, Aubri S Hoffman, Mirjam Koerner, France Légaré, Marie-Chantal Loiselle, Richard L Street) • **Establishing the effectiveness of patient decision aids: key constructs and measurement instruments** (Karen R Sepucha, Cornelia M Borkhoff, Joanne Lally, Carrie A Levin, Daniel D Matlock, Chirk Ng, Mary E Ropka, Dawn Stacey, Natalie Joseph-Williams, Celia E Wills, Richard Thomson) • **Delivering patient decision aids on the Internet: definitions, theories, current evidence, and emerging research areas** (Aubri S Hoffman, Robert J Volk, Anton Saarimaki, Christine Stirling, Linda C Li, Martin Härter, Geetanjali R Kamath, Hilary Llewellyn-Thomas) • **"Many miles to go …": a systematic review of the implementation of patient decision support interventions into routine clinical practice** (Glyn Elwyn, Isabelle Scholl, Caroline Tietbohl, Mala Mann, Adrian GK Edwards, Catharine Clay, France Légaré, Trudy van der Weijden, Carmen L Lewis, Richard M Wexler, Dominick L Frosch)
URL	http://www.biomedcentral.com/bmcmedinformdecismak/supplements/13/S2

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Creating a safe, reliable hospital at **night handover**: a case study in implementation science (Annette McQuillan, Jane Carthey, Ken Catchpole, Peter McCulloch, Deborah A Ridout, Allan P Goldman) • **Governance of quality of care**: a qualitative study of health service boards in Victoria, Australia (Marie M Bismark, David M Studdert) • Errors in **after-hours phone consultations**: a simulation study (Erel Joffe, James P Turley, K O Hwang, T R Johnson, C W Johnson, E V Bernstam) • Promoting **engagement by patients and families to reduce adverse events in acute care** settings: a systematic review (Zackary Berger, Tabor E Flickinger, Elizabeth Pfoh, Kathryn A Martinez, Sydney M Dy) • Interactive questioning in critical care during **handovers**: a transcript analysis of communication behaviours by physicians, nurses and nurse practitioners (Michael F Rayo, Austin F Mount-Campbell, James M O'Brien, Susan E White, Alexandra Butz, Kris Evans, Emily S Patterson)
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: • Is culture associated with **patient safety** in the **emergency department**? A study of staff perspectives (Inge Verbeek-Van Noord, Cordula Wagner, Cathy Van Dyck, Jos W R Twisk, and Martine C De Bruijne) • **Patient-reported experiences with hospitals**: comparison of proxy and patient scores using propensity-score matching (Oyvind Bjertnaes)
URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc

Online resources

Lead Clinicians Group (LCG) Initiative consultation
http://www.hoi.com.au/projects
The Lead Clinicians Group (LCG) Initiative is being evaluated for the Department of Health by Health Outcomes International. The evaluation seeks the input and clinicians and others in the health sector.