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On the Radar

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On the Radar
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Books

Patient Safety and Managing Risk in Nursing
Fisher MA, Scott M
London: Sage Publishing, 2013.

Notes	From the publisher's website: "Patient safety is a predominant feature of quality healthcare and something that every patient has the right to expect. As a nurse, you must consider the safety of the patient as paramount in every aspect of your role; and it is now an increasingly important topic in pre-registration nursing programmes. This book aims to provide you with a greater understanding of how to manage patient safety and risk in your practice. The book focuses on the essentials that you need to know… Key features: • A practical **introduction to patient safety and risk management** written specifically **for nurses** and nursing students • Case studies and scenarios help you to apply patient safety and risk management principles to actual practice … • Activities throughout help you to think critically and reflect on practice."
URL	http://www.sagepub.com/books/Book240268

Reports

Staff care: how to engage staff in the NHS and why it matters
Point of Care Foundation, 2013

Notes	This report from the UK Point of Care Foundation asserts that **the way healthcare staff feel about their work has a direct impact on the quality of patient care** as well as on an organisation's efficiency and financial performance. It argues that it is not only necessary for healthcare providers to encourage staff engagement but to accelerate it.
URL	http://www.pointofcarefoundation.org.uk/Downloads/Staff-Report-2014.pdf

Journal articles

Responding to clinicians who fail to follow patient safety practices: Perceptions of physicians, nurses, trainees, and patients
Driver TH, Katz PP, Trupin L, Wachter RM
Journal of Hospital Medicine 2013 [epub]

Notes	Working in a manner that ensures the safety of all, including oneself, fellow health workers and patients, may seem to be common sense, self-evident or a minimum standard. However, it is not always the case and the question of what to do with 'outliers', 'rebels', 'deviants' or whether term you case to use can arise. This paper reports on a survey of health care workers, trainees and patients in San Francisco that examined attitudes toward violations of 3 safety protocols: hand hygiene, fall risk assessment, and preoperative time-out. The authors record that "healthcare providers and patients now believe **clinicians should be held accountable** for following basic safety protocols" Survey respondents endorsed feedback and penalties for clinicians that failed to follow these evidence-based practices. However, health care professionals tended to favour more punitive measures such as fines, suspensions, and firing, over public reporting.
DOI	http://dx.doi.org/10.1002/jhm.2136

Medication Event Huddles: A Tool for Reducing Adverse Drug Events
Morvay S, Lewe D, Stewart B, Catt C, McClead JRE, Brilli RJ
Joint Commission Journal on Quality and Patient Safety 2014;40(1):39-45.

Notes	In this paper the authors describe how '**event huddles**' were implemented in a US children's hospital in order to analyse and address adverse drug events. The huddles, including nursing and pharmacy leadership, occurred immediately after any clinical adverse drug event and followed a formal protocol to identify active and latent errors leading to the incident. The protocol, including the form used, are described and included. Staff and management considered the approach as useful and non-punitive.
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2014/00000040/00000001/art00005

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

A unified model of patient safety (or "Who froze my cheese?")
Coiera E, Collins S, Kuziemsky C
BMJ 2013;347.

Notes	There have been a number of ways of theorising or **conceptualising patient safety**. In this commentary in the BMJ the authors have, in the words of the ARHQ PS Net, combined "two models of systems safety concepts—Reason's Swiss Cheese model and the Iceberg theory—and applies variations of the hybrid concepts [including the Swiss cheeseberg!] to explain hazards in care delivery. The authors suggest that these models demonstrate how oversimplifying complex health systems may inhibit understanding about patient safety."
DOI	http://dx.doi.org/10.1136/bmj.f7273

Evidence-based de-implementation for contradicted, unproven, and aspiring healthcare practices
Prasad V, Ioannidis JPA
Implementation Science 2014;9(1) [epub].

Notes	Following some previous work on 'contradicted' medical process these authors have written this piece to propose a conceptual framework to guide and prioritise the **abandoning** of **ineffective medical practices** and **mitigating the risks of untested practices**. They seek to shift the emphasis "toward the principles of evidence-based medicine, while acknowledging that evidence may still be misinterpreted or distorted by recalcitrant proponents of entrenched practices and other biases." But, as they note, this process has historically "relied on the evidence base, societal values, cultural tensions, and political sway, but not necessarily in that order".
DOI	http://www.implementationscience.com/content/9/1/1

Eight Critical Factors in Creating and Implementing a Successful Simulation Program
Lazzara EH, Benishek LE, Dietz AS, Salas E, Adriansen DJ
Joint Commission Journal on Quality and Patient Safety 2014;40(1):21-29.

Notes	Implementation is commonly the most difficult aspect of improvement. This paper describes a series of factors those implementing simulation-based training could usefully consider. The authors state that "The large simulation, training, and learning literature was used to provide a synthesized yet innovative and "memorable" heuristic of the important facets of simulation program creation and implementation, as represented by eight **critical** "S" **factors—science, staff, supplies, space, support, systems, success,** and **sustainability**."
DOI	http://www.ingentaconnect.com/content/jcaho/jcjqs/2014/00000040/00000001/art00003

Sustainable, Effective Implementation of a Surgical Preprocedural Checklist: An "Attestation" Format for All Operating Team Members
Porter AJ, Narimasu JY, Mulroy MF, Koehler RP
Joint Commission Journal on Quality and Patient Safety 2014;40(1):3-9.

Notes	Checklists have been one of the most common approaches to attempt to address various safety and quality issues. This paper describes how in one hospital the checklist process had a pre-procedural pause and "attestation" formalised so as to enforce the **engagement and involvement** of all surgical team members. The form used in the OT is included (in the online content).
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2014/00000040/00000001/art00001

Communication in the operating theatre
Weldon SM, Korkiakangas T, Bezemer J, Kneebone R
British Journal of Surgery 2013;100(13):1677-1688.

Notes	Communication, or lapses or errors in communication, cause or contribute to a very great proportion of errors. This paper reports on a systematic literature review of observational studies addressing communication in the operating theatre. Of the initial 1174 studies, 26 were included in the review. The authors conclude that "**Communication** was shown to **affect operating theatre practices** in all of the studies reviewed" and identified six key concepts: signs of effective communication, signs of communication problems, effects on teamwork, conditions for communication, effects on patient safety and understanding collaborative work.
DOI	http://dx.doi.org/10.1002/bjs.9332

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

The Dutch health care performance report: seven years of health care performance assessment in the Netherlands
van den Berg MJ, Kringos DS, Marks LK, Klazinga NS
Health Research Policy and Systems 2014;12(1) [epub].

Notes	The Netherlands was among the first countries in the world developing comprehensive tool for reporting performance on quality, access, and affordability of health care. The tool contains **125 performance indicators**. The authors seek to "reflect on important lessons learned after seven years of health care system performance assessment. These lessons entail the importance of a good **conceptual framework** for health system performance assessment, the importance of **repeated measurement**, the strength of combining **multiple perspectives** (e.g., patient, professional, objective, subjective) on the same issue, the importance of a central role for the **patients' perspective** in performance assessment, how to deal with the **absence of data** in relevant domains, the value of international **benchmarking** and the **continuous exchange** between researchers and policy makers."
DOI	http://www.health-policy-systems.com/content/12/1/1/abstract

Nurse Education Today
February 2014, Vol. 34, No. 2

Notes	This issue of *Nurse Education Today* has the theme of 'Patient Safety'. Articles in this issue include: • **Patient safety**: Committing to learn and acting to improve (Di Twigg, Moira Attree) • Methodological aspects in the assessment of **safety culture** in the hospital setting: A review of the literature (María J Pumar-Méndez, Moira Attree, Ann Wakefield) • **Medication fall risk** in old hospitalized patients: A retrospective study (Maria José Costa-Dias, A Santos Oliveira, T Martins, F Araújo, et al.) • Evaluation of nurses' knowledge and understanding of obstacles encountered when administering **resuscitation medications** (Mei-Jung Chen, Shu Yu, I-Ju Chen, Kai-Wei K. Wang, et al.)

	• A multi-disciplinary approach to **medication safety** and the implication for nursing education and practice (Radha Adhikari, Jennifer Tocher, Pam Smith, Janet Corcoran, et al) • Prevention of **healthcare associated infections**: Medical and nursing students' knowledge in Italy (Daniela D'Alessandro, Antonella Agodi, Francesco Auxilia, Silvio Brusaferro, et al) • How do university education and clinical experience influence pre-registration nursing students' **infection control** practice? A descriptive, cross sectional survey (Jonathan Hinkin, Jayne Cutter) • Prevention of **central venous catheter infections**: A survey of paediatric ICU nurses' knowledge and practice (Amanda J Ullman, Debbie A Long, Claire M Rickard) • **Information literacy** during entry to practice: Information-seeking behaviors in student nurses and recent nurse graduates (Olive Wahoush, Laura Banfield) • The **Safe Clinical Assessment**: A patient safety focused approach to clinical assessment (Paul Silverston) • **Interprofessional service improvement** learning and patient safety: A content analysis of pre-registration students' assessments (Alison I Machin, Diana Jones) • Identification of **prescribing errors** by pre-registration student nurses: A cross-sectional observational study utilising a prescription medication quiz (Leeann Whitehair, Steve Provost, John Hurley) • **Safety consciousness**: Assignments that expand focus beyond the bedside (Susan A Seibert) • Deviations from **venous blood specimen collection** guideline adherence among senior nursing students (Karin Nilsson, Kjell Grankvist, Christina Juthberg, Christine Brulin, et al.) • **Learning in action**: Developing safety improvement capabilities through action learning (Angela Christiansen, Trish Prescott, Judith Ball) • **Patient safety education** — A description and evaluation of an international, interdisciplinary e-learning programme (Alison M Evans, Gemma Ellis, Sharon Norman, Karl Luke) • **Simulation in nursing education**: An evaluation of students' outcomes at their first clinical practice combined with simulations (Rabia Khalaila) • An **interprofessional communication training** using simulation to enhance safe care for a **deteriorating patient** (Sok Ying Liaw, Wen Tao Zhou, Tang Ching Lau, Chiang Siau, et al.) • **Nursing students' perspectives** and suggestions on patient safety—Implications for developing the nursing education curriculum in Iran (Mojtaba Vaismoradi, Terese Bondas, Melanie Jasper, Hannele Turunen) • Third year nursing **students' viewpoints** about circumstances which threaten safety in the clinical setting (Phyllis Montgomery, Laura Killam, Sharolyn Mossey, Corey Heerschap) • **Patient safety in nursing education**: Contexts, tensions and feeling safe to learn (Alison Steven, Carin Magnusson, Pam Smith, Pauline H. Pearson)
URL	http://www.nurseeducationtoday.com/issues

Health Affairs
January 2014, Vol. 33, No. 1

Notes	A new issue of *Health Affairs* has been published. This issue has the theme 'Exploring Alternatives To Malpractice Litigation'. Articles in this issue include: • How Policy Makers Can Smooth The Way For **Communication-And-Resolution Programs** (William M. Sage, Thomas H. Gallagher, Sarah Armstrong, Janet S. Cohn, Timothy McDonald, Jane Gale, Alan C. Woodward, and Michelle M. Mello) • **Communication-And-Resolution Programs**: The Challenges And Lessons Learned From Six Early Adopters (Michelle M. Mello, Richard C. Boothman, Timothy McDonald, Jeffrey Driver, Alan Lembitz, Darren Bouwmeester, Benjamin Dunlap, and Thomas Gallagher) • Implementing Hospital-Based **Communication-And-Resolution Programs**: Lessons Learned In New York City (Michelle M. Mello, Susan K. Senecal, Yelena Kuznetsov, and Janet S. Cohn) • Ascension Health's Demonstration Of Full **Disclosure Protocol** For Unexpected Events During Labor And Delivery Shows Promise (Ann Hendrich, Christine Kocot McCoy, Jane Gale, Lora Sparkman, and Palmira Santos) • Structuring Patient And Family Involvement In Medical **Error Event Disclosure And Analysis** (Jason M. Etchegaray, Madelene J. Ottosen, Landrus Burress, William M. Sage, Sigall K. Bell, Thomas H. Gallagher, and Eric J. Thoma)
URL	http://content.healthaffairs.org/content/33/1.toc

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

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Editorial: **Simulation modelling** and resource allocation in complex services (Steffen Bayer) • Practices to prevent **venous thromboembolism**: a brief review (Brandyn D Lau, Elliott R Haut) • **Surgical checklists**: a systematic review of impacts and implementation (Jonathan R Treadwell, Scott Lucas, Amy Y Tsou) • **Human factors** and ergonomics as a patient safety practice (Pascale Carayon, Anping Xie, Sarah Kianfar) • 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) • The Cystic Fibrosis Foundation **Patient Registry** as a tool for use in **quality improvement** (Michael S Schechter, Aliza K Fink, Karen Homa, Christopher H Goss)
URL	http://qualitysafety.bmj.com/content/early/recent

Online resources

[USA] Alarms and Infusion Pumps Top Our Annual Top 10 Health Technology Hazards List for 2014
https://www.ecri.org/blog/Lists/Posts/Post.aspx?ID=210
The Emergency Care Research Institute (ECRI)—an international, independent, non-profit organisation researching the best approaches to improving patient care—, has listed its top 10 health technology hazards list. These are:

1. Alarm hazards
2. Infusion pump medication errors
3. CT radiation exposure in paediatric patients
4. Data integrity failures in electronic health records and other health IT systems
5. Occupational radiation hazards in hybrid operating rooms
6. Inadequate reprocessing of endoscopes and surgical instruments
7. Neglecting change management for networked devices and systems
8. Risks to paediatric patients from 'adult' technologies
9. Robotic surgery complications due to insufficient training
10. Retained devices and unretrieved fragments.
