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On the Radar

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On the Radar
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Books

SAFER Electronic Health Records: Safety Assurance Factors for EHR Resilience
Sittig DF, Singh H, editors
Apple Academic Press 2015.

URL	https://www.crcpress.com/product/isbn/9781771881173
Notes	Book offering a "one-stop resource on the [US] SAFER Guides along with the guides themselves and information on their use, development, and evaluation. The Safety Assurance Factors for EHR Resilience (SAFER) guides…identify recommended practices to optimize the safety and safe use of electronic health records (EHRs). These guides are designed to help organizations self-assess the safety and effectiveness of their EHR implementations, identify specific areas of vulnerability, and change their cultures and practices to mitigate risks.

For information on the Commission's work on safety in e-health, including the Clinical safety program for the Personally Controlled Electronic Health Record (PCEHR), see
http://www.safetyandquality.gov.au/our-work/safety-in-e-health/

Journal articles

Reducing the burden of iatrogenic harm in children
Carson-Stevens A, Edwards A, Panesar S, Parry G, Rees P, Sheikh A, et al.
The Lancet.385(9978):1593-4.

Safety Incidents in the Primary Care Office Setting
Rees P, Edwards A, Panesar S, Powell C, Carter B, Williams H, et al.
Pediatrics. 2015 [epub].

The Trigger Tool as a Method to Measure Harmful Medication Errors in Children
Maaskant JM, Smeulers M, Bosman D, Busink A, van Rijn-Bikker P, van Aalderen W, et al
Journal of Patient Safety. 2015 [epub].

DOI	Carson-Stevens *et al* http://dx.doi.org/10.1016/S0140-6736(14)61739-6 Rees *et al* http://dx.doi.org/10.1542/peds.2014-3259 Maaskant *et al* http://dx.doi.org/10.1097/PTS.0000000000000177
Notes	A pair of papers – with overlapping authorship – looking at the issue of iatrogenic harm to children, including an attempt to identify the scale of the problem of children being harmed during health care. These pieces note research showing that in the **UK 26% of child deaths have identifiable failures in care** and in the **USA** an estimated **15–35% of children admitted to hospitals have health-care associated harm**. Children are a particularly vulnerable population and "have an increased risk of health-care-related harm because of factors including the complexity of prescribing and dispensing of drugs, a reduced physiological reserve compared with adults, and dependency on others (i.e., parents and health-care providers) to recognise the emergence of a hazardous situation." In Rees et al's examination of UK data they report "three crosscutting priority areas were identified: **medication management**, **assessment and referral**, and **treatment**. The 4 incident types associated with the most harmful outcomes are errors associated with **diagnosis and assessment**, delivery of **treatment and procedures**, **referrals**, and **medication** provision." These two pieces argue that this in under-recognised and under-researched area. Carson-Stevens et al call for an "international patient safety learning system…designed to describe care failures or safety incidents, shape priorities for improvement, corroborate insights from research studies, develop potential solutions for application in practice, and share learning of the context-specific approaches of application of solutions". Further, they say that there also needs to be "a culture of open reporting from staff, parents, and patients to provide future high-quality incident reports, build improvement capability within their workforce to apply the lessons learned, and educate family and patients for early warning and early action to mitigate care failure". The third paper (Maaskant *et al*) compares the use of trigger tool with a method based on chart reviews and voluntary incident reports for detecting harmful medication errors in children. In the sample of 369 patients the latter method identified 33 harmful medication errors, whereas the trigger tool failed to pick up any of these incidents and identified only false-positive events.

Improving clinician–carer communication for safer hospital care: a study of the 'TOP 5' strategy in patients with dementia
Luxford K, Axam A, Hasnip F, Dobrohotoff J, Strudwick M, Reeve R, et al
International Journal for Quality in Health Care. 2015.

DOI	http://dx.doi.org/10.1093/intqhc/mzv026
Notes	This article reports on a study conducted by the New South Wales Clinical Excellence Commission (CEC) that examined the impact of implementing a clinical care-communication tool, 'Top 5', in hospitalised patients with dementia. The study has indicated that the use of this **simple, low-cost communication tool** for patient care is associated with **improvements in clinician and care experience**. The 'Top 5' strategy also has potential for broader application by health services applying patient focused approaches to care delivery.

For information on the Commission's work on cognitive impairment (dementia and delirium), see http://www.safetyandquality.gov.au/our-work/cognitive-impairment/

Safety Culture and Care: A Program to Prevent Surgical Errors
Hemingway MW, O'Malley C, Silvestri S
AORN Journal. 2015;101(4):404-15.

DOI	http://dx.doi.org/10.1016/j.aorn.2015.01.002
Notes	Addressing culture is seen as a key element in improving the safety and quality of care in a given setting. However, it is also often perceived as difficult. This commentary piece looks at the nexus between culture and care with a focus on surgical care and as means for reducing errors in surgery as experienced in a single facility. The interventions included incident reporting, adverse event review, additional resources and nurse roles, and creating communication strategies around adverse safety events and how to improve care. The authors report finding "a 54% increase in the percentage of personnel who indicated …that they would speak up if they saw something negatively affecting patient care".

Information Gaps in Newborn Care and Their Potential for Harm
Kumar P, Biswas A, Iyengar H, Kumar P
Joint Commission Journal on Quality and Patient Safety 2015;41(5):228-33.

URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2015/00000041/00000005/art00006
Notes	Gaps in information and communication can lead to lapses in care. This can be particularly so in vulnerable patients, such as – in this study – newborns. This paper reports on a study that used interviews with 72 mothers that were compared with maternal prenatal histories and infant medical records. These comparisons found that in the majority of cases there was at least one information gap. The authors conclude that "**significant information gaps are common in newborn care at birth** and may have the potential for an adverse impact on the care and outcomes of the newborn. Obtaining a history directly from the parents rather than relying on maternal medical records may minimize or eliminate these information gaps and thus improve newborn care."

An Anesthesia Preinduction Checklist to Improve Information Exchange, Knowledge of Critical Information, Perception of Safety, and Possibly Perception of Teamwork in Anesthesia Teams
Tscholl DW, Weiss M, Kolbe M, Staender S, Seifert B, Landert D, et al.
Anesth Analg 2015 [epub].

DOI	http://dx.doi.org/10.1213/ANE.0000000000000671
Notes	An addition to the extensive literature on checklists, this paper describes the introduction of an anaesthesia checklist. This was a prospective interventional study comparing 105 anaesthesia teams using the anaesthesia preinduction checklist (APIC) with a control group (100 teams) not using the APIC. Key improvements came in the teamwork and communication aspects, as the authors report that "the use of a preinduction checklist **significantly improves information exchange**, **knowledge** of critical information, and **perception of safety** in anesthesia teams-all parameters contributing to patient safety."

Unexpected death within 72 hours of emergency department visit: were those deaths preventable?
Goulet H, Guerand V, Bloom B, Martel P, Aegerter P, Casalino E, et al
Critical Care 2015;19(1):154.

DOI	http://dx.doi.org/10.1186/s13054-015-0877-x
Notes	This study examined 555 cases from 4 Parisian hospitals to investigate medical patients who died in hospital within 72 hours of emergency department (ED) attendance and were not admitted to the intensive care unit (and thus were an 'unexpected death') in order to investigate the rate of preventable death in patients who died early and unexpectedly following hospital admission from the ED. From the 555 cases; 47 unexpected deaths were analysed and 24 (**51%**) were considered as **preventable**. The median number of medical errors identified was two. The most common process breakdowns were **incorrect choice of treatment** (47% of patients) and **failure to order appropriate diagnostic tests** (38% of patients). The most common medical error was a severe delay or absence of recommended treatment for **severe sepsis**, which occurred in 10 (42%) patients. The authors conclude that "In our sample, **more than half of unexpected deaths are related to a medical error, and could have been prevented**."

BMJ Quality and Safety online first articles

URL	http://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Back to basics: **checklists in aviation and healthcare** (Robyn Clay-Williams, Lacey Colligan) • Editorial: The husband's story: **from tragedy to learning and action** (Martin Bromiley) • Editorial: What are **patients' care experience priorities**? (Rick A Iedema, Blake Angell) • **Patient and carer identified factors** which contribute to safety incidents in **primary care**: a qualitative study (Andrea L Hernan, Sally J Giles, Jeffrey Fuller, Julie K Johnson, Christine Walker, James A Dunbar) • Pseudo-understanding: an analysis of the **dilution of value** in healthcare (Jens Jacob Fredriksson, David Ebbevi, Carl Savage) • **Taking complaints seriously**: using the patient safety lens (Thomas H Gallagher, Kathleen M Mazor) • Crossing the quality chasm for ***Clostridium difficile*** infection prevention (Nasia Safdar, Eli Perencevich)

	• Improving the care of patients with a **hip fracture**: a quality improvement report (David Hawkes, Jonathan Baxter, Claire Bailey, Gemma Holland, Jennifer Ruddlesdin, Alun Wall, Philip Wykes)

International Journal for Quality in Health Care online first articles

URL	http://intqhc.oxfordjournals.org/content/early/recent?papetoc
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • An Assessment of facilities and services at Anganwadi centers under the **Integrated Child Development Service** scheme in Northeast District of Delhi, India (Akash Malik, Meenakshi Bhilwar, Neeti Rustagi, and Davendra K. Taneja) • What are **hospital nurses'** strengths and weaknesses in **patient safety competence**? Findings from three Korean hospitals (Jee-In Hwang) • Compliance with **hospital accreditation** and **patient mortality**: a Danish nationwide population-based study (Anne Mette Falstie-Jensen, Heidi Larsson, Erik Hollnagel, Mette Nørgaard, Marie Louise Overgaard Svendsen, and Søren Paaske Johnsen) • The relationship between **accessibility** of healthcare facilities and **medical care utilization** among the middle-aged and elderly population in Taiwan (Ya-Ting Yang, Usman Iqbal, Hua-Lin Ko, Chia-Rong Wu, Hsien-Tsai Chiu, Yi-Chieh Lin, Wender Lin, and Yi-Hsin Elsa Hsu)