AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Reports

The practice of system leadership: Being comfortable with chaos
Timmins N
London: The King's Fund, 2015.

URL	http://www.kingsfund.org.uk/publications/practice-system-leadership
Notes	This report, published by the [UK] King's Fund draws on the experiences of ten UK senior healthcare leaders to look in depth at the skills needed to be a system leader. Despite their varying backgrounds, work settings they all have a track record of having tried to bring about change (not always successfully) through using 'soft' power, enabling others to see and deliver the changes that are needed. Some key approaches and strategies emerge, including: • Start with a **coalition** of the willing, build an **evidence base**, and **build outwards**; it is vital to **engage clinicians** in understanding the need for change and to lead efforts to achieve that change. • **Involve patients, service users and carers** because they have an invaluable role to play in helping to identify which services need to be redesigned.

	• Strike the right **balance** between constancy of purpose and flexibility by facilitating conversations about what needs to change and how; being flexible about how that might be achieved; and ensuring the momentum is there to deliver change despite the inevitable opposition. • Pursue **stability of leadership**, something that has proved difficult in a context of frequent reorganisation of the provider and commissioning landscape.

Journal articles

Insensible Losses: When The Medical Community Forgets The Family
Elias P
Health Affairs 2015 April 1, 2015;34(4):707-10.

DOI	http://dx.doi.org/10.1377/hlthaff.2014.0536
Notes	Narrative piece that focuses on a single patient to draw together issues of **clinical handover**, **clinical deterioration** and – crucially – **patient-centred care**. A more patient (and family) centred approach may have ameliorated some of the pain of a delay in recognising and responding to clinical deterioration that then led to a number of clinical handovers (in which the family were forgotten).

Does Employee Safety Matter for Patients Too? Employee Safety Climate and Patient Safety Culture in Health Care
Mohr DC, Eaton JL, McPhaul KM, Hodgson MJ
Journal of Patient Safety 2015 [epub].

DOI	http://dx.doi.org/10.1097/PTS.0000000000000186
Notes	That the culture of a health facility has implications for patient safety is generally accepted. This piece looks at how that culture also has implications for the well-being of those who work there. Using surveys of perceptions of employee safety and safety culture, the researchers report a consistent association between the safety climate for employees and the patient safety culture. The authors speculate that "patient safety culture and employee safety climate could be mutually reinforcing, such that investments and improvements in one domain positively impacts the other." Perhaps it seems self-evident that a place that is good to be a patient in is also likely to be a positive working environment. But does it apply in both directions?

Role of cognition in generating and mitigating clinical errors
Patel VL, Kannampallil TG, Shortliffe EH
BMJ Quality & Safety 2015 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2014-003482
Notes	The role of cognition in clinical error –and how better understanding of cognitive issues – may mitigate or ameliorate these errors has been a topic gathering some interest. This narrative review argues that enhancing error detection and improving error recovery are also important. Further, the authors suggest that "departures from clinical protocols or guidelines can yield innovative and appropriate solutions to unusual problems". The review looks at cognitive approaches to the study of human error and the recovery process, along with methods for enhancing error recognition, and promoting suitable responses, through external cognitive support and virtual reality simulations for the training of clinicians.

Human Factors Engineering: Its Place and Potential in OR Safety
Criscitelli T
AORN Journal 2015;101(5):571-73.

DOI	http://dx.doi.org/10.1016/j.aorn.2015.02.013
Notes	In the last few years the possibility that human factors engineering can help in producing safer healthcare has been raised more than once. This review piece rehearses some of these arguments in the context of the operating theatre,

BMJ Quality and Safety
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URL	http://qualitysafety.bmj.com/content/24/6
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: **SQUIRE and the evolving science of healthcare improvement** (David P Stevens) • Editorial: **Taking complaints seriously**: using the patient safety lens (Thomas H Gallagher, Kathleen M Mazor) • Editorial: What are **patients' care experience priorities**? (Rick A Iedema, Blake Angell) • The **PRONE score**: an algorithm for predicting **doctors' risks of formal patient complaints** using routinely collected administrative data (Matthew J Spittal, Marie M Bismark, David M Studdert) • Can **staff and patient perspectives on hospital safety** predict harm-free care? An analysis of staff and patient survey data and routinely collected outcomes (Rebecca Lawton, Jane Kathryn O'Hara, Laura Sheard, Caroline Reynolds, Kim Cocks, Gerry Armitage, John Wright) • Introducing **consultant outpatient clinics** to community settings to improve access to paediatrics: an observational impact study (Hugh McLeod, Gemma Heath, Elaine Cameron, Geoff Debelle, Carole Cummins) • Preventing **device-associated infections** in US hospitals: national surveys from 2005 to 2013 (Sarah L Krein, Karen E Fowler, David Ratz, Jennifer Meddings, Sanjay Saint) • A qualitative study of the variable effects of **audit and feedback in the ICU** (Tasnim Sinuff, John Muscedere, Linda Rozmovits, Craig M Dale, Damon C Scales) • The effect of the **SQUIRE (Standards of QUality Improvement Reporting Excellence) guidelines** on reporting standards in the quality improvement literature: a before-and-after study (Victoria Howell, Amanda Eva Schwartz, James Daniel O'Leary, Conor Mc Donnell)

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: • Exploring demographic and lifestyle associations with **patient experience** following telephone triage by a primary care doctor or nurse: secondary analyses from a cluster randomised controlled trial (Fiona C Warren, Raff Calitri, Emily Fletcher, Anna Varley, Tim A Holt, Valerie Lattimer, David Richards, Suzanne Richards, Chris Salisbury, Rod S Taylor, J L Campbell)

	• Are we **recording postoperative complications** correctly? Comparison of NHS Hospital Episode Statistics with the American College of Surgeons National Surgical Quality Improvement Program (Muralidharan Parthasarathy, Vicki Reid, Laura Pyne, Thomas Groot-Wassink) • **A 'Just Culture' for performance measures** (Molly J Horstman, Aanand D Naik) • **Quality improvement in academic medical centres**: a resident perspective (Daniel Z Fang, Molly A Kantor, Paul Helgerson) • Is **safe surgery** possible when resources are scarce? (Nathan N O'Hara)

Online resources

Have your say about research in health communication and participation
The Cochrane Consumers and Communication Review Group would like to hear from patients, consumers, carers, and their advocates, health professionals, policy makers, researchers and funders about their ideas for future research topics in the area of health communication and participation. The Group publish reviews of the latest evidence in health communication and participation research. The ideas generated will be used to inform the selection of their next round of reviews. To find out more or take the brief survey visit the project page at
http://www.latrobe.edu.au/chcp/projects/research-priority-setting/survey/

[USA] Patient Safety Primers
http://psnet.ahrq.gov/primerHome.aspx
The Patient Safety Primers from the (US) Agency for Healthcare Research and Quality (AHRQ) discuss key concepts in patient safety. Each primer defines a topic, offers background information on its epidemiology and context, and provides links to relevant materials. AHRQ have released a new primer:

- *Alert Fatigue* – Computerised warnings and alarms are used to improve safety by alerting clinicians of potentially unsafe situations. However, this proliferation of alerts may also have implications for patient safety. http://psnet.ahrq.gov/primer.aspx?primerID=28

[USA] Effective Health Care Program reports
http://effectivehealthcare.ahrq.gov/
The US Agency for Healthcare Research and Quality (AHRQ) has an Effective Health Care (EHC) Program. The EHC has released the following final reports and updates:

- *Management Strategies to Reduce Psychiatric Readmissions*
  http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2082

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