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On the Radar

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On the Radar
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Reports

Computerized Prescriber Order Entry Medication Safety (CPOEMS): Uncovering and Learning from Issues and Errors
Brigham and Women's Hospital, Harvard Medical School, Partners HealthCare
Silver Spring, MD: US Food and Drug Administration; 2015. p. 88.

URL	http://www.fda.gov/Drugs/DrugSafety/MedicationErrors/ucm477360.htm
Notes	The USA's Food and Drug Administration (FDA) has produced this report of a project examining issues and errors associated with computerised medication ordering systems. The project was an exploration of computerised prescriber order entry-related potential for errors in prescribing, particularly as these relate to drug name displays, and ordering and workflow design issues. The project investigated ways to better identify, understand, and prevent electronic ordering errors in the future. The report also includes recommendations, including standardising drug names, minimising alert incidence, and better search functions.

For information on the Commission's work on electronic medication management, including draft national guidelines for on-screen display of clinical medicines information, see http://www.safetyandquality.gov.au/our-work/medication-safety/electronic-medication-management-systems/

Journal articles

Shared Decision Making — Finding the Sweet Spot
Fried TR
New England Journal of Medicine. 2016;374(2):104-6.

DOI	http://dx.doi.org/10.1056/NEJMp1510020
Notes	Decisions that involve choosing between more than one reasonable option should involve clinicians sharing the decision with patients by providing information about the options, the risks and benefits and helping the patient to identify their preferences in the context of their values. This commentary piece explores the different roles that patients can be asked to play in decision making. Fried raises concern that the greater the uncertainty surrounding the benefits and harms of the options and the greater the clinician's ambivalence about the 'right' choice, the greater the likelihood that the patient will be asked to make the decision. Fried cautions against this approach, explaining that patients who are faced with complex decisions may benefit most from a clinician's recommendation. Conversely, the greater the precision with which the outcomes can be predicted (such as benefit-risk assessments in some screening guidelines), the greater likelihood that the clinician will make a strong recommendation. However, the elicitation of the patient's preferences remains important as patients may weigh the benefits and harms differently. Fried notes, "Finding the sweet spot for shared decision making will require clinicians to work against their natural impulses to tell the patient what to do when they're certain of what's best and to leave the patient to decide when they're not".

For information on the Commission's work on shared decision making, see
http://www.safetyandquality.gov.au/our-work/shared-decision-making/

Missed opportunities for diagnosis: lessons learned from diagnostic errors in primary care
Goyder CR, Jones CH, Heneghan CJ, Thompson MJ
British Journal of General Practice. 2015;65(641):e838-e44.

DOI	http://dx.doi.org/10.3399/bjgp15X687889
Notes	Issues around diagnosis and how to identify, measure and ameliorate them have emerged as a focus in recent years. This paper reports on a qualitative study that used 36 interviews with English GPs on the topic of missed and delayed diagnoses. The 'learning points' that the authors identified include "GPs' reliance on 'pattern recognition' and the failure of this strategy to identify atypical presentations; the importance of considering all potentially serious conditions using a 'restricted rule out' approach; and identifying and acting on a sense of unease. Strategies to help manage uncertainty in primary care were also discussed." How clinicians respond to and communicate uncertainty has also been identified as an issue in shared decision-making.

Quality management and perceptions of teamwork and safety climate in European hospitals
Kristensen S, Hammer A, Bartels P, Suñol R, Groene O, Thompson CA, et al.
International Journal for Quality in Health Care. 2015;27(6):498-505.

DOI	http://dx.doi.org/10.1093/intqhc/mzv079
Notes	This European study used a multi-method, cross-sectional approach to analysing survey data of quality management systems and perceived teamwork and safety climate using data on the implementation of quality management system from seven European countries, including patient safety culture surveys from 3622 clinical leaders and 4903 frontline clinicians. These groups showed distinct variance as "Teamwork climate was reported as positive by 67% of clinical leaders and 43% of frontline clinicians. Safety climate was perceived as positive by 54% of clinical leaders and 32% of frontline clinicians. We found positive associations between implementation of quality management systems and teamwork and safety climate". The authors assert that their analyses confirm the "importance of quality management systems as a supportive structural feature for promoting teamwork and safety climate".

Medication safety at the interface: evaluating risks associated with discharge prescriptions from mental health hospitals
Keers RN, Williams SD, Vattakatuchery JJ, Brown P, Miller J, Prescott L, et al
Journal of Clinical Pharmacy and Therapeutics. 2015;40(6):645-54.

DOI	http://onlinelibrary.wiley.com/doi/10.1111/jcpt.12328/abstract
Notes	The importance of reviewing or reconciling mediations on discharge from acute care has been covered previously. This study looked at the quality and safety of discharge prescriptions in mental health hospitals (specifically acute adult and later life inpatient units at three English National Health Service mental health trusts). Examining 274 discharge prescriptions over a 6-week period, the study found that 259 contained a total of 1456 individually prescribed items and that one in five [20.8%] eligible discharge prescriptions and one in twenty [5.1%] prescribed or omitted items were affected by at least one prescribing error. One or more clerical errors were found in 71.9% of discharge prescriptions, and more than two-thirds [68.8%] of eligible discharge prescriptions erroneously lacked information on medicines discontinued during hospital admission.

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

Opioid Prescribing After Nonfatal Overdose and Association With Repeated Overdose: A Cohort Study
Larochelle MR, Liebschutz JM, Zhang F, Ross-Degnan D, Wharam JF
Annals of Internal Medicine. 2016;164(1):1-9.

DOI	http://dx.doi.org/10.7326/M15-0038
Notes	This US study looked at the experiences of 2848 adult patients who had a non-fatal opioid overdose during long-term opioid therapy for non-cancer pain between May 2000 and December 2012. The study found that more than 90% of these patients were then prescribed opioids following the overdose, and within 2 years as many as 17% had experienced another overdose event.

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

BMJ Quality and Safety
February 2016, Vol. 25, Issue 2

URL	http://qualitysafety.bmj.com/content/25/2
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: Can we talk? The art (and science) of **handoff conversation** (Julie K Johnson, Vineet M Arora) • Advancing the next generation of **handover research and practice** with cognitive load theory (John Q Young, Robert M Wachter, Olle ten Cate, Patricia S O'Sullivan, David M Irby) • The problem with **incident reporting** (Carl Macrae) • "Anybody on this list that you're more worried about?" Qualitative analysis exploring the functions of questions during **end of shift handoffs** (Colleen M O'Brien, Mindy E Flanagan, A A Bergman, P R Ebright, R M Frankel) • "Mr Smith's been our problem child today…": anticipatory management communication (AMC) in VA **end-of-shift medicine and nursing handoffs** (Alicia A Bergman, Mindy E Flanagan, Patricia R Ebright, Colleen M O'Brien, Richard M Frankel) • **Patient safety incident reporting**: a qualitative study of thoughts and perceptions of experts 15 years after 'To Err is Human' (Imogen Mitchell, Anne Schuster, Katherine Smith, Peter Pronovost, Albert Wu) • Sustained **reductions in time to antibiotic delivery** in febrile immunocompromised children: results of a quality improvement collaborative (Christopher E Dandoy, Selena Hariharan, Brian Weiss, Kathy Demmel, Nathan Timm, Janis Chiarenzelli, Mary Katherine Dewald, Stephanie Kennebeck, Shawna Langworthy, Jennifer Pomales, Sylvia Rineair, Erin Sandfoss, Pamela Volz-Noe, R Nagarajan, E Alessandrini) • A systematic review of reliable and valid tools for the **measurement of patient participation** in healthcare (Nicole Margaret Phillips, Maryann Street, Emily Haesler) • Meta-analysis of the central line bundle for **preventing catheter-related infections**: a case study in appraising the evidence in quality improvement (Perla J Marang-van de Mheen, Leti van Bodegom-Vos)

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: • Fake and expired medications in **simulation-based education**: an underappreciated risk to patient safety (Jane Torrie, David Cumin, Janie Sheridan, Alan F Merry) • The problem with **medication reconciliation** (Joshua M Pevnick, Rita Shane, Jeffrey L Schnipper) • One size fits all? Mixed methods evaluation of the impact of 100% **single-room accommodation** on staff and patient experience, safety and costs (Jill Maben, Peter Griffiths, Clarissa Penfold, Michael Simon, Janet E Anderson, Glenn Robert, Elena Pizzo, Jane Hughes, Trevor Murrells, James Barlow)

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: • Improving trustworthiness for the codes of **International Classification of Diseases** 11th version and **reducing hospital readmissions** in order to improve healthcare services (Shabbir Syed-Abdul, Usman Iqbal, and Yu-Chuan (Jack) Li) • Development and Psychometric Characteristics of the **Pediatric Inpatient Experience Survey** (PIES) (Sonja I. Ziniel, Jean A. Connor, Dionne Graham, Jennifer Koch Kupiec, Nina A. Rauscher, Amanda S. Growdon, Anne Berger, Kathy J. Jenkins, and Sion Kim Harris) • Prevalence and patterns of **potentially avoidable hospitalizations** in the US long-term care setting (Rosemary M. McAndrew, David C. Grabowski, Ankit Dangi, and Gary J. Young) • Guide to **Clinical Practice Guidelines**: The Current State of Play (Tamara Kredo, Susanne Bernhardsson, Shingai Machingaidze, Taryn Young, Quinette Louw, Eleanor Ochodo, and Karen Grimmer) • Should quality goals be defined for **multicenter laboratory testing**? Lessons learned from a pilot survey on a national surveillance program for diabetes (Limin Wang, Nanxun Mo, Richard Pang, Qian Deng, Yong Liu, Yan Hu, Chaohui Hu, and Linhong Wang)

Online resources

Medical Devices Safety Update
Volume 4, Number 1, January 2016
http://www.tga.gov.au/publication-issue/medical-devices-safety-update-volume-4-number-1-january-2016
The Therapeutic Goods Administration (TGA) has released the latest edition of its medical device safety bulletin. Topics covered in this issue include:

- **Battery management** a growing issue
- Safety alerts issued for two **knee implants –** related to the ACS fixed-bearing cementless porous coated tibial component and the Scorpio Series 7000 cementless beaded tibial components, both of which are used in total knee replacements
- **IUCDs** (intrauterine contraceptive device) and uterine perforation
- Recent **safety alerts**, relating to Anatomic Locked Plating System, Silimed medical devices, InSync III cardiac resynchronisation therapy pacemakers, Optisure dual coil defibrillation leads, and EndoBarrier duodenal-jejunal bypass liner with delivery system
- **inSite program** extends to Sydney.

[UK] NICE Guidelines and Quality Standards
http://www.nice.org.uk
The UK's National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest updates are:

- NICE Quality Standard QS109 **Diabetes in pregnancy**
  https://www.nice.org.uk/guidance/qs109
- NICE Quality standard QS110 **Pneumonia** in adults
  https://www.nice.org.uk/guidance/qs110

- NICE QS111 **Obesity** in adults: prevention and lifestyle weight management programmes https://www.nice.org.uk/guidance/qs111

[UK] Self-monitoring of warfarin is safe and cost-effective
https://discover.dc.nihr.ac.uk/portal/article/4000029/self-monitoring-of-warfarin-is-safe-and-cost-effective
Item from the UK National Institute for Health Research Dissemination Centre summarising a systematic review that investigated the clinical and cost-effectiveness of self-monitoring by people receiving long-term anticoagulation. The review examined 26 studies and found that found that self-monitoring was clinically effective at reducing blood clots and was cost-effective compared with standard care.

[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:

- *For Clinicians: Therapies for Clinically Localized* ***Prostate Cancer***
  http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2143
- *For Consumers: Treating Localized* ***Prostate Cancer****: A Review of the Research for Adults*
  http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2171
- *Diagnosis and Management of* ***Infantile Hemangioma***
  http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2170
