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On the Radar

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On the Radar
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Journal articles

Nature of Blame in Patient Safety Incident Reports: Mixed Methods Analysis of a National Database
Cooper J, Edwards A, Williams H, Sheikh A, Parry G, Hibbert P, et al
The Annals of Family Medicine. 2017;15(5):455-61.

DOI	https://doi.org/10.1370/afm.2123
Notes	Members of this group have published a number of papers based on analyses of information from UK national datasets, particular the England and Wales National Reporting and Learning System (as the case in this paper). This study analysed a random sample of family practice patient safety incident reports to examine the nature of blame in family practice safety incident reports. As the authors note, "A culture of blame and fear of retribution are recognized barriers to reporting patient safety incidents. The extent of blame attribution in safety incident reports, which may reflect the underlying safety culture of health care systems, is unknown." In their sample of family practice incident reports, the authors found that in 45% of case the health professional making the report apportioned blame to a specific person in 45% of cases (n = 975 of 2,148) with 36% of cases attributing fault to another person, and 2% of those reporting acknowledging personal responsibility. The authors also observed that blame was commonly associated with incidents where a complaint was anticipated.

	These results indicate that **British family practice** may have a "**culture** that leads to **blame and retribution**, rather than to identifying areas for **learning and improvement**, and a failure to appreciate the contribution of system factors in others' behavior. Successful improvement in patient safety through the analysis of incident reports is unlikely without achieving a blame-free culture.

False Dawns and New Horizons in Patient Safety Research and Practice
Mannion R, Braithwaite J
International Journal of Health Policy and Management. 2017 [pub].

DOI	http://www.ijhpm.com/article_3419.html http://dx.doi.org/10.15171/ijhpm.2017.115
Notes	In this editorial the authors lament the apparent inability to sustain and generalise improvements in the safety of health care and asserting that there has been no measurable, systems-level improvement in the overall rates of preventable harm. They suggest the conceptualisation of safety in health may be hindering change and flag other approaches to understanding and addressing patient safety in complex, dynamic health systems, particularly the Safety-II perspective and embracing the complexity of health the produces both positive and negative outcomes.

The Age-Friendly Health System Imperative
Fulmer T, Mate KS, Berman A
Journal of the American Geriatrics Society. 2017 [epub].

A bipartisan "moonshot" in health: Improving care for high-need patients
Chokshi DA
Journal of the American Medical Association. 2017;318(9):788-9.

DOI	Fulmer et al http://dx.doi.org/10.1111/jgs.15076 Chokshi http://dx.doi.org/10.1001/jama.2017.10801
Notes	The push for a health system that focuses more on patients and their needs (and those of their families and carers) has also seen a number of particular groups as being identified. These articles discuss the needs of a couple of these groups, namely ageing patients (and many nations have a growing proportion of aged people) and those with 'high needs'. Fulmer at el describe a collaboration that is attempting to imagine and prototype "an **age-friendly health system** of the future". This is an effort to address the complex and interrelated needs of older people in shaping a more-effective, patient-directed, safer healthcare system. The [US] Institute for Healthcare Improvement (IHI) defines an age-friendly health care system as one in which: • Older adults get the best care possible; • Healthcare-related harms to older adults are dramatically reduced and approaching zero; • Older adults are satisfied with their care; and • Value is optimised for all — patients, families, caregivers, health care providers and health systems. In various issues of *On the Radar* there have been items on 'high needs' patients. Chokshi's commentary is the latest addition to the literature. This commentary focuses on a recent [US] National Academy of Medicine report, *Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health* (previously covered in *On the Radar* and available at https://nam.edu/effective-care-for-high-need-patients/) As with the 'age friendly' models, key elements must be a **focus on the individual** and **co-ordination** and **continuity of care**.

For information on the Commission's work on patient and consumer centred care, see
https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Public reporting of clinician-level data
Canaway R, Bismark MM, Dunt D, Kelaher MA
Medical Journal of Australia. 2017;207(6):231-2.

DOI	http://dx.doi.org/10.5694/mja16.01402
Notes	In this Perspective piece, the authors provide a brief description of the use of public reporting internationally and in Australia. To date, individual clinician-level public reporting has not been part of public reporting of hospital performance in Australia. They observe that the research on the impacts of clinician-level reporting is limited but argue that it should be investigated and discussed. They also note that "Public reporting of hospital performance data at any level, however, remains just one mechanism for the continuous improvement of hospital quality and safety." Ina recent issue of *On the Radar*, we included Ashish Jha's post on the JAMA Forum *Public Reporting of Surgical Outcomes: Surgeons, Hospitals, or Both?* (https://newsatjama.jama.com/2017/08/24/jama-forum-public-reporting-of-surgical-outcomes-surgeons-hospitals-or-both/) Jha gave a succinct summary of the arguments around public reporting, noting the importance of timely feedback and reporting as a spur to quality and safety. He was much less equivocal on the subject than this piece.

The value of inpatient rehabilitation after uncomplicated knee arthroplasty: a propensity score analysis
Naylor JM, Hart A, Mittal R, Harris I, Xuan W
Medical Journal of Australia. 2017;207(6):250-5.

Is inpatient rehabilitation after a routine total knee replacement justified?
Loefler A
Medical Journal of Australia. 2017;207(6):241-2.

DOI	Naylor et al http://dx.doi.org/10.5694/mja16.01362 Loefler http://dx.doi.org/10.5694/mja17.00362
Notes	Rehabilitation after total knee replacement is standard practice. The value (or otherwise) of completing this as an inpatient (often in a private hospital in the Australian context) or as an outpatient or in the community has been debated. Naylor and colleagues have used patient-reported knee pain and function and health rating scores from 258 patients (129 pairs of matched patients) to compare the effectiveness of rehabilitation after total knee arthroplasty (TKA) after discharge to an inpatient rehabilitation facility or home. Their analyses led to the conclusion "pathways incorporating inpatient rehabilitation did not achieve better joint-specific outcomes or health scores than alternatives not including inpatient rehabilitation" In a related editorial, Loefler observes that this study has "clearly shown that **inpatient rehabilitation** after an uncomplicated total knee replacement is **more expensive** than outpatient rehabilitation, yet the **functional outcomes are the same**. If there are indeed some individuals in our large pool of patients who need extra time and care in hospital, we will need to further analyse the benefits of inpatient rehabilitation for such subgroups. And we should perhaps ask the rehabilitation industry to show cause and to justify their costs." Variation in knee replacement surgery in Australia was examined in the *Second Australian Atlas of Healthcare Variation*. For further information, see http://safetyandquality.gov.au/atlas

Cataract surgery coverage rates for Indigenous and non-Indigenous Australians: the National Eye Health Survey
Foreman J, Xie J, Keel S, van Wijngaarden P, Crowston J, Taylor HR, et al
Medical Journal of Australia. 2017;207(6):256-61.

DOI	http://dx.doi.org/10.5694/mja17.00057
Notes	Paper reporting in an attempt to determine cataract surgery coverage rates for Indigenous and non-Indigenous Australians based on sampling at 30 randomly selected Australian geographic sites, stratified by remoteness. The survey included 3098 non-Indigenous Australians aged 50 years or more and 1738 Indigenous Australians aged 40 years or more. The authors report that (based on World Health Organization definitions) coverage rates were 92.5% and 98.9% for Indigenous and non-Indigenous Australians respectively, "indicating the need to improve cataract surgery services for Indigenous Australians." Variation in cataract surgery across Australia was examined in both the *Australian Atlas of Healthcare Variation* and the *Second Australian Atlas of Healthcare Variation*. For information on these, see http://safetyandquality.gov.au/atlas

Toward More Proactive Approaches to Safety in the Electronic Health Record Era
Sittig DF, Singh H
The Joint Commission Journal on Quality and Patient Safety. 2017 [epub].

DOI	http://dx.doi.org/10.1016/j.jcjq.2017.06.005
Notes	Commentary piece giving a summary of the updated SAFER (Safety Assurance Factors for EHR Resilience) Guides. The SAFER Guides were designed to help health care organisations conduct self-assessments to optimize the safety and safe use of electronic health records (EHRs) in these areas: High Priority Practices, Organizational Responsibilities, Contingency Planning, System Configuration, System Interfaces, Patient Identification, Computerized Provider Order Entry with Decision Support, Test Results Reporting and Follow-Up, and Clinician Communication. The guides are used for proactive EHR risk assessment and recommend practices developed to improve the safety and safe use of EHRs. The authors describe how the Guide can be used and how wider adoption of SAFER Guides may be encouraged.

For information on the Commission's work on safety in e-health, see
https://www.safetyandquality.gov.au/our-work/safety-in-e-health/

Assessment of automating safety surveillance from electronic health records: analysis for the quality and safety review system
Fong A, Adams K, Samarth A, McQueen L, Trivedi M, Chappel T, et al.
Journal of Patient Safety. 2017 [epub].

DOI	http://dx.doi.org/10.1097/PTS.0000000000000402
Notes	Paper describing the development and testing of a patient safety surveillance system called the Quality and Safety Review System (QSRS), including an assessment of the feasibility of automatically populating QSRS questions from electronic health records EHR data. From their assessment of the complexity of the questions devised and assessed the authors concluded that "abstracting information from these records is still very challenging". An aspect of this complexity is the variation in how data is represented across different electronic systems, perhaps emphasising the need for interoperability and standards. The heuristic framework developed in this work could be used to help guide conversations around the feasibility of automating QSRS data abstraction.

User-centered collaborative design and development of an inpatient safety dashboard
Mlaver E, Schnipper JL, Boxer RB, Breuer DJ, Gershanik EF, Dykes PC, et al
The Joint Commission Journal on Quality and Patient Safety. 2017 [epub].

DOI	https://doi.org/10.1016/j.jcjq.2017.05.010
Notes	This paper describes another attempt at using electronic health records (EHRs) to identify patient safety issues. In this instance it was a patient safety dashboard for interdisciplinary rounding teams on inpatient medical services in a US hospital. The article summarises the development, features, functions, and initial evaluation of the dashboard. The dashboard collects real-time data covering thirteen safety domains through web services and generate stratified alerts. The authors argue that this technological infrastructure is adaptable to other EHR environments.

An electronic trigger based on care escalation to identify preventable adverse events in hospitalised patients
Bhise V, Sittig DF, Vaghani V, Wei L, Baldwin J, Singh H
BMJ Quality & Safety. 2017 [epub].

DOI	http://dx.doi.org/10.1136/bmjqs-2017-006975
Notes	This paper also describes a safety tool using electronic health record (EHR) data. In this study the project team refined the [US] Institute of Healthcare Improvement's Global Trigger Tool (GTT) and leveraged EHR data to improve detection of preventable adverse events, including diagnostic errors.

The economic burden of nurse-sensitive adverse events in 22 medical-surgical units: retrospective and matching analysis
Tchouaket E, Dubois C-A, D'Amour D
Journal of Advanced Nursing. 2017;73(7):1696-711.

DOI	http://dx.doi.org/10.1111/jan.13260
Notes	This study sought to estimate the economic burden of nurse-sensitive adverse events (pressure ulcers, falls, medication administration errors, pneumonia and urinary tract infections) in 22 acute-care units in Quebec by estimating excess hospital-related costs and calculating resulting additional hospital days. Using retrospective analysis of charts of 2699 patients hospitalized between July 2008–August 2009 for at least 2 days the study found the five adverse events considered nurse-sensitive caused nearly 1300 additional hospital days for 166 patients and generated more than $CDN600,000 in excess treatment costs.

Recognizing and Responding to the "Toxic" Work Environment: Worker Safety, Patient Safety, and Abuse/Neglect in Nursing Homes
Pickering CEZ, Nurenberg K, Schiamberg L
Qualitative Health Research. 2017 [epub].

DOI	https://doi.org/10.1177/1049732317723889
Notes	It is unsurprising that a **poor work environment** contributes to a **poor work culture**. The culture in healthcare is regarded as important to the safety and quality of care and to the wellbeing of those who work there as well as those receiving care. This small qualitative study interviewed certified nursing assistants (CNAs) who experienced bullying while employed in a nursing home. The strategies CNAs used in responding to the "toxic" environment affected their care provision and were attributed to the development of several resident and worker safety outcomes.

DOI	http://dx.doi.org/10.2146/ajhp170228
Notes	This article gives the results of the 2016 American Society of Health-System Pharmacists (ASHP) survey of pharmacy practice in hospital settings. The survey was sent to a stratified random sample of pharmacy directors at 1,315 general and children's medical–surgical hospitals in the USA and was completed by 29.8%. Results noted include: • Drug policy development by pharmacy and therapeutics committees continues to be an important strategy for improving prescribing. • Strict formulary systems are maintained in 63.0% of hospitals • 89.7% of hospitals use clinical practice guidelines that include medications. Pharmacists have the authority to order laboratory tests in 89.9% of hospitals and order medications in 86.8% of hospitals. • Therapeutic interchange policies are used in 89.2% of hospitals. • Electronic health records (EHRs) have been implemented partially or completely in most hospitals (99.1%). • Computerised prescriber-order-entry (CPOE) systems with clinical decision support are used in 95.6% of hospitals, and 92.6% of hospitals have barcode-assisted medication administration systems. • Transitions-of-care programs are increasing in number, with 34.6% of hospitals now offering discharge prescription services. • Pharmacists practice in 39.5% of hospital ambulatory or primary care clinics. • The most common service offered by pharmacists to outpatients is anticoagulation management (26.0%). When pharmacists practice in ambulatory care clinics, 64.5% have prescribing authority through collaborative practice agreements.

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

BMJ Quality and Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Editorial: **Compassionate care**: constitution, culture or coping? (Elaine Maxwell) • Editorial: Addressing the **multisectoral impact of pressure injuries** in the USA, UK and abroad (William V Padula, Peter J Pronovost) • Development of the **Huddle Observation Tool** for **structured case management discussions** to improve situation awareness on inpatient clinical wards (Julian Edbrooke-Childs, Jacqueline Hayes, Evelyn Sharples, Dawid Gondek, Emily Stapley, Nick Sevdalis, Peter Lachman, J Deighton) • **Optimising impact and sustainability**: a qualitative process evaluation of a complex intervention targeted at compassionate care (Jackie Bridges, Carl May, Alison Fuller, Peter Griffiths, Wendy Wigley, Lisa Gould, Hannah Barker, Paula Libberton) • An **electronic trigger based on care escalation** to identify **preventable adverse events** in hospitalised patients (Viraj Bhise, Dean F Sittig, Viralkumar Vaghani, Li Wei, Jessica Baldwin, Hardeep Singh)

Online resources

Promoting the mental health of health services staff
https://www.headsup.org.au/healthy-workplaces/information-for-health-services
Heads Up has been developed by the Mentally Healthy Workplace Alliance and beyondblue. The website provides a wide range of resources, information and advice for individuals and organisations – all of which are designed to offer simple, practical and, importantly, achievable guidance.
This particular page is aimed at promoting the mental health of health services staff, including health professionals. Risk factors in the workplace include heavy workloads, long working hours, shift work, bullying, harassment, occupational violence and home-work stress.
beyondblue has recently launched a guide to developing a workplace wellbeing strategy in health service settings. The guide is available from this page.

[USA] Health Care Facility Design Safety Risk Assessment Toolkit
https://www.ahrq.gov/professionals/systems/hospital/safetyassess-toolkit/index.html
The US Agency for Healthcare Research and Quality has released this safety risk assessment toolkit to help designers ensure that new or renovated health care facilities adequately support workflow, procedures, and capability while keeping patients and staff safe from harm. The toolkit targets six areas: infections, falls, medication errors, security, behavioural health, and patient handling. The toolkit also addresses more than 200 potential environmental considerations for the built environment and provides a quality check tool that allows teams to prioritise risks within budget.

[UK] NICE Guidelines and Quality Standards
https://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 reviews or updates are:
- Clinical Guideline CG28 **Depression in children and young people**: *identification and management* https://www.nice.org.uk/guidance/cg28
- NICE Guideline NG74 **Intermediate care** *including reablement* https://www.nice.org.uk/guidance/ng74

[UK] Childhood eczema
http://www.dc.nihr.ac.uk/highlights/Childhood-eczema
The UK's National Institute for Health Research (NIHR) has produced this 'Highlights' web page drawing together studies looking at a range of treatments for childhood eczema. The Highlight also contains perspectives from parents and their children who have eczema.

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