On the Radar

Issue 43
6 June 2011

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This week's content

Books

Error Reduction in Health Care: A Systems Approach to Improving Patient Safety. 2nd ed.
Spath PL, editor

According to the ARHQ PSnet email:
‘Error Reduction in Health Care remains one of the few comprehensive textbooks in patient safety. This updated edition covers key concepts in safety, beginning with the systems approach and the role of human factors engineering in patient safety. Also included are sections on measurement and interpretation of safety data, error analysis techniques, and approaches to improving patient safety (e.g., teamwork training and developing a culture of safety). The book's chapters …strike a balance between background theory and practical approaches to reducing preventable adverse events.’

The publisher says that the new edition covers ‘contemporary material on innovative patient safety topics such as applying Lean principles to reduce mistakes, opportunity analysis, deductive adverse event investigation, improving safety through collaboration with patients and families, using technology for patient safety improvements, medication safety, and high reliability organizations’.

The Table of Contents is:
PART ONE The Basics of Patient Safety.
1: A Formula for Errors; Good People + Bad Systems
2: The Human Side of Medical Mistakes
3: High Reliability and Patient Safety

Notes
### Journal articles

#### A New Frontier in Patient Safety
McCannon J, Berwick DM

| Notes | One of the pioneers of patient safety, Don Berwick, is now leading the US Centers for Medicare & Medicaid in the US Department of Health and Human Services. This 2-page piece describes the rationale, aims and approach of the recently announced (an announcement that was covered in *On the Radar* at the time) US government-funded ‘Partnership for Patients’. The Partnership has 2 fundamental aims:  
*To Accelerate the Reduction of Harm to Patients in Hospitals.* By the end of 2013 the nation should achieve a 40% reduction in preventable harm compared with 2010, amounting to approximately 1.8 million fewer injuries to patients, 60,000 lives saved, and $20 billion in health care costs avoided.  
*To Decrease Preventable Hospital Readmissions Within 30 Days of Discharge.* By the end of 2013 readmissions would be reduced by 20% compared with 2010, meaning prevention of more than 1.6 million hospital readmissions and an estimated $15 billion in health care costs avoided. |

| DOI | [http://dx.doi.org/10.1001/jama.2011.742](http://dx.doi.org/10.1001/jama.2011.742) |

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#### Developing and testing a tool to measure nurse/physician communication in the intensive care unit
Manojlovich M, Saint S, Forman J, Fletcher CE, Keith R, Krein S

| Notes | Report on a survey tool for assessing nurse-physician communication that suggested that intensive care units with lower perceived safety culture also appeared to have poorer inter-disciplinary communications. |
The study was undertaken in 3 ICUs at a single US Department of Veterans Affairs Medical Center. The study used qualitative data came from 4 observations of patient care rounds and 8 interviews with nurses and physicians and quantitative data came from anonymous surveys distributed to nurses in all 3 ICUs (n = 66). Analysis showed significant differences between the 3 ICUs in nurses' perceptions of a safety culture. According to qualitative analyses, nurses from the unit which reported the weakest safety culture also were the least satisfied in their communication with physicians. Qualitative analyses corroborated the quantitative findings and demonstrated the importance of contextual influences on nurse/physician communication.

DOI http://dx.doi.org/10.1097/PTS.0b013e3182192463

Patient-assisted incident reporting: including the patient in patient safety
Millman EA, Pronovost PJ, Makary MA, Wu AW

Notes Short commentary piece suggesting that patient-assisted incident reporting following an adverse event can reveal contributing factors the care team may have missed. The paper describes the use of including the patient's perspective to provide a complementary perspective of the event. The methodology for obtaining and using this information is briefly described in the paper.

DOI http://dx.doi.org/10.1097/PTS.0b013e31821b3c5f

Patient involvement in patient safety: Protocol for developing an intervention using patient reports of organisational safety and patient incident reporting
BMC Health Services Research 2011;11(1):130 [epub].

Notes More on involving the patient, including in reporting and addressing incidents. Recognising that patients may be a rich source of information on both organisational aspects of safety and patient safety incidents, the project sought to develop two patient safety interventions to promote organisational learning about safety - a patient measure of organisational safety and a patient incident reporting tool to help the NHS prevent patient safety incidents by learning more about when and why they occur. The paper discusses how these tools will be developed and tested. It is hoped that the tools will provide a reliable means of gaining patient views about patient safety and that the tools will have relevance and practical utility for hospital operators.

DOI http://dx.doi.org/10.1186/1472-6963-11-130


A framework for classifying patient safety practices: results from an expert consensus process
BMJ Quality & Safety 2011 [epub].

Notes Meetings of the patient safety luminaries has led to a number of recent papers. This paper proposes an update framework for classifying patient safety practices based on the collective knowledge of this group. The paper’s abstract reads:
‘Development of a coherent literature evaluating patient safety practices [PSPs] has been hampered by the lack of an underlying conceptual framework…. The authors developed a framework to classify PSPs by identifying and synthesising existing conceptual frameworks, evaluating the draft framework by asking a group of experts to use it to classify a diverse set of PSPs and revising the framework through an expert-panel consensus process.

Results
The 11 classification dimensions in the framework include: regulatory versus voluntary; setting; feasibility; individual activity versus organisational change; temporal (one-time vs repeated/long-term); pervasive versus targeted; common versus rare events; PSP maturity; degree of controversy/conflicting evidence; degree of behavioural change required for implementation; and sensitivity to context.

Conclusion
This framework offers a way to classify and compare PSPs, and thereby to interpret the patient-safety literature….’

DOI http://dx.doi.org/10.1136/bmjqs.2010.049296

What context features might be important determinants of the effectiveness of patient safety practice interventions?
BMJ Quality & Safety 2011 [epub].

Notes
Another paper reporting on an expert panel consensus process – indeed the same group (all bar one) as in the paper discussed above. This time looking at the contextual issues that can influence the efficacy of interventions. The issue of context is becoming more recognised as a critical factor in the transferability of interventions.

As they note, ‘knowledge of which contextual features are important determinants of PSP effectiveness is limited and consensus is lacking on a taxonomy of which contexts matter.’

The expert panel ‘reached a consensus on a taxonomy of four broad domains of contextual features important for PSP implementations: safety culture, teamwork and leadership involvement; structural organisational characteristics (eg, size, organisational complexity or financial status); external factors; and availability of implementation and management tools (eg, training organisational incentives)’.

DOI http://dx.doi.org/10.1136/bmjqs.2010.049379

Trends in Hospital Volume and Operative Mortality for High-Risk Surgery
Finks JF, Osborne NH, Birkmeyer JD

Notes
A further contribution to the volume-quality debate which has tended to see calls for surgical procedures, particularly higher risk procedures, to be concentrated in centres that do a high volume. The argument being that surgeons (and units) that specialise or at least do higher volumes of procedures tend to be better performing. This paper problematises that argument and suggests that while mortality has fallen, in concert with such concentration, and that may have influenced the reduction in mortality in some high-risk cancer operations, ‘declines in mortality with other procedures are largely attributable to other factors.’

URL http://healthpolicyandreform.nejm.org/?p=14613
Meaningful use and certification of health information technology: what about safety?  
Hoffman S, Podgurski A  
Related website: http://www.aha.org/aha/issues/HIT/mu/index.html

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<th>Notes</th>
<th>Short paper examining some of the potential safety concerns surrounding the implementation of health information technology.</th>
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<td>DOI</td>
<td><a href="http://dx.doi.org/10.1111/j.1748-720X.2011.00572.x">http://dx.doi.org/10.1111/j.1748-720X.2011.00572.x</a></td>
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For information about the Commission’s work in safety in e-health, visit  

Process changes to increase compliance with the universal protocol for bedside procedures  
Barsuk JH, Brake H, Caprio T, Barnard C, Anderson DY, Williams MV  

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<th>Notes</th>
<th>The paper describes a quality improvement process that included forcing functions that apparently produced significantly improved adherence to the Universal Protocol for prevention of wrong-site procedures.</th>
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Online resources

http://www.hhs.gov/ash/initiatives/hai/training/index.html  
The [US] HHS Office of Healthcare Quality has released Partnering to Heal: Teaming Up Against Healthcare-Associated Infections, an interactive learning tool for clinicians, health professional students, and family caregivers. The training videos include information on basic protocols for universal precautions and isolation precautions to protect patients, visitors, and practitioners from the most common disease transmissions. The training promotes six key behaviours: teamwork, communication, hand washing, vaccination against the flu, appropriate use of antibiotics, and proper insertion, use, and removal of catheters and ventilators. These resources support the new Partnership for Patients, a national public-private partnership with hospitals, medical groups, consumer groups and employers that aims to prevent millions of injuries and complications in patient care over the next 3 years.

[US] Helps to Prevent Hospital-Acquired Pressure Ulcers  
http://www.ahrq.gov/research/ltc/pressureulcertoolkit/  
The US Agency for Healthcare Research and Quality has released a new web-based resource to assist hospital staff in implementing effective pressure ulcer prevention practices through an interdisciplinary approach to care. The toolkit, Preventing Pressure Ulcers in Hospitals, provides links to tools that outline a step-by-step hospital-based initiative to target interventions in those areas where patient care processes have shown the most risks to patient skin integrity. Hospitals can tailor the toolkit to meet their needs to implement new strategies and to track, record, and assess progress in pressure ulcer management.
[US] TalkingQuality Webinar on the Audience for Quality Reports
https://www.talkingquality.ahrq.gov/content/resources/Podcasts_and_Webinar.aspx

On 11 May, the [US] Agency for Healthcare Research and Quality’s TalkingQuality project hosted a free Webinar to help developers of public reports better understand the audience for comparative information on health care quality. An audio recording of the webinar, a transcript of speakers’ presentations and the Q&A and speakers’ slides are now available.

For information on Hand Hygiene Australia, visit http://www.hha.org.au
For information about the Commission’s work on healthcare associated infection, visit http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-03

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