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On the Radar

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This week's content

Reports

[UK] First steps towards quality improvement: A simple guide to improving services
NHS Improvement, London, 2012.

Notes	From the UK NHS Improvement this guide is intended to support health care workers undertaking quality improvement projects by providing 'the information you need for your first steps towards making quality improvements'. Topics include improvement models and tools, and the human dimensions of change in service design. It is a 'short overview' or introduction rather than a comprehensive guide.
URL	http://www.santepop.qc.ca/url.php?i=14536&f=News&l=En

[UK] Can changing clinician–patient interactions improve healthcare quality? A scoping report for the Health Foundation
Fischer M, Ereaut G
London. Health Foundation, 2011.

Notes	This scoping report stems from a study examining the dynamic between health service users and providers. It examines five major themes: making sense of the consultation; fear as a driver;' invisible structures'; fragmented conversations; and system dynamics. Based on the precept that 'The quality of care is a factor of the quality of the interactions between people who use services and people who provide them. Thus, transforming this dynamic is a [lever] for improving quality', the Health Foundation commissioned this report 'to help create a rich picture of a key aspect of this dynamic, the individual clinician–patient interaction.'

URL	http://www.health.org.uk/public/cms/75/76/313/3121/Can%20changing%20clinician%20patient%20interactions%20improve%20healthcare%20quality.pdf?realName=b7L0jo.pdf http://tinyurl.com/d4u7aoo

[UK] Could quality be cheaper? How quality improvements helped to reduce costs for three local services
White C
London. The Health Foundation, 2011.

Where Are the Health Care Cost Savings?
Emanuel EJ
The Journal of the American Medical Association 2012;307(1):39-40.

Notes	Following on recent items on questions of costs and savings related to safety and quality are these two items. One reporting three UK case studies and the other a US commentary piece. The argument described previously was one of savings being made at the patient/case level but not translating to the facility, service or system level as reduction in costs, length of stay, etc. allow greater capacity or throughput. A system may be more efficient and treat more patients at a lower cost per patient, but that does not make for a cheaper system overall. The Health Foundation report describes three local services that used quality improvements in order to reduce costs. The projects covered reduction in blood transfusions in joint replacement surgery by testing and treating for anaemia earlier, changing operative hysteroscopy to an outpatient procedure performed under local anaesthetic and using reusable equipment, and restructuring antenatal case for high-risk pregnancies. The report notes the difficulty in quantifying costs and savings but concludes that the three projects described 'did succeed in substantially raising quality and making *some* local cost savings.' The commentary piece in JAMA suggests that if savings are to be found they lie in how chronic disease is managed, particularly in keeping these patients out of hospital. Thus, '[c]umulatively, the savings appear to occur through fewer hospitalizations, emergency department visits, and lower use of specialist services'.
URL/ DOI	White: http://www.health.org.uk/publications/could-quality-be-cheaper/# Emanuel: http://dx.doi.org/10.1001/jama.2011.1927

Journal articles

A conceptual framework identifying sources of risk to patient safety in primary care
McLeod L, Kingston-Reichers J, Jonsson E
Australian Journal of Primary Health [epub].

Notes	Recognising that possible risks to patient safety in primary care settings may be different to those in an acute care setting, this paper describes a proposed Patient Safety in Primary Care Framework (PSPCF) to conceptualise the sources of risk to patient safety. The PSPCF takes a system approach — based on the Health Care Error Proliferation Model (HCEPM) — and re-configures the four defensive layers of the HCEPM and adds a fifth defensive layer, namely patient performance.
DOI	http://dx.doi.org/10.1071/PY11062

For information on the Commission's work on patient safety in primary health care, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PatientSafety-PHC

Failure to Follow-Up Test Results for Ambulatory Patients: A Systematic Review
Callen J, Westbrook J, Georgiou A, Li J
Journal of General Internal Medicine 2012 [epub].

Notes	How great a risk is the failure to follow-up diagnostic results is something of a 'known unknown'. Logically failure to follow-up and act appropriately to diagnostics are safety and quality lapses in care. This review examined the literature to see what work had been on quantifying the extent of failure to follow-up test results and the impact for ambulatory patients. From 768 English-language only articles from 1995–2010, 19 studies were selected. These reported wide variation in the extent of tests not followed-up: 6.8% to 62% for laboratory tests; 1.0% to 35.7% for radiology. The impact on patient outcomes included missed cancer diagnoses. Test management practices varied between settings and there were few guidelines regarding responsibility for patient notification and follow-up. The authors recommend that solutions to these issues need to 'be multifaceted and include: policies relating to responsibility, timing and process of notification; integrated information and communication technologies facilitating communication; and consideration of the multidisciplinary nature of the process and the role of the patient.'
DOI	http://dx.doi.org/10.1007/s11606-011-1949-5

A systematic review to evaluate the accuracy of electronic adverse drug event detection
Forster AJ, Jennings A, Chow C, Leeder C, van Walraven C
Journal of the American Medical Informatics Association 2012;19(1):31-38.

Methods for assessing the preventability of adverse drug events: a systematic review
Hakkarainen KM, Andersson Sundell K, Petzold M, Hagg S.
Drug Safety 2012;35(2):105-126.

Notes	A pair of systematic reviews concerned with adverse drug events (ADEs) – one on electronic detection and one on assessing preventability. The automatic detection of ADEs has been sought for a while. The review by Forster et al aimed to examine established electronic detection systems and their accuracy. The review identified 44 studies, of which 24 (50%) studies reported rule accuracy but only 9 (18.8%) utilized a proper gold standard (chart review in all patients). Rule accuracy was variable and often poor. 5 studies derived or used detection rules that were defined by clinical need or underlying ADE prevalence. The authors report that several factors led to inaccurate ADE detection algorithms, including immature underlying information systems, non-standard event definitions, and variable methods for detection rule validation. Few ADE detection algorithms considered clinical priorities. They conclude that '[t]o enhance the utility of electronic detection systems, there is a need to systematically address these factors.' The second review paper sought to identify and evaluate methods for assessing the preventability of ADEs. From the 142 papers 18 unique instruments for assessing the preventability of adverse drug events were found. There is a lack of evidence on the validity of these instruments, and few seem reliable enough for wider use.
DOI	Forster et al. http://dx.doi.org/10.1136/amiajnl-2011-000454 Hakkarainen et al. http://dx.doi.org/10.2165/11596570-000000000-00000

For information on the Commission's work on medication safety, see
http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-06

A Review of Verbal Order Policies in Acute Care Hospitals
Wakefield DS, Wakefield BJ, Despins L, Brandt J, Davis W, Clements K, et al.
Joint Commission Journal on Quality and Patient Safety 2012;38(1):24-33.

Notes	While there has been a focus on how computerised/electronic prescribing can enhance safety verbal orders (VOs) for medications do still exist. This paper sought to examine the strategies and tactics used to ensure their appropriate use or how to ensure that they are accurately communicated, understood, documented, and transcribed into the medical record and ultimately carried out as intended. In the 40 studied hospitals (in Iowa and Missouri), the authors found substantial differences in terms of who is authorised to give and take VOs, time allowed for the prescriber to co-sign the VO, review of VOs, and authentication of the identity of the person making telephone VOs, and use of practices to improve communication reliability. The authors conclude that 'review and updating of hospital VO policies is necessary to ensure that they are internally consistent and optimize patient safety.'
DOI	http://dx.doi.org/10.1071/PY11062

Association Between Implementation of a Medical Team Training Program and Surgical Morbidity.
Young-Xu Y, Neily J, Mills PD, Carney BT, West P, Berger DH, et al.
Arch Surg 2011;146(12):1368-1373.

The impact of nontechnical skills on technical performance in surgery: a systematic review
Hull L, Arora S, Aggarwal R, Darzi A, Vincent C, Sevdalis N
J Am Coll Surg 2012;214(2):214-230.

Notes	The Young et al paper examines the role of team training and surgical morbidity in the US Veterans Health system. The Veterans Health Administration Medical Team Training (MTT) program was assessed in this retrospective health services study using outcome data were obtained from the Veterans Health Administration Surgical Quality Improvement Program. The analysis covered measures representing 119,383 sampled procedures from 74 Veterans Health Administration facilities. The analysis sought to determine change in annual surgical morbidity rate 1 year after facilities enrolled in the MTT program as compared with 1 year before and compared with the non-MTT program sites. Facilities in the MTT program (n = 42) had a significant decrease of 17% in observed annual surgical morbidity rate. Facilities not trained (n = 32) had an insignificant decrease of 6% in observed morbidity. These trends remained after risk adjustment. The steeper decline in annual surgical morbidity rates in the trained teams was also observed in specific morbidity outcomes, such as surgical infection. Hull et al. offer a systematic review of literature on the 'non-technical' skills on surgical performance. From the final 28 articles selected, they report strong evidence that nontechnical skills can both affect technical performance. Fatigue and teamwork failures were associated with error, but having structured feedback on procedures was associated with improved technical skills. Interventions have been shown to improve patient outcomes by examining non-technical skills, such as teamwork training programs and the development of surgical checklists.
DOI	Young-Xu et al. http://dx.doi.org/10.1001/archsurg.2011.762 Hull et al. http://dx.doi.org/10.1016/j.jamcollsurg.2011.10.016

International Journal for Quality in Health Care online first articles

Notes	In recent weeks the *International Journal for Quality in Health Care* has published a number of 'online first' articles. These include: • Tearing down walls: opening the border between hospital and ambulatory care for quality improvement in Germany (J Szecsenyi, B Broge, J Eckhardt, G Heller, P Kaufmann-Kolle, and Michel Wensing) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzr086v1?papetoc

BMJ Quality and Safety online first articles

Notes	In recent weeks the *BMJ Quality and Safety* has published a number of 'online first' articles. These include: • Perceptions of junior doctors in the NHS about their training: results of a regional questionnaire (Alexandra Gilbert, Peter Hockey, Rhema Vaithianathan, Nick Curzen, Peter Lees)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[UK] The King's Fund *Reading lists*
http://www.kingsfund.org.uk/library/reading_lists.html
The King's Fund's Information and Library Service has produced a series of reading lists on topics that are popular with its visitors and enquirers. Included are reading lists on:

- Clinical governance
- Clinician-led change
- Enhancing the healing environment
- Integrated care and partnership working
- Patient choice
- Payment by Results
- Point of Care: Improving patients' experience
- Public involvement in health services

[USA] AHRQ Toolkit Supports Hospital Efforts To Improve Quality and Safety
http://www.ahrq.gov/qual/qitoolkit
The US Agency for Healthcare Research and Quality (AHRQ) has released a toolkit designed to guide US hospitals through the process of using the AHRQ Inpatient Quality Indicators (IQIs) and Patient Safety Indicators (PSIs) to improve care. The AHRQ Quality Indicators Toolkit for Hospitals is designed and tested to meet the needs of a variety of hospital-based users, including senior leaders, quality staff, and multi-stakeholder improvement teams.
The toolkit includes an 'Introduction and Roadmap' to help users identify the resources suitable to their specific needs at any given point in the improvement process. It is arranged into 7sections:

1. Determining Readiness To Change
2. Applying QIs to the Hospital Data
3. Identifying Priorities for Quality Improvement
4. Implementing Improvements
5. Monitoring Progress for Sustainable Improvements
6. Analysing Return on Investment
7. Using Other Resources

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