



On the Radar

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This week's content

Reports

Hospital Incident Reporting Systems Do Not Capture Most Patient Harm.

Levinson DR

Washington, DC: US Department of Health and Human Services, Office of the Inspector General; January 2012. Report No. OEI-06-09-00091.

Notes	Report from the Inspector General of the US Department of Health and Human Services highlighting some of the limitations of incident reporting systems.
URL	Summary: http://oig.hhs.gov/oei/reports/oei-06-09-00091.asp Full report: http://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf

Books

Fundamentals of Health Care Improvement: A Guide to Improving Your Patients' Care. 2nd ed.

Ogrinc GS, Headrick LA, Moore SM, Barton AJ, Dolanksy MA, Madigosky WS

Oakbrook Terrace, IL: Joint Commission, 2012. ISBN: 978-1-59940-569-8

Notes	<p>A new edition of this book from the [US] Joint Commission and Institute for Healthcare Improvement [IHI]. Intended as an introduction into healthcare quality improvement it attempts to cover theory, principles, and methods of quality improvement. According to the publisher it includes:</p> <ul style="list-style-type: none"> ● Methods for identifying and closing the 'quality gap' and improving patient safety ● Instruction on how to find, evaluate, and apply scientific evidence for improving care
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	<ul style="list-style-type: none"> • Discussion of communication, teamwork, and an inter-professional approach • Description of process literacy and a variety of process modelling/mapping procedures • Comparisons between and practical applications of types of measurement • Interviews with well-respected change agents about their QI success stories • Educator’s Guide chapter with activities for medical and nursing students
URL	http://www.jcrinc.com/Books-and-E-books/PIMS11/4037/

Journal articles

Eradicating Central Line-Associated Bloodstream Infections Statewide: The Hawaii Experience
 Lin DM, Weeks K, Bauer L, Combes JR, George CT, Goeschel CA, et al.
 American Journal of Medical Quality 2011 [epub].

Notes	<p>The latest addition to the literature indicating that a range of healthcare associated infections can be successfully tackled. This paper reports on how the efforts to reduce central line-associated blood stream infections (CLABSI) can be much reduced in intensive care units (ICUs). In this case it was undertaken in Hawaii. The project sought to determine if a [US] national ICU collaborative to reduce CLABSIs) would succeed in Hawaii. The intervention period (July 2009 to December 2010) included a comprehensive unit-based safety program; a multifaceted approach to CLABSI prevention; and monitoring of infections. A total of 20 ICUs, representing 16 hospitals and 61 665 catheter days, were analysed. The overall mean CLABSI rate decreased from 1.5 infections per 1000 catheter days at baseline to 0.6 at 16 to 18 months post-intervention. The authors conclude that ‘Hawaii demonstrated that the national program can be successfully spread, providing further evidence that most CLABSIs are preventable’.</p> <p>One of the challenges is to make improvements like this commonplace. That is, rather than having isolated beacons of success, to scale up and spread out what works so as to provide safer, quality care in all settings.</p>
DOI	http://dx.doi.org/10.1177/1062860611414299

For information on the Commission’s work on healthcare associated infection, see <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-03>

Toward Improving Patient Safety Through Voluntary Peer-to-Peer Assessment
 Hudson DW, Holzmuller CG, Pronovost PJ, Gianci SJ, Pate ZT, Wahr J, et al.
 American Journal of Medical Quality 2011 [epub].

Notes	<p>If incident reporting (as noted above) and other approaches are not sufficient, what other ways are there to improving safety and quality? This piece argues that – again – the ‘high reliability’ industries may have something. In this case it is the peer-to-peer assessment process used in the nuclear power industry. According to the authors, this process aims at prospective error detection through the use of a robust peer-to-peer assessment process. Apparently, nuclear facilities can request peer review by an independent non-regulatory body, which conducts a detailed safety assessment and makes specific recommendations for safety improvement. This article suggests a similar process for hospitals and discusses the barriers that would need to be overcome in order to implement such a process.</p>
DOI	http://dx.doi.org/10.1177/1062860611421981

The Nurse's Role in Medication Safety. 2nd ed

Cima L, Clarke S, editors

Oakbrook Terrace, IL: Joint Commission, 2012. ISBN: 978-1-59940-618-3

Sayre MM, McNeese-Smith D, Leach LS, Phillips LR.

An Educational Intervention to Increase "Speaking-Up" Behaviors in Nurses and Improve Patient Safety

J Nurs Care Qual 2011 [epub]

Achieving quality improvement in the nursing home: influence of nursing leadership on communication and teamwork

Vogelsmeier A, Scott-Cawiezell J.

J Nurs Care Qual 2011;26(3):236-242.

Effects of nurse staffing and nurse education on patient deaths in hospitals with different nurse work environments

Aiken LH, Cimiotti JP, Sloane DM, Smith HL, Flynn L, Neff DF

Med Care 2011;49(12):1047-1053.u

Notes	<p>A number of items on the importance of nurses in ensuring safety and quality of care. These pieces look at the role of nurses, the importance of their taking leadership and on communication.</p> <p>The [US] Joint Commission has published a new edition of <i>The Nurse's Role in Medication Safety</i>. Aimed at nurses the book focuses on the hands-on role nurses play in the delivery of care and their unique opportunity and responsibility to identify potential medication safety issues.</p> <p>Sayre et al report on an educational intervention using scenarios, personal reflection, and peer support in small groups that aimed at improving 'speaking up' behaviours in registered nurses. They claim a significant difference in speaking-up behaviours and scores in the intervention group.</p> <p>Vogelsmeier and Scott-Cawiezell report on a comparative case study indicating that nursing leadership who facilitated open communication and teamwork achieved quality improvements while nursing leadership who impeded open communication and teamwork did not.</p> <p>Aiken et al looked at how reducing patient-to-nurse ratios improves outcomes. Using a database of patient discharges and nurse surveys from 665 hospitals in 4 US states, they report that decreasing the number of patients per nurse improved mortality and failure to rescue predominantly in hospitals rated as having a good work environment. Hospitals with a poor work environment derived no benefit from reducing patient-to-nurse ratios. This would seem to strengthen the arguments about the importance of culture – as the two previous would also.</p>
DOI	<p>Cima and Clarke http://jointcommissioninternational.org/Books-and-E-books/NRMS11/2227/</p> <p>Sayre et al. http://dx.doi.org/10.1097/NCQ.0b013e318241d9ff</p> <p>Vogelsmeier and Scott-Cawiezell http://dx.doi.org/10.1097/NCQ.0b013e31820e15c0</p> <p>Aiken et al. http://dx.doi.org/10.1097/MLR.0b013e3182330b6e</p>

Adverse event reporting tool to standardize the reporting and tracking of adverse events during procedural sedation: a consensus document from the World SIVA International Sedation Task Force

Mason KP, Green SM, Piacevoli Q.

British Journal of Anaesthesia 2012;108(1):13-20.

Notes	While anaesthesia in Australia is generally a low-risk area this is a report of the work of the International Sedation Task Force (ISTF) of the World Society of Intravenous Anaesthesia (World SIVA). They have developed an adverse event reporting tool to standardise the reporting and tracking of adverse events during procedural sedation. The rationale given is that by having agreed terminology and definitions, sedation events can be accurately identified and tracked, providing a benchmark for defining the occurrence of adverse events.
DOI	http://dx.doi.org/10.1093/bja/aer407

Perspective: a road map for academic departments to promote scholarship in quality improvement and patient safety

Neeman N, Sehgal NL.

Academic Medicine 2012;87(2):168-171.

Notes	A commentary piece suggesting how universities might approach quality improvement and patient safety education.
DOI	http://dx.doi.org/10.1097/ACM.0b013e31823f3c2c

Online resources

[UK] NHS Evidence –

Prevention of inpatient falls: systematic risk assessment and reduction programme

<https://www.evidence.nhs.uk/qipp>

<http://arms.evidence.nhs.uk/resources/qipp/617473/attachment>

Case study of an initiative to reduce falls has been published on the NHS Evidence website as an example of best QIPP practice after a trust-wide roll out led to a 34% reduction in falls

Note: The current issue of the *Journal of Safety Research* focuses on falls prevention in elderly populations. Papers cover strategies, literature reviews, and progress reports from organisations involved in fall prevention efforts. <http://www.sciencedirect.com/science/journal/00224375/42/6>

For information on the Commission's work on falls, including the Falls Prevention Guidelines, see <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/FallsGuidelines>

Institute of Safe Medication Practices

ISMP List of High-Alert Medications in Community/Ambulatory Healthcare.

<http://www.ismp.org/communityRx/tools/ambulatoryhighalert.asp>

<http://www.ismp.org/communityRx/tools/highAlert-community.pdf>

A list of high-alert medications commonly used in ambulatory care and recommends strategies to reduce risk of errors.

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