



On the Radar

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This week's content

Books

Safety Culture: Building and Sustaining a Cultural Change in Aviation and Healthcare.
Patankar MS, Brown JP, Sabin EJ, Bigda-Peyton TG
Burlington, VT: Ashgate; 2012. ISBN: 9780754672371.

Notes	Another recent book from Ashgate looking at culture in healthcare. This one revisiting the comparison of healthcare with aviation. The authors attempt to describe the dynamic nature of a culture-change process, particularly in safety-critical domains. Using the Safety Culture Pyramid model to give a mixed-method approach to analysis of safety culture at four levels: safety values, safety strategies, safety climate, and safety performance. Cases from aviation and healthcare are used to illustrate the various assessment methods, and the book concludes with more comprehensive case studies from both these domains.
URL	http://www.ashgate.com/default.aspx?page=637&calcTitle=1&title_id=7671&editon_id=10898

Journal articles

A Successful and Sustainable Health System — How to Get There from Here

Fineberg HV

New England Journal of Medicine 2012;366(11):1020-1027.

Notes	<p>Harvey Fineberg is the President of the (US) Institute of Medicine and recently delivered a lecture titled <i>A Successful and Sustainable Health System — How to Get There from Here</i> in which he described the issue of the US health system, the need ‘to adopt many strategies and use them to reach one big goal’ in order to reach that successful and sustainable health system. He cited six steps that are ‘within the purview of health professionals and administrators.’</p> <p>‘First, redouble efforts to enhance the quality and safety of medical care... meet the health needs of patients who require high-cost care in a more humane way that will money over time... elicit and hono[u]r patients’ preferences... rely on systems engineering and operations research to smooth the flow of patients... learn from peers and from the evidence... Finally, champion a new ethos of medical professionalism that values accountability above autonomy; supports team-based care and interprofessional education; and accepts responsibility for a system to serve all patients, not only one's own patients.’</p>
DOI	<p>http://dx.doi.org/10.1056/NEJMsa1114777</p>

A Comprehensive Overview of Medical Error in Hospitals Using Incident-Reporting Systems, Patient Complaints and Chart Review of Inpatient Deaths

de Feijter JM, de Grave WS, Muijtjens AM, Scherpbier AJJA, Koopmans RP

PLoS ONE 2012;7(2):e31125.u

Notes	<p>To understand the risks and events or incidents in a healthcare setting usually requires sing a range of sources of information. This paper reporting on a cohort study undertaken in a Dutch hospital reinforces the notion that single error detection methods do not provide a comprehensive picture of patient safety. The authors found adverse events detected by the hospital's voluntary incident reporting system, retrospective chart review, and patient complaints were different as the type and severity of safety issues varied between detection methods, with little overlap of identified incidents.</p>
DOI	<p>http://dx.doi.org/10.1371/journal.pone.0031125</p>

A qualitative study of stakeholder views of the conditions for and outcomes of successful clinical networks

McInnes E, Middleton S, Gardner G, Haines M, Haertsch M, Paul CL, et al

BMC Health Services Research 2012;12(1):49.

Notes	<p>A study examining views of 27 stakeholders conditions for effective clinical networks and their desired outcomes.</p> <p>Five key factors were identified as necessary for the establishment of successful clinical networks: building relationships, effective leadership, adequate resources, strategic evidence-based work plans, and the ability to evaluate network initiatives.</p>
DOI	<p>http://dx.doi.org/10.1186/1472-6963-12-49</p>

Novel use of electronic whiteboard in the operating room increases surgical team compliance with pre-incision safety practices

Mainthia R, Lockney T, Zotov A, France DJ, Bennett M, St. Jacques PJ, et al.
Surgery [epub].

Surgical checklists: A detailed review of their emergence, development, and relevance to neurosurgical practice

McConnell D, Mocco J, Fargen K

Surgical Neurology International 2012;3(2).

Notes	A pair of items on checklists. More specifically on refining or augmenting checklists so that they perform more effectively in a given context or setting. Mainthia et al report on how a US tertiary care hospital improved adherence to a surgical safety checklist by implementing an electronic whiteboard in the operating room (OR) that tracked completion of checklist items and was visible to all OR personnel. This made the checklist more visible to all OR personnel and was associated with a statistically significant increase in time out procedure compliance. McConnell et al provide a review on how checklists can improve quality and safety in surgery, specifically in the area of neurosurgery. Neurosurgery is a complex area with complex issues and apparently there has been some resistance to checklists, and the authors conclude that ‘as a surgical subspecialty with complex patients, lengthy operations, fatigued residents, costly complications, and low tolerance for medical errors, our patients are particularly vulnerable to human fallibility. Even routine procedures... represent potential targets where patient care may be enhanced through checklists.... We encourage the neurosurgical community to investigate, develop, and share such tools to enhance patient care by eliminating preventable human mistakes through simple, systematic checklist devices. In a field driven by remarkable technological advancements in imaging, instruments, and therapies, we must remember that it is often the most rudimentary reminders that keep us, and our patients, out of harm's way.’
DOI/ URL	Mainthia et al http://dx.doi.org/10.1016/j.surg.2011.12.005 McConnell et al http://dx.doi.org/10.4103/2152-7806.92163 or http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3279961/

A Case Study on the Safety Impact of Implementing Smart Patient-Controlled Analgesic Pumps at a Tertiary Care Academic Medical Center

Tran M, Ciarkowski S, Wagner D, Stevenson JG

Joint Commission Journal on Quality and Patient Safety 2012;38(3):112-119.

Notes	There are many devices involved in delivering care. Of late there has been a lot of attention to certain implanted medical devices. This paper looks at a fairly commonplace device in hospital – pumps – and an approach to improving the safety of pumps through ‘smart’ patient-controlled pumps. Following adverse events due to incorrect dosing of patient-controlled analgesia, smart infusion pumps were installed and a significant decrease in potential medication error followed. The authors also recommend that patient-controlled pumps with additional safety features such as bar-code verification of the drug and concentration, as well as dosage limits, to prevent pump-programming errors could be considered.
URL	http://www.ingentaconnect.com/content/jcaho/jcjq/2012/00000038/00000003/art0003

He Thought the Lady in the Door Was the Lady in the Window: A Qualitative Study of Patient Identification Practices

Phipps E, Turkel M, Mackenzie ER, Urrea C

Joint Commission Journal on Quality and Patient Safety 2012;38(3):127-134.

Notes	<p>Correctly identifying a patient is a basic and fundamental task in all healthcare encounters. However, it can and does get taken for granted or even just assumed or forgotten. This can sometimes lead to catastrophic consequences. Many approaches to improving patient identification exist, including standardised wristbands, identification protocols, unique identifier numbers, etc. The range of approaches reflects the range of healthcare settings, etc.</p> <p>This item in the (US) <i>Joint Commission Journal on Quality and Patient Safety</i>, reports on a qualitative study examining why healthcare workers do not follow appropriate identification practices and how to address these.</p> <p>The 30 nurses and residents surveyed understand the importance and requirements to verify identity, but their adherence was influenced by a variety of factors, including their assessment of necessity or risk, impact on their relationship with the patient, and practices in place in the hospital environment that protect patient privacy.</p>
URL	<p>http://www.ingentaconnect.com/content/jcaho/jcjq/2012/00000038/00000003/art0005</p>

Quality in general practice - definitions and frameworks

Gardner K, Mazza D

Australian Family Physician 2012;41(3):151-154.

Notes	<p>Short piece attempting to summarise the quality frameworks in general practice in New Zealand, the United Kingdom, Germany and Australia. The authors note that there are ‘multiple and varying definitions of quality in general practice, but most emphasise patient experience as their primary focus’. They also note that the frameworks share the primary goal of provision of high quality care and that ‘external standards, targets and incentives are important initiatives, but countries with high quality general practice excel at empowering general practice to own the quality agenda’.</p> <p>It would seem a tad unfortunate that the authors are apparently not aware of the Australian Safety and Quality Framework for Health Care, which specifies three core principles for safe and high quality care. These principles are that care is consumer centred, driven by information, and organised for safety. Similarly there is no reference to the draft set of Australian Safety and Quality Goals for Health Care or the National Safety and Quality Health Service Standards.</p>
URL	<p>http://search.informit.com.au/documentSummary;dn=003250379203937;res=IELHEA</p>

For information on the Australian Safety and Quality Framework for Health Care, see <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/NSQF>

For information on the Australian Safety and Quality Goals for Health Care, see <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/ASQGHC>

For information on the National Safety and Quality Health Service Standards, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/com-pubs_PP7-NSQHSS

Notes	<p>A new issue of the <i>American Journal of Medical Quality</i> has been published. Articles in this issue include:</p> <ul style="list-style-type: none"> • Editorial: The Need for Customized and Standardized Health Care Quality Measures (Albert G. Crawford) • Editorial: Faculty Development in Quality Improvement: Crossing the Educational Chasm (Jennifer S. Myers and Jeffrey Jaeger) • Quality Improvement “201”: Context-Relevant Quality Improvement Leadership Training for the Busy Clinician-Educator (Christopher J. Stille, Judith A. Savageau, Jeanne McBride, and Eric J. Alper) • Leadership at the Front Line: A Clinical Partnership Model on General Care Inpatient Units (C S Kim, M Calarco, T Jacobs, C Loik, J Rohde, D McClish, K P Mychaliska, G Brand, J Froehlich, J McNeice, R Chang, J Grunawalt, P L Schmidt, and D A. Campbell, Jr.) • Hospital-wide Mortality as a Quality Metric: Conceptual and Methodological Challenges (David M. Shahian, Lisa I. Iezzoni, Gregg S Meyer, Leslie Kirle, and Sharon-Lise T. Normand) • Effectiveness of a Quality Improvement Training Course: Mayo Clinic Quality Academy (K L Ruud, J R Leland, J T Liesinger, M G Johnson, A J Majka, and J M Naessens) • Identification of Adverse Events in Ground Transport Emergency Medical Services (P D Patterson, M D Weaver, K Abebe, C Martin-Gill, R N Roth, J Suyama, F X Guyette, J C Rittenberger, D Krackhardt, R Arnold, D M Yealy, and Judith Lave) • Voluntary Electronic Reporting of Laboratory Errors: An Analysis of 37 532 Laboratory Event Reports From 30 Health Care Organizations (L K Snyderman, B Harubin, S Kumar, J Chen, R E Lopez, and D N Salem) • A Review of Patient Safety Measures Based on Routinely Collected Hospital Data (C Tsang, W Palmer, A Bottle, A Majeed, and P Aylin)
URL	<p>http://ajm.sagepub.com/content/27/2.toc</p>

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