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On the Radar

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This week's content

Reports

Overcoming challenges to improving quality: Lessons from the Health Foundation's improvement programme evaluations and relevant literature
Dixon-Woods M, McNicol S, Martin G
London. The Health Foundation, 2012.

Notes	For nearly ten years, the Health Foundation has been working with the NHS to deliver improvement through service and staff development programmes. All Health Foundation improvement programmes are evaluated so as to gather evidence of their impact and to better understand how it has been achieved. In 2011, a team of researchers undertook a synthesis of learning from 14 of the Health Foundation's improvement programme evaluations and set the learning in the context of the wider literature. They looked at the factors that affected the likelihood of improvement methods being applied and new interventions adopted. The researchers organised their analysis within three broad themes: • design and planning • organisational and institutional contexts, professions and leadership • sustainability, spread and unintended consequences. Within these themes, they identified 10 key challenges to improvement that consistently emerged in the programmes evaluated: • convincing people that there is a problem • convincing people that the solution chosen is the right one

	• getting data collection and monitoring systems right • excess ambitions and 'projectness' • the organisational context, culture and capacities • tribalism and lack of staff engagement • leadership • balancing carrots and sticks – harnessing commitment through incentives and potential sanctions • securing sustainability • considering the side effects of change. This report explores these challenges, and suggests ways to overcome them. A shorter version of this work appeared in *BMJ Quality and Safety* and was covered in the previous issue of *On the Radar*.
URL	http://www.health.org.uk/publications/overcoming-challenges-to-improving-quality/
TRIM	62618

Journal articles

Can patients report patient safety incidents in a hospital setting? A systematic review
Ward JK, Armitage G
BMJ Quality & Safety 2012 [epub].

Notes	The centrality and role of patients to safe and high quality care is an area of much interest. This paper reports on a review of literature into how patients may contribute to reporting of patient safety problems within a hospital setting. The systematic review sought to determine (a) What can patients report? (b) In what settings can they report? (c) At what times have patients been asked to report? (d) How have patients been asked to report? The search led to 13 papers being reviewed. As is often the case with reviews, the researches report great variability. In this instance they 'varied considerably in focus, design and analysis, with all papers lacking a theoretical underpinning'. The authors report that patient reports to date have been 'actively solicited from patients, with no evidence currently supporting spontaneous reporting. The impact of timing upon accuracy of information has yet to be established, and many vulnerable patients are not currently being included in patient reporting studies, potentially introducing bias and underestimating the scale of patient reporting.' They also suggest that the 'future of patient reporting may well be as part of an 'error detection jigsaw' used alongside other methods as part of a quality improvement toolkit.' A couple of observations could be made. This paper is a look at what has happened and has been reported – there may be much else that has not (yet) been reported and there may also be other ways to integrate patient reporting. It may also be that placing the patient at the centre of care is not fundamentally about a role in reporting but that the safety and quality benefits from that re-positioning are due to other aspects.
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000213

Factors predicting change in hospital safety climate and capability in a multi-site patient safety collaborative: a longitudinal survey study
Benn J, Burnett S, Parand A, Pinto A, Vincent C
BMJ Quality & Safety 2012 [epub].

Evaluating the effect of a national collaborative: a cautionary tale
Sales A, Saint S
BMJ Quality & Safety 2012 [epub].

Findings from a national improvement collaborative: are improvements sustained?
Glasgow JM, Davies ML, Kaboli PJ
BMJ Quality & Safety 2012.

Notes	Two papers discussing the impact and sustainability of interventions, in this case two large scale collaborative projects that both had less impact than may have been hoped for. Benn et al. conducted two surveys of 284 respondents representing programme teams at 19 hospital sites across the UK with the aims of: '(1) To analyse change in a survey measure of organisational patient safety climate and capability (SCC) resulting from participation in the UK Safer Patients Initiative and (2) To investigate the role of a range of programme and contextual factors in predicting change in SCC scores.' The UK Safer Patients Initiative was 'a multi-component quality improvement collaborative focused upon patient safety and designed to impact upon hospital leadership, communication, organisation and safety climate'. The paper reports 'modest but significant positive movement in SCC score was observed between the study time-points' and that 'individual programme responsibility, availability of early adopters, multi-professional collaboration and extent of process measurement were significant predictors of change in SCC.' The conclusion is perhaps a little disappointing in suggesting that while 'a range of social, cultural and organisational factors may be sensitive to this type of intervention but the *measurable effect is small*. Perhaps the key feature is the suggestion that 'supporting critical **local** programme implementation factors may be an effective strategy in achieving development' – another piece noting how local context may be a vital factor. Sales and Saint, in commenting on the Glasgow et al. paper that reported on outcomes of a large, national quality collaborative focused on reducing length of stay and discharging hospitalised patients before noon in 130 hospitals of the Veterans Health Administration, note that the key finding was that less than half the hospitals showed improvement in the primary outcomes and even among hospitals that showed initial improvement, sustainability was difficult to achieve. They go on to discuss some of the issues around '(1) fidelity to the collaborative and the interventions adopted; (2) understanding barriers and facilitators that may have had an impact on both short-term and long-term success in achieving goals; and (3) understanding the impact of other simultaneous initiatives.'
DOI	Benn et al. http://dx.doi.org/10.1136/bmjqs-2011-000286 Sales and Saint http://dx.doi.org/10.1136/bmjqs-2012-001065 Glasgow et al. http://dx.doi.org/10.1136/bmjqs-2011-000243

Two Hundred Years of Surgery
Gawande A
New England Journal of Medicine 2012;366(18):1716-1723.

Notes	In this survey of 200 years of surgery – one of a series of articles marking the NEJM's 200th anniversary – Atul Gawande concludes by noting how commonplace surgery has become and the implications this has for the importance of safety and quality of that surgery. While surgery has become far safer from the days when mortality was of 50% due to either shock or sepsis, the prevalence of surgery brings other demands. With more than 50 million surgical procedures each year in the US, this is leading to a prediction that the average American can expect to undergo seven operations during their lifetime. As Gawande notes, 'This profound evolution has brought new societal concerns, including how to ensure the quality and appropriateness of the procedures performed, how to make certain that patients have access to needed surgical care nationally and internationally, and how to manage the immense costs. As early as the 1970s, researchers began documenting substantial rates of fatal errors in surgical care, wide differences in outcomes among institutions, and large disparities in access to care both within the United States and between countries. The science of effectively routinizing surgery for mass populations is still in its infancy, as it is for all areas of medicine. The Journal is entering its third century of publication, yet we are still unsure how to measure surgical care and its results. Experiments in the delivery of care will probably provide the next major advancement in the field of surgery.'
DOI	http://dx.doi.org/10.1056/NEJMra1202392

Identifying and categorising patient safety hazards in cardiovascular operating rooms using an interdisciplinary approach: a multisite study
Gurses AP, Kim G, Martinez EA, Marsteller J, Bauer L, Lubomski LH, et al
BMJ Quality & Safety 2012 [epub].

Notes	Cardiac surgery is a domain of complex, high risk activity. This paper examines this domain in order to understand and categorise the safety issues and makes some suggestions about how safer care could be delivered. An interdisciplinary team of researchers used prospective methods, including direct observations, contextual inquiry and photographs to 'collect hazard data pertaining to the cardiac surgery perioperative period, which started immediately before the patient was transferred to the operating room and ended immediately after patient handoff to the post-anaesthesia/intensive care unit.' Twenty cardiac surgeries – including the corresponding handoff processes from operating room to post-anaesthesia/intensive care unit – were observed in 5 hospitals in the period February–September 2008. The researchers identified 58 categories of hazards related to care providers (e.g., practice variations), tasks (e.g., high workload), tools and technologies (e.g., poor usability), physical environment (e.g., cluttered workspace), organisation (e.g., hierarchical culture) and processes (e.g., non-compliance with guidelines). The authors suggest that there are many opportunities for safety improvements and that efforts 'should focus on creating a **stronger culture of safety** in the cardiovascular operating room, increasing **compliance with evidence-based infection control practices**, improving **communication and teamwork**, and developing a partnership among all stakeholders to improve the design of tools and technologies.'
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000625

Safety skills training for surgeons: A half-day intervention improves knowledge, attitudes and awareness of patient safety
Arora S, Sevdalis N, Ahmed M, Wong H, Moorthy K, Vincent C
Surgery 2012 [epub]

Notes	Paper reporting on how a course as short as half of a day improved the knowledge, attitudes and awareness of patient safety in a group of surgeons. 27 surgical residents from 19 London hospitals complete a half-day training program incorporating safety awareness, analysis, and improvement skills. Participants were assessed in terms of safety knowledge and attitudes to safety before and after training. To determine long-term effects, 6 months after training participants identified and reported on observed safety events in their own workplace by using an observational form for data collection. The authors report that knowledge of safety significantly improved after the course as did attitudes to error analysis and improving safety and ability to influence safety. They also claim that following the course, 'participants reported richer, detailed sets of observations demonstrating enhanced understanding, recognition, and analysis of patient safety issues in their workplace.'
DOI URL	http://dx.doi.org/10.1016/j.surg.2012.02.006 http://www.sciencedirect.com/science/article/pii/S0039606012000487

A Collaborative Of Leading Health Systems Finds Wide Variations In Total Knee Replacement Delivery And Takes Steps To Improve Value
Tomek IM, Sabel AL, Froimson MI, Muschler G, Jevsevar DS, Koenig KM, et al
Health Affairs 2012 [epub].

Notes	This paper reports on how the members of a consortium of US health care systems, known as the High Value Healthcare Collaborative, examined differences in their delivery of primary total knee replacement. The aim was to identify opportunities to improve health care value by increasing quality and reducing costs. The paper reports finding substantial variations in surgery times, lengths-of-stay, discharge dispositions, and in-hospital complication rates across the participating health care organisations. The authors report that **higher surgeon caseloads were associated with shorter lengths-of-stay and operating time, as well as fewer in-hospital complications**. These findings led the consortium to test more coordinated management for medically complex patients, more use of dedicated teams, and a process to improve the management of patients' expectations. This paper ties in with other work showing that high-performing and self-improving health systems/facilities almost invariably reflect on their activities and their performance. The use of information to reflect upon and influence activity appears to be a key element.
DOI	http://dx.doi.org/10.1377/hlthaff.2011.0935

Positive patient outcomes in acute care: does obtaining and recording accurate weight make a difference?
Evans A
Australian Journal of Advanced Nursing 2012;29(3):62-67.

Notes	The measurement of patient weight (and possibly other metrics) may seem self-evident or perhaps even trivial but the author argues that actually accurately measuring and recording patient weight can have important safety and quality implications – for both clinician and provider.

URL	http://www.ajan.com.au/ajan_29.3.html http://www.ajan.com.au/Vol29/29-3_Evans.pdf

Quality of type 2 diabetes management in general practice is associated with involvement of general practice nurses
Juul L, Maindal HT, Frydenberg M, Kristensen JK, Sandbaek A
Prim Care Diabetes 2012.

Notes	A Danish study looking into whether the use of GP nurses can improve type 2 diabetes care with improved adherence to national guidelines on monitoring, and with lower HbA1c and cholesterol levels in the type 2 diabetes population. The authors surveyed 193 Danish general practices and used register data on 12,960 patients with type 2 diabetes. They report that general 'practices with well-implemented nurse-led type 2 diabetes consultations and practices with no nurse(s) employed differed according to the mean proportions of patients whose HbA1c was measured … and the mean proportions of patients whose HbA1c was ≥8% … Small non-significant differences were found in the cholesterol analyses.' Thus, the presence of nurses was associated with better patient diabetes status.
DOI	http://dx.doi.org/10.1016/j.pcd.2012.04.001

Patients and tests – a study into patient understanding of blood tests ordered by their doctor
Kljakovic M.
Australian Family Physician 2012;41(4):241-4.

Notes	Another general practice paper – this one being an Australian study of how well patients received and understood information about tests from their GPs. The study looked specifically at blood tests but it would not seem unreasonable to expect similar patterns with other diagnostic tests. Based on a survey of 135 patients attending two hospital blood collection centres in Canberra the author reports that: 90% of patients understood the reasons for tests but only 19% could name them; 86% reported that their doctor explained their tests and 89% reported they understood their doctor's explanation; and 35% of patients were offered a copy of test results by their doctor. The author notes that 'A strong relationship was found between doctors explaining blood tests and patients understanding the reasons for tests. Nevertheless, information sharing was at a low level.' These results suggest that the move to a more patient-centred health care still has some way to go and that both patients and clinicians may need to consider greater engagement with one another and in their own health.
URL	http://www.racgp.org.au/afp/201204/46229

Safety in the Home Healthcare Sector: Development of a New Household Safety Checklist
Gershon RRM, Dailey M, Magda LA, Riley HEM, Connolly J, Silver A
Journal of Patient Safety 2012 [epub].

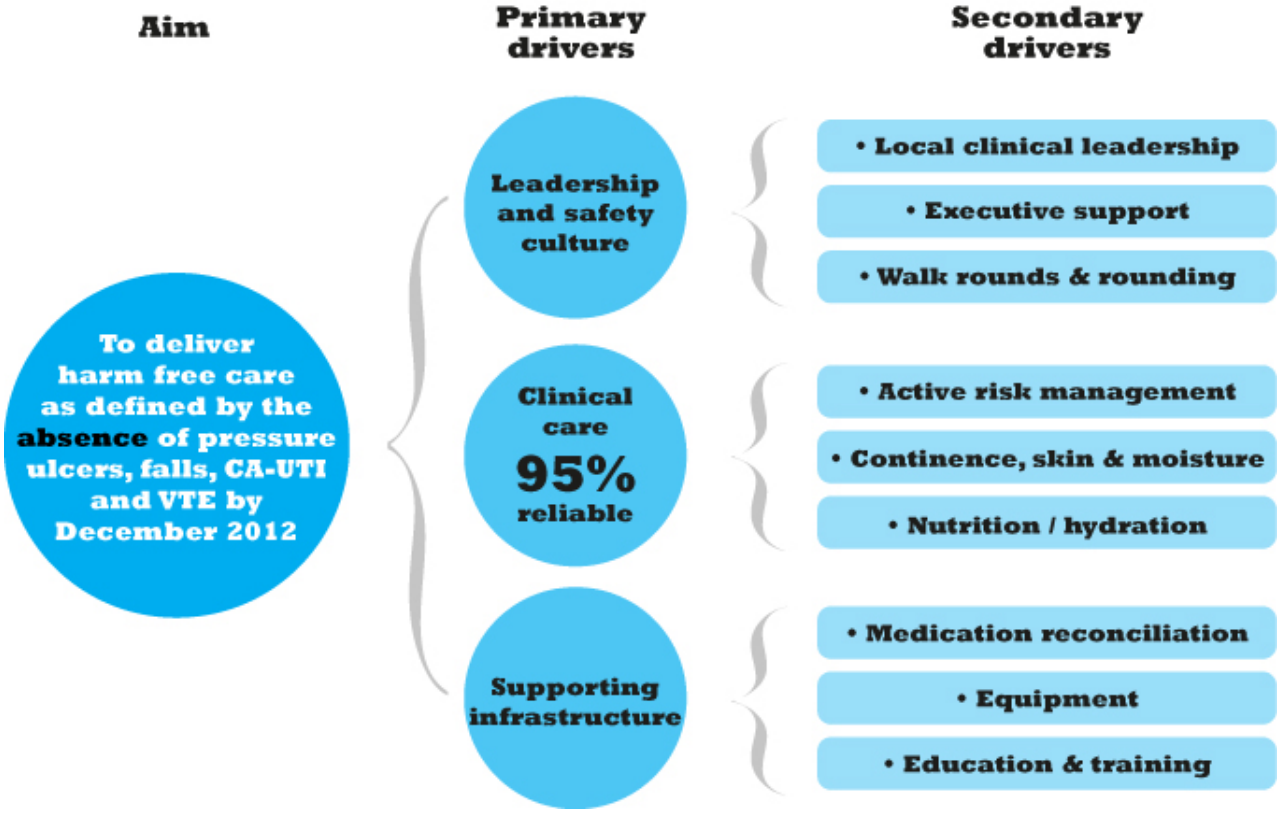
Notes	One of the more recent additions to the checklist movement is this – a checklist for home health paraprofessionals to identify safety hazards in patients' homes. This paper reports on the development and piloting of the 50-item, photo-illustrated, multi-hazard checklist. 57 home healthcare paraprofessionals participated in a 1-hour training program, followed by pilot testing of the checklist in 116 of their patients' households.
DOI	http://dx.doi.org/10.1097/PTS.0b013e31824a4ad6u

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • A collaborative project to improve identification and management of patients with chronic kidney disease in a primary care setting in Greater Manchester (John Humphreys, Gill Harvey, Michelle Coleiro, Brook Butler, Anna Barclay, Maciek Gwozdziewicz, D O'Donoghue, J Hegarty) • Older veterans and emergency department discharge information (Susan Hastings, Karen Stechuchak, Eugene Oddone, Morris Weinberger, Dana Tucker, William Knaack, Kenneth Schmader) • Innovative strategy for effective critical laboratory result management: end-to-end process using automation and manual call centre (Lian Kah Ti, Sophia Bee Leng Ang, Sharon Saw, Sunil Kumar Sethi, James W L Yip) • **Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?** (Juliet Higginson, R Walters, N Fulop) • **Error disclosure: a new domain for safety culture assessment** (Jason M Etchegaray, Thomas H Gallagher, Sigall K Bell, Ben Dunlap, E J Thomas) • **The H-PEPSS: an instrument to measure health professionals' perceptions of patient safety competence at entry into practice** (Liane Ginsburg, Evan Castel, Deborah Tregunno, Peter G Norton) • Improving healthcare quality through organisational peer-to-peer assessment: lessons from the nuclear power industry (Peter J Pronovost, Daniel W Hudson) • The effects of a 'discharge time-out' on the quality of hospital discharge summaries (Namita Mohta, Prashant Vaishnava, Cathy Liang, Kye Ye, Matt Vitale, Anuj Dalal, Jeff Schnipper)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[UK] 'Harmfree' care
http://www.harmfreecare.org/
Website from a UK initiative aiming to deliver higher quality 'Harm Free' Care at lower cost by reducing the number of patients who experience harm from pressure ulcers, falls, infections in patients with urinary catheters and blood clots. These are common complications of healthcare which affect over 200,000 people each year in England alone and cost the British taxpayer over £400 million pounds in treatment. The diagram below indicates the drivers used to achieve the aim of eliminating several types of harm.



The 'harm free' care website is an evolving resource which can be accessed for support materials and networking.

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