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On the Radar

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This week's content

Books

Understanding Patient Safety. 2nd ed
Wachter RM
New York: McGraw-Hill Professional, 2012.
ISBN: 9780071765787

Notes	A new edition of this book, considerably longer than the previous edition, that (according to the ARHQ PSNet synopsis) 'continues to blend case studies with broad discussions of error types and strategies to improve safety but adds substantial new content in areas such as checklists, measures of harm (including trigger tools), information technology, complexity theory and high reliability, policy initiatives in patient safety, and balancing "no blame" and accountability.'
URL	http://www.mhprofessional.com/product.php?isbn=0071765786

Journal articles

Common patterns in 558 diagnostic radiology errors
Donald JJ, Barnard SA
Journal of Medical Imaging and Radiation Oncology 2012;56(2):173-178.

Notes	This study of radiology diagnosis errors found that **80% were perceptual** (radiologists failed to identify the abnormality) with a smaller proportion (20%) due to **incorrect interpretation** of findings. Based on a New Zealand radiology department's regular discrepancy meetings a total of 558 cases that had been were referred for discussion over 92 months were retrospective analysed.

	The authors suggest that radiological diagnostic errors 'are not uncommon and are most frequently perceptual in nature. Identification of the most common patterns of error has the potential to improve the quality of reporting by improving the search behaviour of radiologists.'
DOI	http://dx.doi.org/10.1111/j.1754-9485.2012.02348.x

Design and trial of a new ambulance-to-emergency department handover protocol: 'IMIST-AMBO'
Iedema R, Ball C, Daly B, Young J, Green T, Middleton PM, et al
BMJ Quality & Safety 2012 [epub].

Notes	Another paper on handover, this time about a specific tool for improving handover from ambulance to emergency in New South Wales. The aims of the project were '(1) identify the existing structure of paramedic-to-emergency staff handovers by video recording and analysing them; (2) involve practitioners in reflecting on practice using the footage; (3) combine those reflections with formal analyses of these filmed handovers to design a handover protocol; (4) trial-run the protocol; and (5) assess the protocol's enactment.' Using a 'video-reflexive ethnography' approach 137 pre- and post-handovers were studied involving 291 staff, and 368 staff were educated in the use of the new protocol. The authors report that there was 'agreement that **I**dentification of the patient, **M**echanism/medical complaint, **I**njuries/information relative to the complaint, **S**igns, vitals and GCS, **T**reatment and trends/response to treatment, **A**llergies, **M**edications, **B**ackground history and **O**ther (social) information (IMIST-AMBO) was the preferred protocol for non-trauma and trauma handovers.' They also report that uptake of **IMIST-AMBO protocol showed improvements**, including 'a **greater volume of information per handover** that was more consistently ordered; **fewer questions** from ED staff; a **reduction in handover duration**; and **fewer repetitions** by both paramedics and ED clinicians that may suggest improved recipient comprehension and retention.' The conclusion drawn was that the IMIST-AMBO protocol 'shows promise for improving the ambulance-ED handover communication interface. Involving paramedics and ED clinicians in its development enhanced the resulting protocol, strengthened ED clinicians' and ambulance paramedics' sense of ownership over the protocol and bolstered their peers' willingness to adopt it.'
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000766

For information on the Commission's work on clinical communications, including handover, see http://www.safetyandquality.gov.au/our-work/clinical-communications/

An institution-wide handoff task force to standardise and improve physician handoffs
Horwitz LI, Schuster KM, Thung SF, Hersh DC, Fisher RL, Shah N, et al
BMJ Quality & Safety 2012 [epub].

Notes	Transitions of care are a known opportunity for risk. This paper reports on an institution-wide effort to improve handovers/handoffs. In this setting a physician task force was developed to address issues surrounding handovers and to ensure a consistent approach across the institution (Yale New Haven Hospital – a 966-bed academic medical centre).

	This report discusses the authors' experiences with standardisation of handover, utilisation of a new electronic medical record-based handover tool, and implementation of an educational curriculum; future work in developing hospital-wide policies and procedures for transfers; and the authors' consensus on the best methods for monitoring and evaluation of trainee handoffs. The authors assert that **a task force approach enabled an institution-wide approach and that the task force improved patient care by addressing handover systematically and consistently**. Similar to a number of other handover efforts, this approach seems to favour a form of flexible standardisation – setting the basic parameters but also allowing some context sensitivity.
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000658

What stops hospital clinical staff from following protocols? An analysis of the incidence and factors behind the failure of bedside clinical staff to activate the rapid response system in a multi-campus Australian metropolitan healthcare service
Shearer B, Marshall S, Buist MD, Finnigan M, Kitto S, Hore T, et al
BMJ Quality & Safety 2012 [epub].

Notes	The development and use of guidelines, protocols, checklists and other material and resources to aid (and direct) clinical decision making and processes is something to which a lot of resources are devoted. However, if these are then not used (or useable) it greatly undermines such efforts. This paper is interesting for both the specific subject area (rapid response systems) and for what it suggests more generally. The study sought to explore the causes of failure to activate the rapid response system (RRS) within Southern Health in Melbourne (a comprehensive healthcare network with 570 adult in-patient beds across four metropolitan teaching hospitals). This was a multi-method study including: a point prevalence survey to determine the incidence of abnormal simple bedside observations and activation of the rapid response team by clinical staff; a prospective audit of all patients experiencing a cardiac arrest, unplanned intensive care unit admission or death over an 8-week period; and structured interviews of staff to explore barriers to activating the RRS. The study found that the incidence of physiological instability in the acute adult population was 4.04%. Nearly half of these patients (42%) did not receive an appropriate clinical response from the staff, despite most (69.2%) recognising their patient met physiological criteria for activating the RRS, and being 'quite', or 'very' concerned about their patient (75.8%). Structured interviews with 91 staff members identified predominantly sociocultural reasons for failure to activate the RRS. The authors concluded that 'the main reason why staff did not follow the RRS activation protocol was not failure of cognition, but rather local sociocultural factors and intra-professional hierarchies in the clinical areas.' Further, 'implementing systems of care that significantly alter the traditional hierarchical referral model of care, regardless of their potential benefits, takes years to appropriately implement.' Again, the message is that understanding culture and context are key.
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000692

For information on the Commission's work on recognising and responding to clinical deterioration, see http://www.safetyandquality.gov.au/our-work/recognising-and-responding-to-clinical-deterioration/

Prophylaxis rates for venous thromboembolism and gastrointestinal bleeding in general medical patients: too low or too high?
Herzig SJ, Rothberg MB
BMJ 2012;344 [epub]

Notes	An article comparing clinical recommendations and general conceptions of prophylaxis prescribing for venous thromboembolism and gastrointestinal bleeding among hospitalised general medical patients. Both VTE and gastrointestinal bleeding have a similar incidence, and preventative treatments for both conditions have a similar efficacy, yet more patients receive VTE prophylaxis than receive acid suppressive drugs to prevent stress ulcer. This is due in part to differing guideline recommendations for preventative treatment. This article explores why the published literature and clinical recommendations for each condition have such divergent views on prophylaxis prescribing, concluding that the reasons are complex and multifactorial, and include "the perceived risk associated with each condition, the lack of studies in general medical patients, the focus on relative rather than absolute risk in published literature, and drug company influence. The differing conceptions surrounding these two prophylactic strategies say much about our publication practices, guideline development process, and the politics of healthcare." The authors urge a closer examination of this situation and an effort to make guidelines more consistent. They argue that "development of clinical guidelines should be standardised, transparent, and independent of pharmaceutical funding". They stress that clinical decisions should be made on a patient-by-patient basis.
DOI	http://dx.doi.org/10.1136/bmj.e3248

For information on the Commission's work on VTE prevention, see http://www.safetyandquality.gov.au/our-work/medication-safety/vte-prevention-resource-centre/

For information on the *2009 Clinical Practice Guideline for the Prevention of Venous Thromboembolism (Deep Vein Thrombosis and Pulmonary Embolism) in Patients Admitted to Australian Hospitals*, see http://www.nhmrc.gov.au/nics/nics-programs/vte-prevention-guideline

Effects of an online personal health record on medication accuracy and safety: a cluster-randomized trial
Schnipper JL, Gandhi TK, Wald JS, Grant RW, Poon EG, Volk LA, et al
Journal of the American Medical Informatics Association 2012 [epub].

Notes	Paper examining potential gains in use of electronic health records, in this case involving the patient so as to enhance the medication safety benefits of electronic records. From the ARHQ PSNet email: 'Medication errors are likely the most common safety problem in primary care, and ensuring accurate medication reconciliation remains a challenge in the outpatient setting. This innovative cluster-randomized trial, conducted in a health system with integrated electronic medical records (EMRs), used a novel method of engaging patients in safety to attempt to reduce medication error risk. **Patients in the**

	intervention completed their own medication lists, which could then be viewed and reconciled within the EMR by their physicians. Patients who participated had a **lower incidence of medication discrepancies and fewer potential adverse drug** events than control patients. Although preliminary, the study results point toward further ways in which EMRs can enhance safety by improving patient–physician communication.'
DOI	http://dx.doi.org/10.1136/amiajnl-2011-000723

Comparing physician and patient perceptions of quality in ambulatory care
Levine R, Shore K, Lubalin J, Garfinkel S, Hurtado M, Carman K
International Journal for Quality in Health Care 2012 [epub].

Notes	Paper reporting on a survey of 168 patients and 39 clinicians in 2 US states (Hawaii and Chicago, Illinois) to examine what commonality there may be in how clinicians and patients understand quality primary care. The participants were interviewed about behaviours that resulted in consultations being considered either good or poor quality and compared the prevalence of different types of 'quality' behaviours. Using a taxonomy, comprising 9 major categories and 106 subcategories of behaviours, the authors report that almost all clinicians and patients agreed that **clinical skill, rapport and health-related communication behaviours were key elements**. Patients were more likely to report behaviours demonstrating thoroughness in routine examinations, spending enough time with them, engaging them and being treated with courtesy and respect as drivers of a quality office visit than were physicians. The authors suggest that increased clinician awareness of the behaviours that patients believe are the drivers of a quality office visit can help clinicians improve patients' experience of care and experience-based measures of quality.
DOI	http://dx.doi.org/10.1093/intqhc/mzs023

For information on the Commission's work on patient and consumer centred care, see http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Challenges of making a diagnosis in the outpatient setting: a multi-site survey of primary care physicians (Urmimala Sarkar, Doug Bonacum, William Strull, Christiane Spitzmueller, Nancy Jin, Andrea López, Traber Davis Giardina, Ashley N D Meyer, Hardeep Singh) • Signal and noise: applying a laboratory trigger tool to identify adverse drug events among primary care patients (Stacey Brenner, Alissa Detz, Andrea López, Claire Horton, Urmimala Sarkar) • Should measures of patient experience in primary care be adjusted for case mix? Evidence from the English General Practice Patient Survey (Charlotte Paddison, Marc Elliott, Richard Parker, Laura Staetsky, Georgios Lyratzopoulos, John L Campbell, Martin Roland)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

International Journal for Quality in Health Care online first articles

Notes	The *International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Are quality improvement methods a fashion for hospitals in Taiwan? (Kuo-Piao Chung and Tsung-Hsien Yu) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs021v1?papetoc • Comparing physician and patient perceptions of quality in ambulatory care (Roger Levine, K Shore, J Lubalin, S Garfinkel, M Hurtado, and K Carman) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs023v1?papetoc • Feasibility of evaluating quality cancer care using registry data and electronic health records: a population-based study (Adele Caldarella, Gianni Amunni, Catia Angiolini, Emanuele Crocetti, F Di Costanzo, A Di Leo, F Giusti, A L Pegna, P Mantellini, L Luzzatto, and E Paci) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs020v1?papetoc • Standard admission orders can improve the management of acute myocardial infarction (L Abrahamyan, P C Austin, L R Donovan, and J V Tu) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs022v1?papetoc

Online resources

[US] Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange
http://www.innovations.ahrq.gov/?utm_source=issueanc&utm_medium=email&utm_campaign=20120523
The 23 May edition of the Health Care Innovations Exchange focuses on co-ordination of care, particularly for seniors.
The Featured Innovations describe two programs that provide seniors with care coordination and support, which reduced hospital and nursing home admissions, and a third program that provides care coordination to adults with serious mental illness, which reduced emergency department visits.
The Featured QualityTools provide resources for health care professionals to collaborate with community organizations and to identify services and supports that can be provided at home.
