



On the Radar

Issue 85
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On the Radar is a summary of some of the recent publications in the areas of safety and quality in health care. Inclusion in this document is not an endorsement or recommendation of any publication or provider.

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This week's content

Reports

Guide to Patient and Family Engagement: Final Environmental Scan Report
(Prepared by American Institutes for Research under contract HHS 290-200-600019). AHRQ Publication No. 12-0042-EF.

Maurer M, Dardess P, Carman KL, Frazier K, Smeeding L
Rockville, MD: Agency for Healthcare Research and Quality; May 2012.

Notes	<p>The US Agency for Healthcare Research and Quality has published this report on engaging patients and their families in the safety and quality of hospital care. The report assesses the current literature, tools, and resources being used to engage patients and their families in the USA.</p> <p>The report, offers:</p> <ul style="list-style-type: none"> • A framework that describes how patient and family engagement can lead to improved quality and safety • A description of factors that influence patient and family engagement, including characteristics and perspectives of patients, families, health care professionals, and hospital organizational and cultural factors • Hospital-based methods and materials currently being used to engage patients and families in the safety and quality of care • An analysis of the kinds of materials that are needed, but do not exist.
URL	http://www.ahrq.gov/qual/engagingptfam.htm

A CEO Checklist for High-Value Health Care

Cosgrove D, Fisher M, Gabow P, Gottlieb G, Halvorson G, James B, et al
 Washington D.C. Institute of Medicine, 2012.

Notes	<p>This discussion paper is authored by the participants in an Institute of Medicine (IoM) ‘Roundtable on Value & Science-Driven Health Care’ and as such is not an official IoM paper. The authors are CEOs and senior executives from a number of well-regarded US medical services, including Cincinnati Children's Hospital Medical Center, Cleveland Clinic, Denver Health, Geisinger Health System, Hospital Corporation of America, Intermountain Healthcare, Kaiser Permanente, Partners HealthCare, ThedaCare Center for Healthcare Value, Veterans Health Administration, and Virginia Mason Health System. In this paper they offer a checklist of 10 strategies that have proven effective in reducing waste and improving outcomes in their facilities.</p> <div data-bbox="347 705 1279 1944" style="border: 1px solid #ccc; padding: 10px; background-color: #fff9c4;"> <p style="text-align: center;">A CHECKLIST FOR HIGH-VALUE HEALTH CARE</p> <p>Just as we offer an invitation to each staff and Board member of our respective institutions to hold us accountable for fully engaging, implementing, and sustaining attention to every Checklist item, we invite you to be in touch as we work together to build the field of health care transformation and better health for all Americans.</p> <p>Foundational elements</p> <ul style="list-style-type: none"> ✓ Governance priority—visible and determined leadership by CEO and Board ✓ Culture of continuous improvement—commitment to ongoing, real-time learning <p>Infrastructure fundamentals</p> <ul style="list-style-type: none"> ✓ IT best practices—automated, reliable information to and from the point of care ✓ Evidence protocols—effective, efficient, and consistent care ✓ Resource utilization—optimized use of personnel, physical space, and other resources <p>Care delivery priorities</p> <ul style="list-style-type: none"> ✓ Integrated care—right care, right setting, right providers, right teamwork ✓ Shared decision making—patient-clinician collaboration on care plans ✓ Targeted services—tailored community and clinic interventions for resource-intensive patients <p>Reliability and feedback</p> <ul style="list-style-type: none"> ✓ Embedded safeguards—supports and prompts to reduce injury and infection ✓ Internal transparency—visible progress in performance, outcomes, and costs </div>
URL	<p>http://www.iom.edu/Global/Perspectives/2012/CEOChecklist.aspx</p>

Journal articles

Current assessment of patient safety education

Mansour M

British Journal of Nursing 2012;21(9):536-543

Interdisciplinary team training: five lessons learned

Contratti F, Ng G, Deeb J

Am J Nurs 2012;112(6):47-52.

“Learning by Doing” —Resident Perspectives on Developing Competency in High-Quality Discharge Care

Greysen S, Schiliro D, Curry L, Bradley E, Horwitz L

Journal of General Internal Medicine 2012 (epub)

The use of simulation in healthcare: from systems issues, to team building, to task training, to education and high stakes examinations.

Orledge J, Phillips WJ, Murray WB, Lerant A

Curr Opin Crit Care 2012 (epub).

Notes	<p>A number of papers relating to education and training around safety and quality, including a couple with a nursing focus.</p> <p>Mansour discusses how student nurses and nursing faculty members perceived the integration of patient safety education in (UK) preregistration/undergraduate nursing training. The author remarks that there is a continuing lack of research on patient safety education in undergraduate/preregistration nursing training and the review suggests areas in nursing education which need to be addressed to develop patient-safety-friendly nursing curricula.</p> <p>Contratti et al describe their teamwork initiative in a maternity unit aimed at improving communication and staff engagement in team training.</p> <p>Greysen et al’s qualitative study led them to report that internal medicine residents lack formal training on safely discharging patients and preventing adverse events after hospital discharge. From their work they found ‘a recurrent theme of lack of formal training about the discharge process, substantial peer-to-peer instruction, and “learning by doing” on the wards’. They suggest that ‘Educational interventions to standardize learning about discharge care may improve the development of systems-based practice during residency and help improve the overall quality of discharge care at teaching hospitals.’</p> <p>Orledge et al. found high-quality evidence that simulation training is an effective strategy to improve team and interdisciplinary communication, technical and cognitive skills, as well as patient outcomes.</p>
URL / DOI	<p>Mansour http://www.internurse.com/cgi-bin/go.pl/library/abstract.html?uid=91687u</p> <p>Contratti et al http://dx.doi.org/10.1097/01.NAJ.0000415127.84605.1f</p> <p>Greysen et al http://dx.doi.org/10.1007/s11606-012-2094-5</p> <p>Orledge et al http://dx.doi.org/10.1097/MCC.0b013e328353fb49</p>

Perspective: A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians

Perspective: A Culture of Respect, Part 2: Creating a Culture of Respect

Leape LL, Shore MF, Dienstag JL, Mayer RJ, Edgman-Levitan S, Meyer GS, et al. Academic Medicine 2012 (epub).

Notes	<p>The question of culture – and whether it can be meaningfully and readily modified – has been attracting a degree of attention. In this two-part commentary the renowned Lucian Leape and colleagues look at an aspect of culture, that of disruptive behaviour by clinicians and its effects on other health care workers. They argue that health care organizations need to act to eliminate disruptive behaviours, suggesting such behaviours are a symptom of a pervasive culture of disrespect. The first part of the commentary identifies six types of disrespectful behaviour (disruptive behaviour; humiliating, demeaning treatment of nurses, residents, and students; passive-aggressive behaviour; passive disrespect; dismissive treatment of patients; and systemic disrespect), and they discuss the role health care system factors play.</p> <p>The second part discusses the role a culture of respect plays in developing high-reliability and high-performing organisations and strategies that can aid in addressing disruptive and disrespectful behaviours.</p> <p>According to the authors, ‘Central to an effective response is a code of conduct that establishes unequivocally the expectation that everyone is entitled to be treated with courtesy, honesty, respect, and dignity. The code must be enforced fairly through a clear and explicit process and applied consistently regardless of rank or station. Creating a culture of respect requires action on many fronts: modeling respectful conduct, educating students, physicians, and nonphysicians on appropriate behavior, conducting performance evaluations to identify those in need of help, providing counseling and training when needed, and supporting frontline changes that increase the sense of fairness, transparency, collaboration, and individual responsibility.’</p>
DOI	<p>Part 1: http://dx.doi.org/10.1097/ACM.0b013e318258338d Part 2: http://dx.doi.org/10.1097/ACM.0b013e3182583536</p>

Lessons from the Johns Hopkins Multi-Disciplinary Venous Thromboembolism (VTE) Prevention Collaborative

Streiff MB, Carolan HT, Hobson DB, Kraus PS, Holzmueller CG, Demski R, et al. BMJ 2012;344:e3935 [epub]

Notes	<p>In 2005 a VTE Prevention Collaborative was established by a multidisciplinary (haematologist, trauma surgeon, critical care intensivist, intensive care nurse, pharmacist, IT specialists, an administrative coordinator, quality and safety clinical researchers) team at the Johns Hopkins Hospital in Baltimore, Maryland. The Collaborative developed and implemented a mandatory clinical decision support tool for VTE risk stratification and risk-appropriate VTE prophylaxis for all hospitalised adult patients.</p> <p>This tool was initially paper-based, but in 2008 the Collaborative launched 16 evidence based, specialty specific, computerised physician order entry (CPOE) VTE order sets. The advantages of the new computerised VTE clinical decision support tools included a forcing function to make risk assessment mandatory, a default feature that recommended risk-appropriate prophylaxis, and an auto-populate feature that displayed relevant medical information from the patient’s electronic medical record.</p>
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	This article describes the strategy used by the Collaborative, the early results of the intervention, the lessons learnt, and the next steps in the project.
DOI	http://dx.doi.org/10.1136/bmj.e3935

Designing incentives for good-quality hospital care

Duckett SJ

Med J Aust 2012; 196 (11): 678-679.

Notes	Dr Stephen Duckett is Professor of Health Policy at the School of Public Health at La Trobe University in Melbourne. In this perspective piece he discusses the national roll-out of activity based funding (ABF), examining how quality can be built into the ABF structure and discussing the ‘non-pay for non-performance’ approach. He concludes that the national ABF roll-out is a pivotal opportunity to improve safety and quality in health care in Australia.
DOI	http://dx.doi.org/10.5694/mja11.11464

Are there any approved medical abbreviations?

Hameed F

BMJ 2012;344:e4140

Notes	A very brief piece in the BMJ from Friday, 15 June 2012. Dr Hameed comments on the absence of ‘approved medical abbreviations’ in the UK and <i>internationally</i> , and the effect this can have on the safety of patients. Dr Hameed calls for a more standardised approach to medical abbreviations and asks if, in the UK, that should be developed by the General Medical Council or the royal colleges.
DOI	http://dx.doi.org/10.1136/bmj.e4140

Improved Functional Outcomes for Major Trauma Patients in a Regionalized, Inclusive Trauma System

Gabbe BJ, Simpson PM, Sutherland AM, Wolfe R, Fitzgerald MC, Judson R, et al.

.Annals of Surgery 2012;255(6):1009-1015.

Notes	<p>Re-organisation of services, particularly reducing the number of locations offering specific types of care to create centres of excellence and recognising the volume effect, has at times been a contentious move. This paper adds to the literature on the re-organisation of trauma services by looking at the longer terms outcomes experienced in Victoria. This work, based on the use of registry data, found that people who survive severe trauma have improved chances of long-term recovery if treated in specialised trauma centres.</p> <p>This study evaluated the 12-month functional outcomes of 4,986 adult major trauma patients managed in the Victorian State Trauma System (VSTS) in 2006–2009, using data from the Victorian State Trauma Registry (VSTR). The authors reported that functional outcomes improved over time, and cases managed at specialist trauma centres demonstrated better functional outcomes.</p> <p>The study reports that, at 12 months from injury, 80 per cent of major trauma survivors continued to experience disability, with 35 per cent achieving good recovery, meaning injury had not affected function in major life areas. Seven per cent had died since discharge from hospital.</p>
DOI	http://dx.doi.org/10.1097/SLA.0b013e31824c4b91

Effectiveness of quality improvement strategies on the management of diabetes: a systematic review and meta-analysis

Tricco AC, Ivers NM, Grimshaw JM, Moher D, Turner L, Galipeau J, et al
The Lancet 2012;379(9833):2252-2261.

Notes	<p>Paper reporting on a systematic review and meta-analysis of diabetes management undertaken by Canadian researchers. The aim of the work was to ‘assess the effects of QI strategies on glycated haemoglobin (HbA1c), vascular risk management, microvascular complication monitoring, and smoking cessation in patients with diabetes’ by examining studies and trials ‘assessing 11 predefined QI strategies or financial incentives targeting health systems, health-care professionals, or patients to improve management of adult outpatients with diabetes’. The review included 48 cluster randomised controlled trials, including 2,538 clusters and 84,865 patients, and 94 patient randomised controlled trials, including 38,664 patients.</p> <p>In random effects meta-analysis, the QI strategies reduced HbA1c by a mean difference of 0.37% (120 trials), LDL cholesterol by 0.10 mmol/L (47 trials), systolic blood pressure by 3.13 mm Hg (65 trials), and diastolic blood pressure by 1.55 mm Hg (61 trials) versus usual care.</p> <p>Apparently, the effectiveness of QI strategies varies depending on baseline HbA1c control. The authors also report that QI strategies increased the likelihood that patients received aspirin, antihypertensive drugs, and screening for retinopathy, renal function, and foot abnormalities. However, statin use, hypertension control, and smoking cessation were not significantly increased.</p> <p>They conclude that ‘Many trials of QI strategies showed improvements in diabetes care. Interventions targeting the system of chronic disease management along with patient-mediated QI strategies should be an important component of interventions aimed at improving diabetes management. Interventions solely targeting health-care professionals seem to be beneficial only if baseline HbA1c control is poor.’</p>
DOI	<p>http://dx.doi.org/10.1016/S0140-6736(12)60480-2</p>

The Australian Primary Care Collaboratives Program: improving diabetes care

Knight AW, Ford D, Audehm R, Colagiuri S, Best J
BMJ Quality & Safety 2012 (epub).

Notes	<p>Another piece examining diabetes care is this Australian study reported in <i>BMJ Quality and Safety</i> reporting on a large-scale quality improvement collaborative implemented in seven waves between 2004 and 2009 in 743 general practices and Aboriginal medical services across Australia serving some 150,000 people. The health services participated in three 2-day workshops, separated by 3-month activity periods and followed by 12 months of further improvement work. Local collaborative program managers supported teams to report measures and plan/do/study/act (PDSA) cycles monthly. Health services received feedback about changes in their measures. The measures included percentage of patients in each health service with haemoglobin A1C (HbA1C), total cholesterol and blood pressure at target levels.</p> <p>The mean numbers of patients at target HbA1c levels improved by 50% from 25% at baseline to 38% at 18 months. Lipid and blood pressure measures showed similar improvement.</p> <p>The authors conclude that the results ‘demonstrated that the collaborative methodology is transferable to Australian primary care. The results may reflect improved data recording and disease coding, and changes in clinical care. Internal</p>
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	evaluation should be built into improvement projects from the start to facilitate improvements and reporting. Enthusiasm, training and resourcing practice teams appeared to be the key to rapid change. Local support of practice teams was instrumental in improvement.'
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000460

Concept and development of a discharge alert filter for abnormal laboratory values coupled with computerized provider order entry: a tool for quality improvement and hospital risk management
 Mathew G, Kho A, Dexter P, Bloodworth N, Fantz C, Spell N, et al.
 Journal of Patient Safety 2012;8(2):69-75.

The Use of Patient Pictures and Verification Screens to Reduce Computerized Provider Order Entry Errors
 Hyman D, Laire M, Redmond D, Kaplan DW
 Pediatrics 2012 (epub).

A novel tool for organisational learning and its impact on safety culture in a hospital dispensary
 Sujan MA
 Reliability Engineering & System Safety 2012;101(0):21-34.

Notes	<p>A number of papers suggesting additions or extensions to systems that could enhance the safety and/or quality impact of such systems.</p> <p>Mathew et al. describe an effort to develop a clinical decision support system activated at the time of discharge to reduce potentially inappropriate discharges from unidentified or unaddressed abnormal laboratory values. The system uses a set of triggers based on selected laboratory abnormalities that could systematically identify patients potentially unsafe for discharge. Triggers that led to a discharge alert included an elevated white blood cell count, a rising creatinine level, specific abnormalities in electrolytes, and an elevated international normalized ratio (INR) in the absence of anticoagulant therapy. The authors conclude that 'A discharge alert filter that reliably and effectively identifies patients that may be discharged in unsafe situations because of unaddressed critical laboratory values can improve patient safety at discharge Further research is needed to validate' the proposed approach.</p> <p>Hyman et al describe how a computerised provider order entry system was augmented an order verification screen, including the patient's photograph, in an effort to reduce the risk that orders will be placed in an unintended patient's electronic health record. From the limited implementation the results were promising.</p> <p>Sujan's paper describes the development of a mechanism for prospectively identifying latent hazards (PRIMO – Proactive risk monitoring tool) in a hospital pharmacy by incorporating frontline personnel's perspectives.</p>
DOI	<p>Mathew et al http://dx.doi.org/10.1097/PTS.0b013e31824aba75</p> <p>Hyman et al http://dx.doi.org/10.1542/peds.2011-2984</p> <p>Sujan http://dx.doi.org/10.1016/j.res.2011.12.021</p>

Medication errors during medical emergencies in a large, tertiary care, academic medical center.
Gokhman R, Seybert AL, Phrampus P, Darby J, Kane-Gill SL
Resuscitation 2012;83(4):482-487.

Errors in medication history at hospital admission: prevalence and predicting factors
Hellstrom L, Bondesson A, Hoglund P, Eriksson T.
BMC Clinical Pharmacology 2012;12(1):9.

Emergency Department Discharge Prescription Interventions by Emergency Medicine Pharmacists
Cesarz JL, Steffenhagen AL, Svenson J, Hamedani AG
Annals of Emergency Medicine 2012 (epub).

Paradoxical effects of a hospital-based, multi-intervention programme aimed at reducing medication round interruptions
Tomietto M, Sartor A, Mazzocoli E, Palese A
Journal of Nursing Management 2012;20(3):335-343.

Deconstructing intraoperative communication failures
Hu Y-Y, Arriaga AF, Peyre SE, Corso KA, Roth EM, Greenberg CC
Journal of Surgical Research 2012 (epub).

Surgical safety checklists: do they improve outcomes?
Walker IA, Reshamwalla S, Wilson IH
British Journal of Anaesthesia 2012;109(1):47-54.

Adverse events are common on the intensive care unit: results from a structured record review
Nilsson L, Pihl A, Tågsjö M, Ericsson E
Acta Anaesthesiologica Scandinavica 2012 (epub)

Cognitive Errors and Logistical Breakdowns Contributing to Missed and Delayed Diagnoses of Breast and Colorectal Cancers: A Process Analysis of Closed Malpractice Claims
Poon E, Kachalia A, Puopolo A, Gandhi T, Studdert D
Journal of General Internal Medicine 2012:1-8.

Notes	<p>A number of papers adding to the literature on a number of safety and quality issues, thereby updating and extending the evidence base. The topics covered include checklists, adverse events, medical errors, diagnosis, interruptions, medication reconciliation. It's interesting to note that these are not from the safety and quality literature but more domain-specific journals.</p> <p>Gokhman et al report on medication errors during medical emergencies in hospitals. They report that in the one site evaluated, nearly 1 in 2 doses administered in error (and this was after breaks in aseptic technique were excluded), while nearly half being prescribing errors. Almost 15% of errors were classified as at least moderate in severity.</p> <p>Hellström et al. report on how in a Swedish hospital medication reconciliation improved by having clinical pharmacists more accurately identifying medication errors on admission.</p>
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	<p>Cesarz et al also found the clinical pharmacists can enhance the safety and quality of care, in this case in the ED setting. This cohort study found that ED pharmacists intervened in 10.1% of prescriptions written for patients discharged from the ED, in order to prevent errors and to enhance medical therapy.</p> <p>In recent times there have been a number of works on interruption, particularly during medication rounds. Tomietto et al report on a study where a set of interventions aimed at reducing nursing interruptions were implemented. They report mixed effects. Although patients responded to nurses wearing a medication managing garment by decreasing interruptions, staff members did not.</p> <p>Hu et al. analysed video recordings of six complex surgical procedures in order to study communications, particularly lapses, in complex operations. They report that communication failures were frequent, especially in discussions about hospital policies and cross-disciplinary exchanges. The authors suggest that ‘Prevention may be achieved by improving synchronous, cross-disciplinary communication. The rate of failure during discussions about/mandated by policy highlights the need for carefully designed standardized interventions. System-level support for asynchronous perioperative communication may streamline operating room coordination and preparation efforts.’</p> <p>Walker et al provide further evidence on the role of checklists as a tool to improve safety in surgical care. They note the importance of leadership, flexibility, and teamwork in implementing surgical safety checklists.</p> <p>Nilsson et al. using the IHI Global Trigger Tool to identify adverse events in intensive care unit patients at a Swedish hospital and found that nearly 1 in 5 patients suffered an adverse event, half of which were preventable. This is in keeping with some of the other literature on the Tool which has also identified higher rates of adverse events compared with other tools.</p> <p>Poon et al. report their study analysing 56 missed or delayed cancer diagnoses and their finding that virtually all cases involved cognitive errors, and half involved logistical breakdowns. They suggest that ‘Prevention strategies should focus on ensuring improving the effectiveness and use of clinical guidelines in the selection of diagnostic strategy, both during office visits and when interpreting test results. Tools to facilitate communication and to ensure that follow-up visits occur should also be considered.’</p>
DOI / URL	<p>Gokhman et al. http://dx.doi.org/10.1016/j.resuscitation.2011.10.001 Hellström et al. http://dx.doi.org/10.1186/1472-6904-12-9 or http://www.biomedcentral.com/1472-6904/12/9 Cesarz et al. http://dx.doi.org/10.1016/j.annemergmed.2012.04.011 Tomietto et al http://dx.doi.org/10.1111/j.1365-2834.2012.01329.x Hu et al. http://dx.doi.org/10.1016/j.jss.2012.04.029 Walker et al. http://dx.doi.org/10.1093/bja/aes175 Nilsson et al http://dx.doi.org/10.1111/j.1399-6576.2012.02711.x Poon et al http://dx.doi.org/10.1007/s11606-012-2107-4u</p>

International Journal for Quality in Health Care online first articles

Notes	<p><i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Using the patient safety indicators to detect potential safety events among US veterans with psychotic disorders: clinical and research implications (Eric G. Smith, Shibe Zhao, and Amy K. Rosen) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs026v1?papetoc • Development and validation of comorbidity index in South Korea (Seol-Ryoung Kil, Sang-Il Lee, Young-Ho Khang, Moo-Song Lee, Hwa-Jung Kim, Seon-Ok Kim, and Min-Woo Jo) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs027v1?papetoc
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BMJ Quality and Safety

July 2012, Vol 21, Issue 7

Notes	<p>A new issue of <i>BMJ Quality and Safety</i> has been published. Many of the papers in this issue have been referred to in previous editions of <i>On the Radar</i> (when they were released online). Articles in this issue of <i>BMJ Quality and Safety</i> include:</p> <ul style="list-style-type: none"> • Editorial: Poverty amid plenty (Robert L Wears) • Cognitive interventions to reduce diagnostic error: a narrative review (Mark L Graber, Stephanie Kissam, Velma L Payne, Ashley N D Meyer, Asta Sorensen, N Lenfestey, E Tant, K Henriksen, K LaBresh, H Singh) • Factors predicting change in hospital safety climate and capability in a multi-site patient safety collaborative: a longitudinal survey study (Jonathan Benn, Susan Burnett, Anam Parand, Anna Pinto, Charles Vincent) • 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 (Bill Shearer, Stuart Marshall, Michael D Buist, M Finnigan, S Kitto, T Hore, T Sturgess, S Wilson, W Ramsay) • Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety? (Juliet Higginson, R Walters, Ni Fulop) • The ins and outs of change of shift handoffs between nurses: a communication challenge (John S Carroll, M Williams, T M Gallivan) • Error disclosure: a new domain for safety culture assessment (Jason M Etchegaray, Thomas H Gallagher, Sigall K Bell, Ben Dunlap, E J Thomas) • Associations between internet-based patient ratings and conventional surveys of patient experience in the English NHS: an observational study (F Greaves, U J Pape, D King, A Darzi, A Majeed, R M Wachter, C Millett) • Failure mode and effects analysis: too little for too much? (Bryony Dean Franklin, Nada Atef Shebl, Nick Barber) • Major cultural-compatibility complex: considerations on cross-cultural dissemination of patient safety programmes (Heon-Jae Jeong, Julius C Pham, Minji Kim, Cyrus Engineer, Peter J Pronovost) • Checklists, safety, my culture and me (Karthik Raghunathan)
URL	http://qualitysafety.bmj.com/content/vol21/issue7/

Online resources

[USA] *Hospital Safety Score.*

<http://hospitalsafetyscore.org/>

Using data reported by the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the Centers for Medicare and Medicaid Services, this site provides scores for US hospitals based on their safety.

[USA] *How-to Guides: Improving Transitions from the Hospital to various settings*

<http://www.ihl.org>

The Institute for Healthcare Improvement has recently updated its four How-to Guides on improving transitions out of the hospital to:

- Community Settings
- Skilled Nursing Facilities
- Home Health Care
- Clinical Office Practice

From the IHI newsletter: “The How-to Guides are designed to support hospital-based teams and their community partners in co-designing and reliably implementing improved care processes to ensure that patients who have been discharged from the hospital have an ideal transition to the next setting of care. All guides focus on reducing avoidable rehospitalizations, and all are free to download.”

URLs:

How-to Guide: Improving Transitions from the Hospital to **Community Settings** to Reduce Avoidable Rehospitalizations

<http://www.ihl.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionstoReduceAvoidableRehospitalizations.aspx>

How-to Guide: Improving Transitions from the Hospital to **Skilled Nursing Facilities** to Reduce Avoidable Rehospitalizations

<http://www.ihl.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionHospitalSNFstoReduceRehospitalizations.aspx>

How-to Guide: Improving Transitions from the Hospital to **Home Health Care** to Reduce Avoidable Rehospitalizations

<http://www.ihl.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionsfromHospitaltoHomeHealthCareReduceAvoidableHospitalizations.aspx>

How-to Guide: Improving Transitions from the Hospital to **Clinical Office Practice** to Reduce Avoidable Rehospitalizations

<http://www.ihl.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionsHospitaltoOfficePracticeReduceRehospitalizations.aspx>

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