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On the Radar

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This week's content

Reports

Harm to Healing—Partnering with Patients Who Have Been Harmed
Trew M, Nettleton S, Flemons W
Edmonton. Canadian Patient Safety Institute, 2012.

Notes	Brief report from the Canadian Patient Safety Institute describing how involving patients who have experienced harm can lead to 'important and often overlooked opportunities to make patient care safer'. According to the author, a key component of their patient safety strategy is **engagement**; engagement with all stakeholders, staff, leaders, health professionals, the public, and the patients and families that have been directly impacted. The research team explored the process of engaging patients and families with a specific focus on: • developing an understanding of the process of healing for these patients and families, and • developing a construct and framework to include them as advisors in collaborative patient safety initiatives. The report includes a Healthcare Harm to Healing model and recommendations for good practices.
URL	http://www.patientsafetyinstitute.ca/english/research/commissionedresearch/harmtohealing/pages/default.aspx http://www.patientsafetyinstitute.ca/English/research/commissionedResearch/HarmtoHealing/Documents/Harm%20to%20Healing.pdf
TRIM	66691

Potentially avoidable hospitalisations in Australia: Causes for hospitalisations and primary health care interventions. PHC RIS Policy Issue Review
Katterl R, Anikeeva O, Butler C, Brown L, Smith B, Bywood P
Adelaide: Primary Health Care Research & Information Service., 2012.

Notes	This Policy Issue Review examined the literature related to potentially avoidable hospitalisations, with the main research question being: 'What initiatives have been implemented in Australia or internationally to improve primary health care service delivery and reduce hospital admissions that are potentially avoidable?' Potentially avoidable hospitalisations (PAHs)have been defined as "admissions to hospital that could have potentially been prevented through the provision of appropriate non-hospital health services" and they tend to be of three main types: vaccine-preventable, chronic and acute conditions. The authors conclude that: 'Targeting reduction in PAHs is a specific objective of health care reform in Australia, with the aim of improving patients' outcomes, reducing pressure on hospitals and enhancing health system efficiency and cost-effectiveness. This review identified several promising programs to reduce PAHs in chronically ill Australians. Common characteristics of effective initiatives included: • **early identification** of patients who are at risk of hospitalisation • **care coordination** and integration of services • enhanced **access** to primary health care and focus on **equity** • **multidisciplinary** care team • **disease management**, particularly for medium to long-term.'
URL	http://www.phcris.org.au/publications/catalogue.php?elibid=8388
TRIM	66690

Journal articles

Care Redesign — A Path Forward for Providers
Lee TH
New England Journal of Medicine 2012;367(5):466-472.

Notes	Paper adapted from a speech describing how Lee and his colleagues at Partners HealthCare System have approached making the care they deliver more effective. There is much of interest in here, but it revolves affirming the organisational (and individual) **purpose**, understanding and **measuring** what is done and what patients **need and want**, understanding **context**, **reflecting** on these data and your practice, and the fundamental importance of **teamwork**. Lee notes that his team's recommendation 'fall into several major categories: implementation of scheduling and "navigation" functions …; use of data and guidelines to reduce unwarranted variation in resource use; reliable implementation of interventions that are likely to reduce adverse clinical events, readmissions, and emergency department visits …; and development of the capacity to monitor patients over time.'
DOI	http://www.nejm.org/doi/full/10.1056/NEJMhpr1204386

Mobile phone app from NHS "hack day" is set to transform handovers and task lists
Kmietowicz Z
BMJ 2012;345:e5162

Notes	News report on the results of the first NHS 'hack day' held in May 2012, which brought together clinicians and IT experts to tackle health care system issues. The winning team has designed an app to improve handover processes, currently paper-based, which can be used on computers and mobile phones and uses a feed from the hospital's electronic patient records. The app will allow doctors to create task lists for patient care, check test results, and update medical records. The team are currently working on a prototype for testing, and believe it has the **potential to save the NHS "more than £3.6m (€4.6m; $5.7m) in time savings**, a calculation based on cutting five minutes from the time that 10,000 junior doctors spend each day on handovers." The potential benefits for patient safety by reducing errors at handover are even greater.
DOI	http://dx.doi.org/10.1136/bmj.e5162

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

Strategies for improving patient safety culture in hospitals: a systematic review
Morello RT, Lowthian JA, Barker AL, McGinnes R, Dunt D, Brand C
BMJ Quality & Safety 2012 [epub].

Notes	Report from a Melbourne group on their systematic review examining the effectiveness of patient safety culture strategies to improve hospital patient safety climate. The group screened more than 2000 studies to identify 21 studies meeting their inclusion criteria. As is often the case, was marked methodological variation. They note that there was 'some evidence to support that **leadership walk rounds** and **multi-faceted unit-based programmes** may have a positive impact on patient safety climate.' Typically, for a systematic review, the authors note 'there is limited evidence to support definitive impacts on patient safety climate outcomes' and they advise organisations 'to consider robust evaluation designs when implementing these potentially resource intensive strategies.'
DOI	http://dx.doi.org/10.1136/bmjqs-2011-000582

Patient safety in psychiatric inpatient care: a literature review
Kanerva A, Lammintakanen J, Kivinen T
J Psychiatr Ment Health Nurs 2012.

Notes	Mental health may not always receive the attention it merits when discussion safety and quality of care. This paper reports on a literature review on safety in mental health inpatient care. The authors recognise that **organisational safety culture** is fundamental and that management has a role in creating good working conditions and environment. They argue that there is a need to **emphasise the patient's role** in developing patient safety practices and safety culture. The authors also suggest that an overly narrow focus on patient safety is to be avoided, as a 'lack of attention in one area may affect others, leading to errors and adverse events in care'.
DOI	http://dx.doi.org/10.1111/j.1365-2850.2012.01949.x

Royal college recommends national system to recognise deteriorating patients
Hawkes N
BMJ 2012;345:e5041

Doctors urge hospitals to adopt national system for scoring acutely ill patients
Kmietowicz Z
BMJ 2012;345:e5135

Notes	Two articles in the BMJ about a UK national 'track and trigger' system for recognising and responding to **clinical deterioration**. The national early warning score (NEWS) uses six physiological measurements that are already routinely taken, and allocates a score based on their variation from the norm. This score then corresponds to a level of response. NEWS has the potential to improve the assessment of illness, detect deterioration better, and ensure a timely clinical response. Currently, individual hospitals have their own recognition and response systems in place. A uniform, national system would avoid the risks of variation in local systems and enable standardised training for students and clinicians. NEWS has been launched by the Royal College of Physicians, and its national implementation is supported by the Society for Acute Medicine, the NHS medical director, and the NHS chief nursing officer.
DOI	Hawkes http://dx.doi.org/10.1136/bmj.e5041 Kmietowicz http://dx.doi.org/10.1136/bmj.e5135

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/

Patient Safety Reporting Systems: Sustained Quality Improvement Using a Multidisciplinary Team and Good Catch Awards
Herzer KR, Mirrer M, Xie Y, Steppan J, Li M, Jung C, et al.
Joint Commission Journal on Quality and Patient Safety 2012;38(8).

Notes	Paper reporting on how the Weinberg Surgical Suite at The Johns Hopkins Hospital (Baltimore)—a 16-operating-room inpatient/outpatient cancer centre—implemented a patient safety reporting process that sought to maximize the usefulness of the reports and the long-term sustainability of quality improvements arising from them. Features included a multidisciplinary team to review reports, mitigate hazards, educate and empower providers, recognize the identifying/reporting individuals or groups with 'Good Catch' awards, and follow-up to determine if quality improvements were sustained over time. Good Catch awards were given in recognition of 29 patient safety hazards since 2008. In all cases, an initiative was developed to mitigate the original hazard. Twenty-five (86%) of these quality improvements have been sustained.
DOI	http://www.ingentaconnect.com/content/jcaho/jcjqs/2012/00000038/00000008/art00001

International Journal for Quality in Health Care online first articles

Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Types and patterns of safety concerns in home care: staff perspectives (Catherine Craven, Kerry Byrne, J Sims-Gould, and A Martin-Matthews)

	http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs047v1?papetoc • Patients' perceived support from physicians and the role of hospital characteristics (Lena Ansmann, Christoph Kowalski, Nicole Ernstmann, Oliver Ommen, and Holger Pfaff) http://intqhc.oxfordjournals.org/cgi/content/abstract/mzs048v1?papetoc

Online resources

On-line Chronic Disease Self Management Training
http://www.archi.net.au/resources/workforce/learning/online-cdsm
http://www.heartresearchcentre.org/
From the ARCHI newsletter: Hunter New England (HNE) Health's Community Health Strategy has worked the Melbourne-based Heart Research Centre to reconfigure their existing two-day CDSM Support training into five on-line modules:
1. Understanding CDSM
2. Effective Communication
3. Goal Setting
4. Cognitive Behavioural Strategies
5. Motivational Interviewing
Each module consists of a theoretical component, interactive quizzes, video demonstrations reflection questions and practical tools which can assist clinical staff to provide effective self management support.

Cleaning for Sustainability
http://www.archi.net.au/resources/safety/infection/cleaning-sustainability
Also from the ARCHI newsletter, Southern Health, the largest public health service in Victoria, conducted a cleaning trial to examine the health, environmental and financial benefits of using steam cleaners and microfibre cloths. They replaced dry-cleaning, detergent and water, disinfectant and other chemicals, a mop and wringer bucket and disposable or dorset cloths.
They conclude that their Green Cleaning trial proved a success in terms of reducing both environmental and economic cost opportunities, but perhaps the best results are for staff and patients with improved infection control and better OH&S conditions.
If these practices were adopted across the state's hospital system, the cleaning methods have the potential to deliver multimillion dollar cost opportunities, improved health outcomes and reduced environmental impact.

More Than 100 Hospitals Achieve Measurable Improvements in Quality and Patient Safety During Aligning Forces for Quality Collaborative
http://www.forces4quality.org
The [US] Robert Wood Johnson Foundation has announced that 90% of hospitals participating in a national program to improve the quality and safety of patient care in America's hospitals achieved measurable improvement in patient care. 150 hospitals participated in an 18-month virtual collaborative through which they developed and shared quality improvement strategies. Their work focused specifically on reducing avoidable readmissions, improving the quality of language services for patients who speak little or no English, or improving the efficiency of the emergency department.

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The fundamental cause of trouble in the world today is that the stupid are cocksure while the intelligent are full of doubt. *Bertrand Russell*

For every complex problem there is an answer that is clear, simple, and wrong. *H.L. Mencken*