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This week's content

Journal articles

Disclosure of Harmful Medical Errors in Out-of-Hospital Care
Lu DW, Guenther E, Wesley AK, Gallagher TH
Annals of Emergency Medicine 2012 [epub].

Notes	Much of the focus of open disclosure and similar efforts has tended to be on in-hospital care and events. This paper looks at disclosure around errors beyond the hospital, particularly involving emergency medical services (EMS). As the authors note, (EMS) providers operate in unpredictable environments that require rapid interventions for patients with whom they have only brief relationships. They also tend to have limited access to patient medical data and risk management resources. Further, out-of-hospital errors may be discovered only at a later, for example after handover to a hospital. The authors suggest that 'EMS organizations should support the disclosure of out-of-hospital errors by fostering a non-punitive culture of error reporting and disclosure, as well as developing guidelines for use'.
DOI	http://dx.doi.org/10.1016/j.annemergmed.2012.07.004

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

A Framework for Encouraging Patient Engagement in Medical Decision Making
Holzmueller CG, Wu AW, Pronovost PJ
Journal of Patient Safety 2012 [epub].

Notes	'Patients have a right to make decisions about their medical care because they have the most at stake.' As opening lines for an abstract, this is quite compelling. In this piece the authors seek to describe the existing culture around the physician-patient relationship, offer a framework and strategies for engaging patients in decision making, and discuss some implications for patient safety.
DOI	http://dx.doi.org/10.1097/PTS.0b013e318267c56e

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/

Physical environments that promote safe medication use
Grissinger M
P&T 2012;37(7):377-378.

Notes	Short piece on how the physical work environment can contribute to safer medication use. Aspects of the physical environment discussed include lighting, managing interruptions and distractions, sound and noise, design and organisation or space, and the use of 'medication safety zones'.
URL	http://www.ptcommunity.com/ptJournal/fulltext/37/7/PTJ3707377.pdf

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

Twenty-four/seven: a mixed-method systematic review of the off-shift literature
de Cordova PB, Phibbs CS, Bartel AP, Stone PW
Journal of Advanced Nursing 2012;68(7):1454-1468.

Notes	Over the years there has been much said about the apparent risks of off-shift hospital time. This paper present a review that sought to "synthesize qualitative and quantitative evidence of 'off-shifts' (nights, weekends and/or holidays) on quality and employee outcomes in hospitals." The study sought studies published in the period 1985–2011 and could be either quantitative and/or qualitative studies. To be included, studies met the following criteria: (1) the independent variable was an off-shift; (2) the article was a research study and peer-reviewed; (3) the article could be obtained in English; and (4) the article pertained to health care. Using these criteria 60 studies were included. Researchers had reported important differences between patients admitted on weekends and mortality, as well as differences were also found between night-time birth and mortality and rotating night work and fatigue, stress and low mental well-being. 9 of 12 studies did not find an important association between patients admitted at night and mortality. The authors conclude that the review reveals "**Patient outcomes on weekends and employee outcomes at night are worse than during the day**."
DOI	http://dx.doi.org/10.1111/j.1365-2648.2012.05976.x

How nurses and physicians judge their own quality of care for deteriorating patients on medical wards: Self-assessment of quality of care is suboptimal
Ludikhuize J, Dongelmans DA, Smorenburg SM, Gans-Langelaar M, de Jonge E, de Rooij SE
Critical Care Medicine 2012 [epub].

Notes	A Dutch study investigated how clinicians judge their own quality of care for deteriorating patients, as compared with the judgment of independent experts. This cross-sectional study used interviews with care-providers regarding their perceived quality of care for clinically deteriorating patients, in this case the care providers for all patients with cardiopulmonary arrests and unplanned intensive care unit admissions from six medical nursing wards in a Dutch academic medical centre in April–July 2009. The study examined 47 events and 198 interviews. The authors say that the **clinicians** mostly **rated their care** provided to patients in the hours preceding a life-threatening adverse event **as good**. However, "**independent experts had a more critical appraisal** of the provided care in regards to timely recognition".
DOI	http://dx.doi.org/10.1097/CCM.0b013e31825fe2cb

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

Is It Possible to Identify Risks for Injurious Falls in Hospitalized Patients?
Mion LC, Chandler AM, Waters TM, Dietrich MS, Kessler LA, Miller ST, et al
Joint Commission Journal on Quality and Patient Safety 2012;38(9).

Notes	Falls are one of the most common adverse events. This paper reports on a US retrospective study that sought to determine predictors and outcomes of fall injuries among a cohort of adult hospitalised patients. The study used data on patients who had a fall in hospital during a 26-month period from 16 adult general medical and surgical units in an urban university-affiliated community hospital The authors report that the 784 patients had a median age of 63.5 years (range, 20 to > 90 years), 390 (50%) were women, and 526 (67%) were black. Some 228 (29%) fallers sustained injury; patients who were white, or were administered a selective serotonin reuptake inhibitor, two antipsychotic agents, an opiate, or a diuretic non-antihypertensive agent were more likely to sustain an injury. Home-based wheelchair use was protective of fall injury. **Seventy-nine percent of the patients had been designated as high fall risk within 24 hours before the fall**. The authors conclude that 'Few variables were able to distinguish patients who sustained injury after a hospital fall, further challenging clinicians' efforts to minimize hospital-related fall injury.' However, it would seem that fall risk assessment was accurately identifying those that did fall and therefore such assessments should be acted upon.
URL	http://www.ingentaconnect.com/content/jcaho/jcjqs/2012/00000038/00000009/art00004

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

A multicenter, phased, cluster-randomized controlled trial to reduce central line-associated bloodstream infections in intensive care units
Marsteller JA, Sexton JB, Hsu YJ, Hsiao CJ, Holzmueller CG, Pronovost PJ, et al.
Critical Care Medicine 2012 [epub].

Notes	Another piece adding to the literature on central line associated bloodstream infections (CLABSI) that further reinforces the fact that it is possible to get these potentially very serious infections down to really quite low levels. Using known strategies various categories of infections can be substantially reduced.
DOI	http://dx.doi.org/10.1097/CCM.0b013e31825fd4d8

For information on the Commission's work on healthcare associated infection, see
http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • **Ten challenges in improving quality** in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature (Mary Dixon-Woods, Sarah McNicol, Graham Martin) • **Personal accountability** in healthcare: searching for the right balance (Robert M Wachter) • What's in a name generator? Choosing the right name generators for social network surveys in healthcare quality and safety research (Ronald S Burt, David O Meltzer, Michael Seid, Amy Borgert, J W Chung, R B Colletti, G Dellal, S A Kahn, H C Kaplan, L E Peterson, P Margolis) • The accident and emergency department questionnaire: a measure for patients' experiences in the accident and emergency department (Nanne Bos, Steve Sizmur, Chris Graham, Henk F van Stel)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

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: • Aligning quality improvement to population health (Stuart Green, Paul Sullivan, Derek Bell, and Ruth Barnes) http://intqhc.oxfordjournals.org/cgi/content/extract/mzs049v1?papetoc

BMJ Quality and Safety
September 2012, Vol 21, Issue 9

Notes	A new issue of *BMJ Quality and Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality and Safety* include: • Editorial: **Deaths due to medical error**: jumbo jets or just small propeller planes? (Kaveh G Shojania) • Editorial: **Systems human factors**: how far have we come? (B J Norris) • Role of organisational structure in implementation of **sedation protocols**: a comparison of Canadian and French ICUs (Peter Dodek, Gerald Chanques, Glen Brown, Monica Norena, Maja Grubisic, Hubert Wong, Samir Jaber) • A framework for **engaging physicians** in quality and safety (Jonathan M Taitz, Thomas H Lee, Thomas D Sequist)

	• 'Tempos' management in primary care: a key factor for **classifying adverse events**, and improving quality and safety (R Amalberti, J Brami) • **Preventable deaths** due to problems in care in English acute hospitals: a retrospective case record review study (Helen Hogan, Frances Healey, Graham Neale, Richard Thomson, Charles Vincent, Nick Black) • Safety by design: effects of operating room floor marking on the position of surgical devices to promote **clean air flow compliance and minimise infection** risks (Dirk F de Korne, Jeroen D H van Wijngaarden, Jeroen van Rooij, Linda S G L Wauben, U Frans Hiddema, Niek S Klazinga) • Structures and processes of care in ambulatory oncology settings and nurse-reported **exposure to chemotherapy** (Christopher R Friese, Laurel Himes-Ferris, Megan N Frasier, Marjorie C McCullagh, Jennifer J Griggs) • A nationwide Hospital Survey on **Patient Safety Culture** in Belgian hospitals: setting priorities at the launch of a 5-year patient safety plan (Annemie Vlayen, Johan Hellings, Neree Claes, H Peleman, W Schrooten) • Participatory healthcare-provider orientation to improve artemether-lumefantrine-based drug treatment of uncomplicated malaria: a cluster quasi-experimental study (Norbert G Anyama, James K Tibenderana, Paul Kutyabami, Pakoyo F Kamba, Freddy E Kitutu, Richard O Adome) • Visualising differences in **professionals' perspectives on quality** and safety (Joanne Francis Travaglia, Peter Ivan Nugus, David Greenfield, Johanna Irene Westbrook, Jeffrey Braithwaite) • Analysis of **risk of medical errors** using structural-equation modelling: a 6-month prospective cohort study (Mika Tanaka, Katsutoshi Tanaka, Tomoki Takano, Noritada Kato, Mayumi Watanabe, Hitoshi Miyaoka) • Predictors of likelihood of **speaking up about safety concerns** in labour and delivery (Audrey Lyndon, J Bryan Sexton, Kathleen Rice Simpson, Alan Rosenstein, Kathryn A Lee, Robert M Wachter) • Viewpoint: Instigating change: trainee doctors' perspective (Nassim Parvizi, Sumera Shahaney, Guy Martin, Ahmir Ahmad, Masood Moghul)
URL	http://qualitysafety.bmj.com/content/vol21/issue9/