



## On the Radar

Issue 97

17 September 2012

*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.

Access to particular documents may depend on whether they are Open Access or not, and/or whether your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

*On the Radar* is available via email or as a PDF document from <http://www.safetyandquality.gov.au/publications-resources/on-the-radar/>

If you would like to receive *On the Radar* via email, you can subscribe on our website <http://www.safetyandquality.gov.au/> or by emailing us at [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au). You can also send feedback and comments to [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au).

For information about the Commission and its programs and publications, please visit <http://www.safetyandquality.gov.au/> You can also follow us on Twitter @ACSQHC.

### This week's content

#### Reports

*From Innovation to Action: The First Report of the Health Care Innovation Working Group*

*Health Outcomes of Care: An Idea Whose Time Has Come*

Canadian Institute for Health Information

Ottawa. Canadian Institute for Health Information, 2012.

*Evidence-Informed Change Management in Canadian Healthcare Organizations*

Dickson G, Lindstrom R, Black C, Van der Gucht D

Ottawa. Canadian Health Services Research Foundation, 2012.

Notes	<p>A number of reports that have a couple of unifying elements. The obvious (and trivial) one is that they are all Canadian. More useful is that they are all reflecting on how to improve health care and the quality of care.</p> <p><i>From Innovation to Action</i> is the report from a Working Group to identify innovations in healthcare delivery across Canada that was established by Canada's provincial premiers. This report focuses on three priority areas: clinical practice guidelines, team-based health care delivery models, and health human resource management initiatives.</p> <p><i>Health Outcomes of Care</i> is the second in a series focused on health outcomes of care produced by Statistics Canada and the Canadian Institute for Health Information. This report focuses on options for data development/enhancement to fill the information gaps in health outcomes of care.</p>
-------	---

	<p><i>Evidence-Informed Change Management</i> was commissioned in order to identify a suite of evidence-informed approaches to support change in small and large systems that are applicable to a variety of contexts within the Canadian health system. Key issues that leaders and managers face in responding to and initiating change were used to identify evidence-informed approaches. Key messages include:</p> <ul style="list-style-type: none"> <li>• A variety of theories, models, approaches, tools, techniques and instruments that decision makers can effectively use to oversee change exist; these approaches need to be deliberately chosen, with attention to stage of change and context, so as to have maximum utility and impact.</li> <li>• More attention to change readiness and change capacity prior to initiating change would contribute to better understanding about what strategies and approaches would help to initiate and support change effectively.</li> <li>• Agencies should be encouraged to develop a support platform devoted to leadership development in support of change.</li> <li>• While using approaches to change may be useful, increased attention to conceptualizing the change process would likely lead to more effective implementation and results.</li> </ul>
URL	<p><i>From Innovation to Action</i>  <a href="http://www.councilofthefederation.ca/pdfs/Health%20Innovation%20Report-E-WEB.pdf">http://www.councilofthefederation.ca/pdfs/Health%20Innovation%20Report-E-WEB.pdf</a>  <i>Health Outcomes of Care</i>  <a href="https://secure.cihi.ca/free_products/HealthOutcomes2012_EN.pdf">https://secure.cihi.ca/free_products/HealthOutcomes2012_EN.pdf</a>  <i>Evidence-Informed Change Management</i>  <a href="http://www.chsrf.ca/publicationsandresources/researchreports/commissionedresearch/12-06-29/39d0d5a8-e64e-425e-aec2-5497c39be338.aspx">http://www.chsrf.ca/publicationsandresources/researchreports/commissionedresearch/12-06-29/39d0d5a8-e64e-425e-aec2-5497c39be338.aspx</a></p>

## Journal articles

### *Nurse leadership and patient safety*

Agnew Ç, Flin R, Reid J

BMJ 2012;345.

Notes	<p>Editorial in the <i>BMJ</i> responding to a UK government call for better nurse leadership and ward management, including undertaking hours rounds. While ‘intentional rounds’ can have beneficial effects, the authors that “rounds themselves are not a solution for poor quality care and cannot compensate for inadequate staffing and poor leadership.”</p> <p>They continue to remind us that “<b>Solutions for quality improvement are inevitably multifarious</b>, and to assure safe, effective, and high quality experiences for patients, their <b>implementation depends on excellent leadership.</b>” Warming to their theme, they suggest that “Leadership at the level of the hospital ward is no different from other domains where safety is crucial. It is essentially about ‘influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives.’”</p> <p>Discussion of leadership and training for leadership has been prevalent for sometime, here they conclude by calling for nurse leadership and that there is a need for “evidence based leadership training programmes designed for nurse leaders. Investing in the leadership potential of nurses should be a priority.”</p>
DOI	<p><a href="http://dx.doi.org/10.1136/bmj.e4589">http://dx.doi.org/10.1136/bmj.e4589</a></p>

*Improving communication of critical laboratory results: know your process*

Wong BM, Etchells EE

BMJ Quality & Safety 2012;21(8):624-626.

Notes	Editorial discussing the experience of various information and communication technology projects that have been intended to enhance clinical communications, particularly around laboratory results. Wong and Etchells are arguing that failings and successes, including unintended consequences (both positive and negative) are often a function of how well the existing processes and context are understood. They argue that automation projects (and other interventions) “ <b>should not be undertaken without careful consideration of the existing clinical processes.</b> ” This attention to detail serves a variety of important purposes: (1) It allows the automation to have the highest likelihood of achieving its intended outcome by integrating it with existing clinical processes and workflows; (2) The automation's unintended negative consequences are anticipated and potentially mitigated; and (3) The indirect benefits of the automation can be taken advantage of and used to extend the benefits of the intervention more broadly. Keeping these steps in mind and having a detailed understanding of the process are ‘critical’ for success.”
DOI	<a href="http://dx.doi.org/10.1136/bmjqs-2012-001272">http://dx.doi.org/10.1136/bmjqs-2012-001272</a>

*Editorial: Engaging Trainees in Health Care Improvement Throughout Medical Education*

Zeltser MV, Schanker BD

American Journal of Medical Quality 2012;27(5):366-368.

Notes	Editorial commenting on the US Accreditation Council for Graduate Medical Education (ACGME) requirements on patient safety and quality improvement education. The ACGME has included the following core competencies as expectations of all resident physicians; the ability to: <ol style="list-style-type: none"><li>1. Systematically analyse practice using QI methods and implement changes with the goal of practice improvement</li><li>2. Advocate for quality patient care and optimal patient care systems</li><li>3. Work in inter-professional teams to enhance patient safety and improve patient care quality</li><li>4. Participate in identifying system errors and implementing potential systems solutions.</li></ol> In supporting these requirements, the authors assert that “ <b>physicians must be prepared to deliver care in a manner that manifests with high-quality outcomes, and a dedicated career pathway should be developed for quality specialists</b> ”. They conclude by suggesting that “ <b>the education of trainees and practicing physicians in QI principles represents one of the most tangible and necessary mechanisms of improving health care delivery.</b> ”
DOI	<a href="http://dx.doi.org/10.1177/1062860612452376">http://dx.doi.org/10.1177/1062860612452376</a>

*Caregivers' Perceptions of Patients as Reminders to Improve Hand Hygiene*

Longtin Y, Farquet N, Gayet-Ageron A, Sax H, Pittet D

Arch Intern Med 2012 [epub 3 Sept]

Notes	A cross-sectional study conducted in 2009 to investigate how healthcare workers (HCWs) feel about being reminded by patients to perform hand hygiene. This Swiss study surveyed 277 HCWs and also sought to identify socio-demographic variables and beliefs that influence their views about patient reminders of hand hygiene. The study found that “29% of respondents did not support the idea of
-------	---

	being reminded by patients to perform hand hygiene” and “ 37% would not consent to wear a badge inviting patients to ask about hand hygiene. Their reasons ranged from feeling that it would be too time-consuming to invite patients to ask about hand hygiene (26%), that patient inquiry would be upsetting (17%), and that patient inquiry would be humiliating (27%). They were also worried about stirring patients anger, seeming inept in front of patients, or leaving themselves open to legal action by their admission.
DOI	<a href="http://dx.doi.org/10.1001/archinternmed.2012.3641">http://dx.doi.org/10.1001/archinternmed.2012.3641</a>

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

*Synergistic Implications of Multiple Postoperative Outcomes*  
 Boltz MM, Hollenbeak CS, Ortenzi G, Dillon PW  
 American Journal of Medical Quality 2012;27(5):383-390.

Notes	Study using data from the US National Surgical Quality Improvement Program (NSQIP) that was used to estimate mortality, length of stay (LOS), and total cost attributable to multiple postoperative events in general and vascular surgery patients in a single academic centre between 2007 and 2009. Of the 2250 patients sampled, 457 patients developed at least 1 postoperative event. LOS increased by 2.59, 5.18, and 10.99 days for 1, 2, and 3+ postoperative events; excess costs were \$6358, \$12,802, and \$42,790, respectively. <b>Multiple postoperative events have a synergistic or compounding effect on mortality, LOS, and the financial cost of patient care.</b>
DOI	<a href="http://dx.doi.org/10.1177/1062860611429612">http://dx.doi.org/10.1177/1062860611429612</a>

*BMJ Quality and Safety* online first articles

Notes	<i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including: <ul style="list-style-type: none"> <li>Honouring patient’s resuscitation wishes: a multiphased effort to improve identification and documentation (Nicola Schiebel, Sarah Henrickson Parker, Richard R Bessette, Eric J Cleveland, J Paul Neeley, Karen T Warfield, Mellissa M Barth, Kim A Gaines, James M Naessens)</li> </ul>
URL	<a href="http://qualitysafety.bmj.com/onlinefirst.dtl">http://qualitysafety.bmj.com/onlinefirst.dtl</a>

*International Journal for Quality in Health Care*  
 October 2012, Vol 24, Issue 5

Notes	A new issue of the <i>International Journal for Quality in Health Care</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 the <i>International Journal for Quality in Health Care</i> include: <ul style="list-style-type: none"> <li>Editorial: What does the <b>patient know about quality?</b> (Karen Luxford)</li> <li>Editorial: Aligning <b>quality improvement to population health</b> (Stuart Green, Paul Sullivan, Derek Bell, and Ruth Barnes)</li> <li>Is the <b>length of stay</b> in hospital correlated with <b>patient satisfaction?</b>(Ine Borghans, Sophia M Kleefstra, Rudolf B Kool, and Gert P. Westert)</li> <li>Implementation of early goal-directed therapy and the surviving <b>sepsis campaign resuscitation bundle</b> in Asia (Sungwon Na, Win Sen Kuan, Malcolm Mahadevan, Chih-Huang Li, Pinak Shrikhande, Sumit Ray, Michael Batech, H. Bryant Nguyen, and for the ATLAS Investigators)</li> </ul>
-------	---

	<ul style="list-style-type: none"> <li>• Learning from <b>large-scale quality improvement</b> through comparisons (John Øvretveit and Niek Klazinga)</li> <li>• <b>Cross-cultural evaluation</b> of the relevance of the HCAHPS survey in five European countries (A Squires, L Bruyneel, L H Aiken, K Van den Heede, T Brzostek, R Busse, A Ensio, M Schubert, D Zikos, and W Sermeus)</li> <li>• Complaints as indicators of health care shortcomings: which groups of patients are affected? (Susanne Schnitzer, Adelheid Kuhlmeier, Holger Adolph, Julie Holzhausen, and Liane Schenk)</li> <li>• A review of <b>hospital characteristics associated with improved performance</b> (Caroline A Brand, Anna L Barker, Renata T Morello, M R Vitale, S M Evans, I A Scott, J U Stoelwinder, and P A Cameron)</li> <li>• An empirical test of <b>accreditation patient journey surveys</b>: randomized trial (David Greenfield, Reece Hinchcliff, Mary Westbrook, Deborah Jones, Lena Low, Brian Johnston, Margaret Banks, Marjorie Pawsey, Max Moldovan, Johanna Westbrook, and Jeffrey Braithwaite)</li> <li>• <b>Patients' perceived support</b> from physicians and the role of hospital characteristics (Lena Ansmann, Christoph Kowalski, Nicole Ernstmann, Oliver Ommen, and Holger Pfaff)</li> <li>• The <b>value of open-ended questions in surveys on patient experience</b>: number of comments and perceived usefulness from a hospital perspective (Erik Riiskjaer, Jette Ammentorp, and Poul-Erik Kofoed)</li> <li>• Development of an instrument to measure face validity, feasibility and utility of <b>patient questionnaire use</b> during health care: the QQ-10 (K.L. Moores, G.L. Jones, and S.C. Radley)</li> <li>• Types and patterns of <b>safety concerns in home care</b>: staff perspectives (Catherine Craven, Kerry Byrne, J Sims-Gould, and A Martin-Matthews)</li> <li>• Reliability and accuracy of the <b>screening for adverse events</b> in Brazilian hospitals (Ana Luiza Braz Pavao, Luiz Antonio Bastos Camacho, Monica Martins, Walter Mendes, and Claudia Travassos)</li> <li>• Using a knowledge translation framework to implement <b>asthma clinical practice guidelines</b> in primary care (Christopher Liciskai, Todd Sands, Michael Ong, Lisa Paolatto, and Ivan Nicoletti)</li> </ul>
URL	<a href="http://intqhc.oxfordjournals.org/content/vol24/issue5/index.dtl?etoc">http://intqhc.oxfordjournals.org/content/vol24/issue5/index.dtl?etoc</a>

*American Journal of Medical Quality*  
1 September 2012; Vol. 27, No. 5

Notes	<p>A new issue of the <i>American Journal of Medical Quality</i> has been published, and includes the following articles:</p> <ul style="list-style-type: none"> <li>• <b>A Resident-Led Institutional Patient Safety and Quality Improvement Process</b> (Jeremy Stueven, David P. Sklar, Paul Kaloostian, Cathy Jaco, Summers Kalishman, Sharon Wayne, Andrew Doering, and D Gonzales)</li> <li>• <b>Variation in Diabetes Care Quality Among Medicare Advantage Plans: Understanding the Role of Case Mix</b> (Jean M. Abraham, Schelomo Marmor, David Knutson, Jessica Zeglin, and Beth Virnig)</li> <li>• <b>Identifying Worsening Surgical Site Infection Performance: Control Charts Versus Risk-Adjusted Rate Outlier Status</b> (Elise H. Lawson, Bruce Lee Hall, Nestor F. Esnaola, and Clifford Y. Ko)</li> <li>• <b>Designing a Comprehensive Strategy to Improve One Core Measure: Discharge of Patients With Myocardial Infarction or Heart Failure on</b></li> </ul>
-------	---

	<p>ACE Inhibitors/ARBs (Calie Santana, M Shaines, P Choi, and R Bhalla)</p> <ul style="list-style-type: none"> <li>• Improving Prompt Effectiveness in <b>Diabetes Care</b>: An Intervention Study (Jason Patrick Bronner, John Fontanesi, and Anupam Goel)</li> <li>• Does <b>Patient Perception of Pain Control</b> Affect Patient Satisfaction Across Surgical Units in a Tertiary Teaching Hospital? (Marie N. Hanna, Marlís González-Fernández, A D Barrett, K A Williams, and P Pronovost)</li> <li>• A Multisite Validity Study of Self-Reported <b>Anesthesia Outcomes</b> (Peter Walker, Renee Pekmezaris, Martin L. Lesser, Christian N. Nouryan, Frank Rosinia, Kathy Pratt, and Catherine LaVopa)</li> <li>• Improving Hospital <b>Mass Casualty Preparedness</b> Through Ongoing Readiness Evaluation (Bruria Adini, Daniel Laor, Tzipora Hornik-Lurie, Dagan Schwartz, and Limor Aharonson-Daniel)</li> <li>• The Connection Between Selective Referrals for Radical Cystectomy and Radical Prostatectomy and <b>Volume–Outcome Effects</b>: An Instrumental Variables Analysis (Veerasathpurush Allareddy, Marcia M. Ward, George L. Wehby, and Badrinath R. Konety)</li> <li>• Commentary: <b>Reducing Hospital Readmissions</b>: Aligning Financial and Quality Incentives (Carolyn M. Clancy)</li> </ul>
URL	<a href="http://ajm.sagepub.com/content/vol27/issue5/?etoc">http://ajm.sagepub.com/content/vol27/issue5/?etoc</a>

## Online resources

[US] AHRQ CLABSI CUSP

<http://www.ahrq.gov/news/press/pr2012/pspclabsipr.htm>

Acronym overload?

The US Agency for Healthcare Research and Quality has announced that a nationwide (USA) patient safety project has **reduced** the rate of central line-associated bloodstream infections (CLABSIs) in intensive care units **by 40 percent**, according to the agency’s preliminary findings of the largest national effort to combat CLABSIs to date. The project used the Comprehensive Unit-based Safety Program (CUSP) to achieve its landmark results that include preventing **more than 2,000 CLABSIs**, saving more than **500 lives** and avoiding more than **\$34 million** in health care costs. The project involved hospital teams at more than 1,100 adult intensive care units (ICUs) in 44 states over a 4-year period. Preliminary findings indicate that hospitals participating in this project reduced the rate of CLABSIs nationally from 1.903 infections per 1,000 central line days to 1.137 infections per 1,000 line days, an overall reduction of 40 percent.

For information on the Commission’s work on healthcare associated infection, see

<http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/>

---

## Disclaimer

*On the Radar* is an information resource of the Australian Commission on Safety and Quality in Health Care. The Commission is not responsible for the content of, nor does it endorse, any articles or sites listed. The Commission accepts no liability for the information or advice provided by these external links. Links are provided on the basis that users make their own decisions about the accuracy, currency and reliability of the information contained therein. Any opinions expressed are not necessarily those of the Australian Commission on Safety and Quality in Health Care.