University of Otago
Te Whare Wānanga o Otāgo
NEW ZEALAND

Articles of Interest : Quality

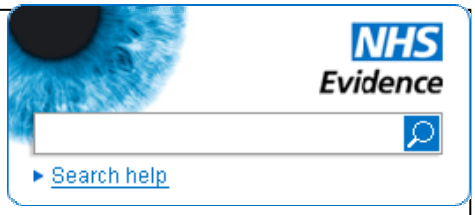
V6 No1 March 2010

Canterbury Medical Library

Quality●Net

NHS Evidence

http://www.evidence.nhs.uk/default.aspx



Have you discovered NHS Evidence yet?

Designed to help health professionals find information for patient care, this site has an easy to use search engine to help you search for information from a wide range of sources, including systematic reviews, guidelines, patient information, evidence summaries, drug information.

- Ranks search results from credible medical sources according to relevance and quality
- Allows you to filter your results by area of interest, type of information, specific medicine, etc.
- Allows you to register – through My Evidence - to receive the latest health information

For health professionals working in the NHS, the portal provides links through to subscribed journals. While these journal links may not work for us the portal is still an excellent source of high quality information.

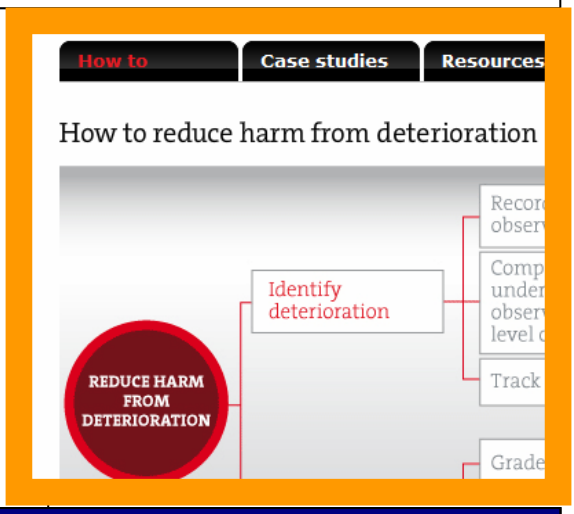
The deteriorating patient

Patient Safety First

http://www.patientsafetyfirst.nhs.uk/

Patient Safety First is a clinician-led campaign in the UK to make patient safety everyone's highest priority. The campaign promotes five Interventions – Leadership, Deterioration, Critical care, Periop care, and High risk meds.

Their *'Deterioration'* intervention aims to reduce avoidable harm and mortality rate through earlier recognition and treatment of the deteriorating patient. Provides useful resource material including a 'How-to' guide.



THE CHECKLIST *If something so simple can transform intensive care, what else can it do?*

In 2001, Peter Pronovost, a critical-care specialist at Johns Hopkins Hospital, designed a checklist to tackle the problem of line infections. Pronovost checked compliance over the course of one month and found that doctors skipped at least one step in more than a third of patients.

The following month, his team persuaded the hospital administration to authorize nurses to stop doctors if they saw them skipping a step on the checklist. The results were dramatic: the ten-day line-infection rate went from eleven per cent to zero. Further research over the next fifteen month showed that the checklist had prevented forty-three infections and eight deaths, and saved two million dollars in costs.

Checklists aren't new and aren't a magic bullet, but Pronovost showed they have the power to save lives. See this article by Atul Gawande in the The New Yorker, Annals of Medicine.

Read more: http://www.newyorker.com/reporting/2007/12/10/071210fa_fact_gawande

Gawande's book 'Checklist manifesto : how to get things right' has been placed on order for the library.

Clinical Audit Support Centre (UK)

http://www.clinicalauditsupport.com/index.html

The Clinical Audit Support Centre (UK) supports clinical audit activities of healthcare professionals across the UK. Their site provides useful resources for clinical audit such as a newsletter (*Clinical Audit Today*), handbooks on clinical audit, and sample size calculators.

The February 2010 issue of the newsletter is well worth a read. John Grant-Casey, Project Manager, NHS Blood and Transplantion, takes a humorous look at getting your sample size right. Simon Dodds, Consultant Surgeon at Good Hope Hospital looks at the challenges of quality improvement in a healthcare environment.

Simon says that quality improvement requires a far more sophisticated approach than just measuring our performance against standards. For instance a standard such as "4 hours maximum wait in A&E" is useful but pushing patients out heedlessly after 4 hours will not improve the quality of care.

Simon suggests that healthcare organizations need access to practitioners with competency in improvement methods such as lean thinking, six sigma and theory of constraints.

> We need to measure our performance against standards, but we also need to ensure that we are actually achieving better healthcare not just meeting targets.
> Simon Dodds, Clinical Audit Today, Feb 2010

Improve communication and patient safety with ISBAR

Several CDHB groups are developing ISBAR communication tools to more effective patient information. ISBAR is a modification of the SBAR tool and stands for:

Identification – identifying people involved in the communication

Situation – the context an aim of the communication

Background – patient background and information – how we got here.

Assessment – what is the problem?

Recommendation or Request – What do we need to do and when?

See page six for links to some SBAR tools and to a presentation on the CDHB Intranet.

The Clinical Audit Committee, Christchurch Hospital, invites you to

For Registered Nurses attendance at Clinical Audit & Quality presentations counts towards professional development for the Nursing Council of New Zealand. Attendance Record sheet provided.

A Lunchtime
CLINICAL AUDIT & QUALITY IMPROVEMENT PRESENTATION

Monday, 19th of April, 2010
12.30 – 13.30 hrs

Oncology Lecture Theatre.

12:00 Paediatric PICCS – what we have learned
Presented by Steve Cotterell, Registered Nurse Radiology

13:00 So you think your patient's blood glucose meter is accurate?
Presented by Helen Lunt, Physician, Diabetes Centre

All Staff Welcome!
Please bring your own lunch

For further information on Clinical Audit & Quality Improvement please contact:
Irena de Rooy , Quality Facilitator - ext 86194
Shona MacMillan, Quality Manager - ext 81363

Library Hours

Monday 12 April - Friday 30 April 2010	
Monday – Thursday	8.30am - 9.00pm
Friday	8.30am - 5.00pm
Saturday	1.00pm - 5.00pm
Sunday	Closed
Saturday 1 May - Sunday 13 June 2010	
Monday – Thursday	8.30am - 9.00pm
Friday	8.30am - 5.00pm
Saturday	1.00pm - 5.00pm
Sunday	1.00pm - 5.00pm
Exception	
Monday 7 June (Queen's Birthday)	1.00pm - 5.00pm

New print & online books of Interest

Some of the new print books may still be on display in the library

1. **Communication skills in medicine : promoting patient-centred care.** [Michele Groves and Jennifer Fitzgerald (Eds.)]. East Hawthorn, Vic. : IP Communications, 2010. W 62 C734 2010

2. **Direct red : a surgeon's story** [Gabriel Weston] London : Jonathan Cape, 2009.
WZ 100 W535 2009
Described as "A surgeon's view of work in the operating theatre of a British hospital in painfully vivid detail": http://www.timesonline.co.uk/tol/news/

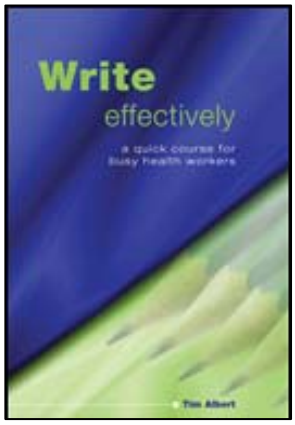
3. **Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers.** [J Øvretveit]. London: the Health Foundation., 2009.
Online book - See page 6 for a link.

4. **Evaluation of a change programme : model of nursing care delivery :** a dissertation submitted in partial fulfilment for the degree of Master of Health Sciences. [Sue Hayward]. Thesis (MHealSc)--University of Otago, 2009
Canterbury Medical Library Thesis collection
Ask at the Loans Desk – reference only.

5. **Falls in older people : risk factors and strategies for prevention** [Stephen R. Lord.]. Cambridge : Cambridge University Press, c2007.
WA 288 F196 2007

6. **Heal+h cheque : the truth we should all know about New Zealand's public health system** [Gareth Morgan and Geoff Simmons ; with John McCrystal]. Auckland, N.Z. : Public Interest Publishing, 2009.
WA 540.KN4 M848 2009

7. **Health and environment in Aotearoa/New Zealand** [Susan Shaw and Bron Deed]. South Melbourne, Vic. : Oxford University Press, 2010.
WA 30 H434 2010



8. **Leadership and management in healthcare** [Neil Gopee and Jo Galloway]. Los Angeles ; London : Sage, c2009. W 84.FA1 G659 2009

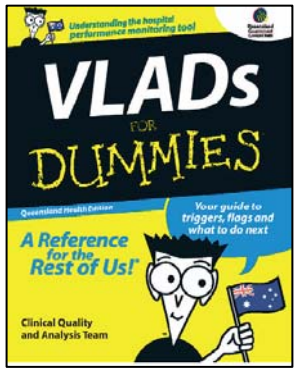
9. **Mixed methods research for nursing and the health sciences** [Sharon Andrew and Elizabeth J. Halcomb]. Chichester, U.K. : Wiley-Blackwell Pub., 2009. WY 20.5 M685 2009

10. **No time to teach? : a nurse's guide to patient and family education** [Fran London]. Philadelphia: Lippincott, c1999.
W 85 L847 1999

11. **Preventing Falls and harm from falls in older people**. Best practice guidelines for Australian hospitals. Canberra : Safety and Quality Council, 2009.
Online book - See page 6 for a link.

12. **Statistics at square one [**M.J. Campbell, T.D.V. Swinscow]. Chichester, UK ; Hoboken, NJ : Wiley-Blackwell/BMJ Books, 2009. HA 29 S978 2009

13. **VLADs for dummies** [Clinical Practice Improvement Centre]. Milton, Qld : Wiley Publishing Australia Pty Ltd, 2008
W 84.1 C641 2008
A VLAD is a type of statistical process control chart that gives a visual presentation of the treatment outcomes for clinical indicators.



14. **Qualitative research proposals and reports : a guide** [Patricia L. Munhall, Ronald Chenail]. Sudbury, Mass. : Jones and Bartlett Publishers, c2008. WY 20.5 M966 2008

15. **Using evidence to guide nursing practice** [Mary Courtney, Helen McCutcheon]. Chatswood, N.S.W. : Elsevier Australia, c2010.
WY 100.7 U85 2010

16. **Write effectively : a quick course for busy health workers** [Tim Albert]. Oxford; New York : Radcliffe Pub., c2008
WZ 345 A333 200

Articles of Interest

Articles listed here are available to the Canterbury District Health Board (CDHB) and University of Otago, Christchurch (UOC) staff and students as indicated.

Online CDHB and UOC Online UOC only

To access the online articles click on the link below the article or locate the journal using the library's electronic journals portal: http://www.chmeds.ac.nz/departments/library/index.htm Or from the CDHB intranet, select the View Library & Manuals option from the CDHB intranet, link through to the Electronic journals portal.

Library members can access all online articles on the Library's public computers (bring a USB memory stick).

Request a copy: University of Otago and CDHB staff may use the attached request form to request a photocopy of articles (except those marked).

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1 Balancing "no blame" with accountability in patient safety.
Wachter RM, Pronovost PJ, Wachter RM, Pronovost PJ
New England Journal of Medicine 2009 Oct 1; 361(14):1401-1406.
http://content.nejm.org/cgi/reprint/361/14/1401.pdf

2 Balancing "no blame" with accountability in patient safety. *[Response to the article by Wachter (above) followed by the author's reply]*
Peled H
New England Journal of Medicine 2010 Jan 21; 362(3):275; author reply 275-276.
http://content.nejm.org/cgi/reprint/362/3/275.pdf

3 Changing culture: a new view of human error and patient safety.
Wiegmann DA, Dunn WF, Wiegmann DA, Dunn WF
Chest 2010 Feb; 137(2):250-252.
Online University Only
http://dx.doi.org/10.1378/chest.09-1176
Print copy in library

4 Creating Quality Evidence Summaries on a Clinician's Schedule.
McGee S, Clark E
Journal of Nursing Administration 2010 40(1):7-9.
http://dx.doi.org/10.1097/NNA.0b013e3181c47ced
Select the option 'OvidSP and Athens'

5 Development and evaluation of an observational tool for assessing surgical flow disruptions and their impact on surgical performance.
Parker SE, Laviana AA, Wadhera RK, Wiegmann DA, Sundt TM, 3rd, Parker SEH, et al.
World Journal of Surgery 2010 Feb; 34(2):353-361.
http://ejournals.ebsco.com/Issue.asp?IssueID=1172934

6 Diagnostic Errors--The Next Frontier for Patient Safety.
Newman-Toker DE, Pronovost PJ
JAMA 2009 Mar 11; 301(10):1060.
http://jama.ama-assn.org/cgi/reprint/301/10/1060

7 Do you hold staff accountable for safety?
Terry K
Hospitals and health networks 2010 Feb; 84(2):34-8.
http://zz5mw5zc7z.search.serialssolutions.com/

8 How perioperative nurses define, attribute causes of, and react to intraoperative nursing errors.
Chard R
AORN Journal 2010 Jan; 91(1):132-145.
http://dx.doi.org/10.1016/j.aorn.2009.06.028
Select the option 'ScienceDirect'.

9 Implementing a pre-operative checklist to increase patient safety: a 1-year follow-up of personnel attitudes.
Nilsson L, Lindberget O, Gupta A, Vegfors M
Acta Anaesthesiologica Scandinavica 2010 Feb; 54(2):176-182.
Online University Only
http://dx.doi.org/10.1111/j.1399-6576.2009.02109.x
Print copy in library

10 Improving the patient experience in Canterbury--a vision for the future: *a recent health showcase in Christchurch has inspired many to think in new ways about how to improve patient care in the region.* **[CDHB Showcase]**
Manchester A
Kai Tiaki: Nursing New Zealand 2010 Feb; 16(1):12(12).
http://zz5mw5zc7z.search.serialssolutions.com/

11 **Meta-analysis: Effect of Interactive Communication Between Collaborating Primary Care Physicians and Specialists.**
Foy R, Hempel S, Rubenstein L, Suttorp M, Seelig M, Shanman R, et al.
Annals of internal medicine 2010 Feb 16; 152(4):247-258.
http://www.annals.org/content/152/4/247.full.pdf+html

12 **Patient Characteristics and the Occurrence of Never Events.**
Fry DE, Pine M, Jones BL, Meimban RJ
Archives of Surgery 2010 145(2):148-151.
http://archsurg.ama-assn.org/cgi/reprint/145/2/148.pdf

13 **Patient safety at ten: unmistakable progress, troubling gaps.**
Wachter RM
Health Affairs 2010 Jan; 29(1):165-173.
Patient safety at ten: unmistakable progress, troubling gaps
Online University Only
http://content.healthaffairs.org/cgi/reprint/29/1/165

14 **The Patient Who Falls: "It's Always a Trade-off".**
Tinetti ME, Kumar C
JAMA 2010 January 20, 2010; 303(3):258-266.
http://jama.ama-assn.org/cgi/content/abstract/303/3/258

15 **Quality and safety in intensive care--A means to an end is critical.**
Hewson-Conroy KM, Elliott D, Burrell AR
Australian Critical Care In Press, Corrected Proof, Available online 18 January 2010
http://dx.doi.org/10.1016/j.aucc.2009.12.001

16 **Rapid response teams: a systematic review and meta-analysis.**
Chan PS, Jain R, Nallmothu BK, Berg RA, Sasson C
Archives of Internal Medicine 2010 Jan 11; 170(1):18-26.
http://archinte.ama-assn.org/cgi/reprint/170/1/18

17 **Safe staffing the key to reducing serious and sentinel events.**
Anonymous
Kai Tiaki: Nursing New Zealand 2009 Dec; 15(11):7.
http://zz5mw5zc7z.search.serialssolutions.com/

18 **Setting priorities for patient safety: ethics, accountability, and public engagement.**
Pronovost PJ, Faden RR, Pronovost PJ, Faden RR
JAMA 2009 Aug 26; 302(8):890-891.
http://jama.ama-assn.org/cgi/reprint/302/8/890

19 **Social scientists and patient safety: Critics or contributors?**
Vincent C
Social Science & Medicine 2009, 69(12):1777-9
http://dx.doi.org/10.1016/j.socscimed.2009.09.046

20 **Solutions for improving patient safety.**
Livingston EH
JAMA 2010 Jan 13; 303(2):159-161.
http://jama.ama-assn.org/cgi/content/extract/303/2/159

WHO Patient Safety Curriculum Guide for Medical Schools

http://www.who.int/patientsafety/education/curriculum/download/en/index.html

This Curriculum Guide from the World Health Organisation aims to encourage and facilitate the teaching of patient safety topics to medical students. It is currently undergoing pilot testing in a range of settings globally.

First, do no harm

Print copy available from Canterbury Medical Library - Reference Only

This article by by Donna Chisholm (North and South, Mar 2010; n.288:p.56-63) discusses the fact that that one in eight patients admitted to our public hospitals suffer unintended harm.

The Commissioner believes that doctors, nurses and hospital manager try to provide the best care they can. He advises health care staff to treat patients and families honestly and decently. His perception is that patients and their families are immensly forgiving if treated with compassion.

Websites mentioned in Quality.Net

Here are the full URLS for the websites mentioned in Quality.Net. Sometimes you will be asked to "Block" or "Allow" a link. This is a security feature but you will need to click on "Allow" in order to see the article.

It can be quite bewildering trying to negotiate through a new website or portal to get to the article you want. If you are having problems phone the library on 80504 or call at the library reference desk for assistance.

Tip If you have trouble opening any URLs instead of clicking or double clicking on the URL, try this:

- Right click on your mouse
- Select 'Save Target as …"
- Open the file that you have saved.

Contact the library Reference Desk for help with electronic resources
03-364-0504 (ext 80504)

Links for items on PAGE 1

NHS Evidence
http://www.evidence.nhs.uk/default.aspx

The Deteriorating Patient

Patient Safety First (Click on the 'Resources' tab for the documentation)
http://www.patientsafetyfirst.nhs.uk

Patient Safety First – Deterioration
http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/Deterioration/

The Summary - Reducing Harm from Deterioration
http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Prevent-harm-from-deterioration.pdf

'How to' guide for Reducing Harm from Deterioration

NHS Institute web page on the SBAR communication tool
http://www.institute.nhs.uk/sbar

THE CHECKLIST: If something so simple can transform intensive care, what else can it do?
http://www.newyorker.com/reporting/2007/12/10/071210fa_fact_gawande

Links for items on PAGE 2

Clinical Audit Support Centre (UK)
http://www.clinicalauditsupport.com/index.html

ISBAR – effective and cooperative communication @ CDHB (view this presentation on the CDHB Intranet)

http://intraweb.cdhb.local/isbar-effective%20and%20cooperative%20communication%20@%20cdhb/isbar.html

NHS Institute web page on the SBAR communication tool
http://www.institute.nhs.uk/sbar

SBAR Tools - Institute for Healthcare Improvement
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/

Links for items on PAGE 3

Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers. [J Øvretveit]. London: the Health Foundation., 2009.
http://www3.chi.unsw.edu.au/pubs/1OvretHFQPQualitysavingEconQuality09.pdf

Preventing Falls and harm from falls in older people. Best practice guidelines for Australian hospitals. Canberra : Safety and Quality Council, 2009.
http://www.health.gov.au/internet/safety/publishing.nsf/Content/FallsGuidelines-AustRACF

WHO Patient Safety Curriculum Guide for Medical Schools
http://www.who.int/patientsafety/education/curriculum/download/en/index.html

ARTICLES OF INTEREST – QUALITY

March 2010

Indicate article numbers as required and return to:

Canterbury Medical Library
Christchurch Hospital
Private Bag 4710
CHRISTCHURCH

In the space below, indicate article numbers which you require from the **March 2010** Articles of Interest - Quality:

_____

☐ Please supply a copy of the article "First, do no harm" from the March 2010 issue of North & South magazine. *(Tick the box to request a copy of this article)*

Copies of these articles are all available on request, at a cost of

$3.50 + GST (i.e. $3.95) per article for current library members
$4.20 + GST (i.e. $4.75) per article for non library members

If you wish to clarify which charge will apply, please contact the library to check whether or not you are enrolled as a current library member. We will, otherwise, simply charge as noted above.

Please tick the appropriate box to indicate how you will pay*:

☐ **Account Code to Charge:** _____ (please specify)
Photocopied articles, charged to a cost code, will be sent to you in your dept via the internal mail.

☐ **Personal payment** – *This option requires payment in cash. You will be contacted when the material is available for collection, & payment, from the Loans Desk of the library***.**

CSM & HS Department ..... (please specify)

CDHB Hospital & Department ..... (please specify)

Signature:_____

* This request will not be processed if [*has not been processed because*] you have failed to supply the information required.

Requester's name: _____

Address: _____

_____

If you have any suggestions regarding topics you would like to see in future Articles of Interest - Quality please list them.

_____