Quality lines

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Adverse events between visits for patients with diabetes mellitus

Adverse events between ambulatory patient visits are increasingly the focus of study. By means of an automated telephone self-management tool, 111 patients with diabetes mellitus were monitored for adverse events between visits in the course of their home management. Of note, the study population was ethnically and linguistically diverse, and most had long-standing and poorly controlled diabetes. Among these patients, 86% had at least one event detected over a 9-month study period totalling 111 adverse events and an additional 153 potential adverse events. Medication management was implicated as the dominant adverse event and constituted 63% of events. Of note inadequate clinician-patient communication was implicated in 59%. In fully 80% of all events, a combination of system, clinician and patient factors contributed to the adverse event. The authors suggest that patient-level self-management support and patient-centred communication offer the greatest opportunities for prevention of adverse events in this setting. ***See page 223***

Patterns of nurse-physician communication regarding care plans in a US teaching hospital

Interdisciplinary communication is critically important to provide safe and effective care for hospitalized medical patients. This study, conducted in a large US urban teaching hospital, sought to assess nurse-physician communication with particular focus on the patient's plan of care. Interviews were conducted among randomly selected patients admitted to medical units, along with their nurses and physicians. The physicians ranged from interns (first year junior doctors) to qualified hospitalists. Nurses and physicians reported communicating with one another regarding their patients' daily plan of care only about half the time, which often consisted of telephone or text message communication, and they were often not in agreement on the plan of care. The authors highlight the opportunities for improvement of interprofessional communication in this teaching hospital, which include teamwork training, daily goals worksheets and interdisciplinary rounds. ***See page 195***

The outcome of restrictive transfusion threshold following knee arthroplasty

This study tracked the results of an innovative transfusion protocol designed to reduce the transfusion rate after knee arthroplasty. The protocol included a restrictive transfusion haemoglobin trigger and endorsed single or multiple units depending on the indication for transfusion. The transfusion rate halved by the end of the first year of implementation, and the reduction was maintained the following year. Importantly, the reduction in the use of blood did not compromise acute and longer-term patient outcomes. Prescription of single-units of blood and the number of successful single-unit transfusions were unchanged despite good compliance with the protocol. The authors conclude that the protocol provides a safe, simple, potent frontline strategy for decreasing transfusion rate, and they emphasize that judicious endorsement of single-units is a secondary strategy when the transfusion haemoglobin trigger is strict. ***See page 239***

Enablers and barriers in reporting adverse incidents via an electronic reporting system

The voluntary reporting of adverse events among health practitioners is important to the reduction of such events. A survey was conducted of the reporting behaviour of 2185 clinicians in New South Wales, Australia, following the introduction of a state wide electronic incident reporting system. Seven enablers and/or barriers to incident reporting were evaluated: training; system accessibility; ease of use; system security; receiving feedback on incidents reported; perceived value of the reporting system; and workplace safety culture. Users with increased reporting rates were more likely to have had favourable experiences relative to all enablers, while the enablers that were most frequently reported were system security and accessibility. The most frequently encountered barrier was a poor workplace reporting culture. Of note, the 79.3% of respondents who had reported incidents were more likely to have undertaken training, and to have rated such training highly, than were those not using the system. These findings suggest opportunities for more effective application of electronic incident reporting systems as a step toward reduction of adverse incidents. ***See page 229***

Streamlining the emergency department admissions process

Busy urban hospitals around the world struggle with dwell times for patients who remain in the Emergency or Casualty Department even after being formally admitted to hospital. This report describes the implementation of a rapid admissions protocol that reduced boarding times—defined as the time elapsed from inpatient bed request to physical departure from the Emergency Department—in a large US teaching hospital. The guiding principles used in the protocol included narrowing clinical roles, improving communication and establishing clear boundaries of authority and responsibility. The authors also identified 'time to admission orders' as an additional process measure that emergency microsystems might use when operating under significant inpatient bed constraints. ***See page 200***