Quality Lines

PATIENT SIGN-OUT COMMUNICATION FAILURES

The transfer of care for hospitalised patients routinely uses written and verbal communication (''sign-outs'' or ''hand-overs''). This study of resident trainees in a teaching hospital describes how communication failures during this process can affect patient care. Omitted content (eg medications, active problems, and pending tests) or failure prone communication processes (eg lack of face-to-face discussion) emerged as major categories of failed communication. In nearly all cases these failures led to uncertainty during patient–care decisions, which at times resulted in suboptimal care. Junior doctors preferred thorough but relevant face-to-face verbal sign-outs that reviewed anticipated issues, together with legible, accurate, updated written sign-out sheets that included standard patient content, such as code status or active and anticipated medical problems. These authors provide a taxonomy of communication failures and potential improvements, which may improve the quality and safety of patient care.
See p 401 and 394

Overestimation of clinical diagnostic performance caused by low autopsy rates

Most studies that assess how well clinicians or diagnostic tests perform in detecting a given condition estimate missed diagnoses by using subsequent clinical follow up and/or cases first detected at autopsy, ignoring the possibility of missed cases among non-autopsied deaths. Using published studies of diagnostic performance for aortic dissection, pulmonary embolism, and tuberculosis—three conditions that carry a high risk of death if the diagnosis is missed—the authors show that adjusting for missed diagnoses among non-autopsied deaths, lowers diagnostic performance significantly below the originally reported values. Many missed diagnoses may represent limitations of current technology or atypical presentations of these conditions rather than errors. Regardless of their causes, clinically significant diagnoses escape detection at a much greater rate than generally appreciated.
See p 408 and 397

Tensions in public health policy

Public and patient engagement in decisions on their own treatment—shared decision making—constitutes a major drive in current health policy. These authors argue that this may produce conflict with other health policy initiatives. They provide a critical analysis of the major initiatives of evidence-based practice, reduction of health inequalities, and public and patient engagement. They posit that policy promoting patient choice may support involvement of patients who are already more likely to engage in decision making—younger, well educated, articulate patients of higher social class—but may not improve communication with less articulate, less well educated patients, thus serving to increase inequalities by further marginalising those already suffering from relative exclusion. This clearly requires greater debate.
See p 398

Hearing the patient's voice

Healthcare systems in the UK and the USA now routinely publish survey data showing variation in patient experience of care by geographical area, hospital, and health plan. There is little evidence, however, that defines the most effective methods for using such data to improve care. The authors developed a framework for the use of such data, using qualitative interviews with senior health professionals and managers in Minnesota, USA. They defined the barriers and promoters to using survey data as organisational, professional, and data related. They argue that organisations need to develop quality improvement capacity and align professional receptiveness and leadership with technical expertise for using data. Simply providing data to organisations is unlikely to be sufficient to motivate, focus, and support the kinds of interventions that are needed to improve care.
See p 428

Staff job evaluation

Staff experiences may be an underused source of information about how hospitals actually work. These investigators analysed work experiences of 2606 nurses working on 124 hospital wards in 15 hospitals across Norway. Their results suggest that staff experiences combined with multilevel modelling may identify which problems belong to specific units and, further, what is the most relevant organisational level for implementing quality improvement. For problems identified by nurses, strategies aimed at the micro-organisational level (ward management) rather than the individual level or the macro-level (hospital top management) might prove worthwhile.
See p 438

The OutPatient Experiences Questionnaire

Patient satisfaction surveys are important components of healthcare evaluation. This study describes the development and evaluation of the OutPatient Experiences Questionnaire (OPEQ), which is used to assess healthcare quality as part of national patient surveys throughout Norway. The OPEQ was included in a national survey of over 35 000 patients attending 52 hospitals. The results strongly reinforce the perceptions that keeping to original appointment times, allowing patients to change appointments where necessary, and seeing the same clinician at follow up visits improve experiences with outpatient care.
See p 433

Qual Saf Health Care: first published as on 2 December 2005. Downloaded from http://qualitysafety.bmj.com/ on October 17, 2019 at MIT Libraries. Protected by copyright.