

Australian Patient Safety Bulletin

Newsletter of the NHMRC Centre of Research Excellence in Patient Safety

October 2006 Issue 4

Are you considering doing research but not sure where to begin or how to progress it? Concerns about what sort of study design to use; what sample size to aim for; how to best analyse the data; what funding opportunities exist; how to write up the results and who is doing similar research, are common.

With a team of epidemiologists and statisticians, the NHMRC Centre of Research Excellence in Patient Safety can assist you in optimising the likelihood of getting meaningful results to drive change. We can also provide advice on potential funding sources, and on how to write up your findings for publication.

Too often, research in the patient safety field is duplicated because people don't publish their findings or don't know that others are doing complimentary work. We are considering the introduction of a registry containing a brief description of projects being undertaken in the Australian healthcare sector. This will enable people to identify other research in progress and potential collaborators. We are seeking your views on whether you have had any experience with a scheme such as this and whether you would contribute to it if it was to be developed. Please email: Sue. Evans@med.monash.edu.au

The NHMRC Centre of Research Excellence in Patient Safety currently has six project portfolios: Improving Communication, Data Development, Education, Health Information Technology, Care Management and Medication Safety.

For further details, visit our website: <www.crepatientsafety.org.au>.

February 2007 Seminar

Our next seminar will be held on Friday, February 23rd 2007 in Brisbane. The focus of the seminar will be clinical handover. This seminar will be run in conjunction with Queensland Health and Princess Alexandra Hospital.

Please see back page of this bulletin for further details.

All comments are welcome and can be made to:
<CREPatientSafety@med.monash.edu.au>

The CRE in Patient Safety is funded by the Australian Council for Safety and Quality in Health Care and designated as a NHMRC Centre of Research Excellence. The CRE is based in the Department of Epidemiology & Preventive Medicine, Monash University, Alfred Hospital.

Collaborating institutions are Bayside Health, University of Queensland, La Trobe University, Melbourne Health, Austin Health, Southern Health, Wimmera Health Care Group, ACT Health, ANU Centre for Health Stewardship, Victorian Institute of Forensic Medicine, CSIRO, Medical Defence Association of Victoria and Peninsula Health.



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Using personal information for research: finding the balance

Kalra D, Gertz R, Singleton P, Inskip HM. Confidentiality of personal health information used for research. *BMJ* 2006; 333:196-8.

This is one of four articles published in the *BMJ* over the previous three months, canvassing the issue of the extent to which a patient's information can be used for research without their explicit consent. Souhami has written a good editorial commenting on the suite of articles.¹

In this particular article Kalra *et al* discuss ways in which a balance can be reached between respecting the privacy of research participants and obtaining good data to improve health delivery and outcomes. It builds on work undertaken by the Medical Research Council in the UK.²

Patients enrolling in studies are usually required to sign a consent form to allow researchers to use their information to answer a specific question. However, this same information could be used to answer a secondary question, for which the person has not given consent. To what extent is it ethically possible to re-use this information? And, if it is possible, how should information be governed (i.e. anonymisation) to ensure that patient's rights are respected?

The principle question that must be asked is the extent to which a person would be harmed or embarrassed if the information they disclose became identifiable to researchers. This is highly subjective, as what is sensitive to one person might not be to another. Anonymising data is the best way to avoid this from occurring; however there is no consensus in health-care as to the extent to which data needs to be removed to make it anonymous.

In the US, names, addresses, identity numbers, dates of birth and other dates and genetic profiles must be removed for a dataset to be regarded as anonymous. Anonymising data raises two problems; (1) valuable clinically rich data is lost; and (2) it makes it impossible to link datasets.

This article highlights the need for researchers to:

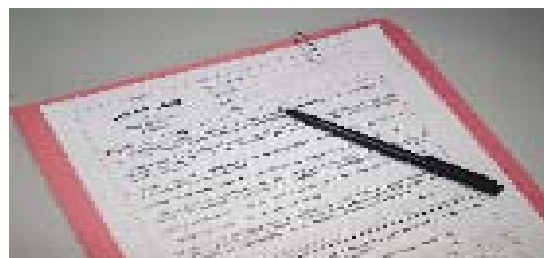
- limit people accessing raw data. Limiting access to required fields by members of the research team will minimise risk of identification of individuals;
- develop standardised techniques to anonymise clinical data sources. Masking is one such technique. It involves changing data values to make them less distinctive (eg removing postcode and making it a district);
- minimise occasions when linkage is required. Record linkage makes it more difficult to maintain anonymity and the process of linkage in itself requires that identifying information be retained.

In recognition of situations where researchers use their position as honorary staff in institutions to access data and thereby bypass provisions of legislation surrounding privacy of information, the authors suggest that confidentiality contracts should be considered.

Take-home message: The ethics of consent for use of personal patient information for secondary purposes is one faced at an international level. While the legal system differs slightly, most of the issues raised in this article are equally valid in the Australian context. The Academy of Medical Science report² will assist the UK in moving forward and will be of interest to people working in this field in Australia, where data linkage units already exist.³ A pragmatic approach to this issue is required to ensure that consumer concerns are addressed and research is not stifled.

Do patients really know what they are consenting for?

Akkad A, Jackson C, Kenyon S, Dixon-Woods M, Taub N, Habiba M. Patients' perceptions of written consent: questionnaire study. *BMJ* 2006;333:528.



In this prospective qualitative study, researchers asked 732 patients (response rate=71%) who had undergone surgery in the Obstetrics and Gynaecology department of a large UK tertiary hospital questions about the consent process. The aim of the study was to identify awareness of the legal implication of consent and the function and remit of the consent form.

Results: The mean age of respondents was 37 years. With regard to the legal status of consent:

- Most patients (88%) believed a consent form needed to be signed for surgery to be performed, with 23% of respondents uncertain as to whether an operation could go ahead if they were unable to sign the form;
- 20% were uncertain whether they could change their mind after the consent form had been signed.;
- 17% believed the surgery could be performed even if consent was refused.

In addition:

- 10% of respondents did not know what they agreed to when they signed the consent form;
- Only 41% believed the consent process made their wishes known;
- More than half felt that the doctor could perform another operation from that on the consent form if it was deemed in the patient's best interest;
- While most thought signing the form was important to them (70%), 40% said they just signed it so they could have the operation;
- Nearly half thought the consent form's main function was to cover the hospital in the event of a legal challenge.

The authors comment that, even though undertaking the consent process is required to meet legal and administrative purposes, it does not necessarily ensure that those people signing it are truly informed - the implication being that a person may consent to surgery they do not want. The authors conclude that, "Current consent procedures seem inadequate as a means for the expression of autonomous choice, and their ethical standing and credibility can be called into question."

Take home message: The fact that this cohort was much younger than the average person admitted to Australian hospitals and that participants were required to have a good grasp of the English language to participate in the interview would suggest that this is an even bigger problem than stated here.

In much the same way as we ask the mechanic to fix the car without knowing the details of what is happening, there are many people who want to be fixed without knowing what this involves.

Preventing pressure ulcers

Reddy M, Gill SS, Rochon PA. *Preventing Pressure Ulcers: A Systematic Review. JAMA 2006; 296(8): 974-984.*



Pressure ulcers are common in hospitals and long term care facilities. Known risk factors for pressure ulcers include reduced mobility, being unable to reposition and feed without assistance, history of stroke, faecal incontinence, low body weight and impaired nutritional intake, lymphopenia, and dry sacral skin.

This article reviewed 59 RCTs aimed at reducing pressure ulcers through strategies to improve mobility (n=51), nutritional intake (N=5) and skin health (n=3).

Strategies to improve mobility

Mattresses/ sheepskins: Tools to relieve pressure may either be *static* (e.g. egg-shell foam, gel, or air filled mattresses going on top of existing beds, sheepskins) or *dynamic* (e.g. beds which mechanically vary pressure beneath the patient).

When compared to normal hospital beds, static tools were consistently superior in reducing pressure ulcers. Specialised foam mattress overlays on operating tables have been shown to be effective in reducing postoperative pressure ulcers. Fourteen studies compared static and dynamic support surfaces. The best designed study of 447 patients found no difference between these two techniques.

Repositioning: It is unclear what impact the frequency of turning has on pressure ulcers. Results of studies comparing two hourly with four hourly turns were inconclusive.

Strategies to improve nutritional intake

Only one of the five studies showed that nutritional supplementation was beneficial in reducing pressure ulcers. This was also the best designed and largest study. Patients given standard diet were more likely to develop a pressure ulcer compared to those who received standard diet plus two oral supplements per day (RR 1.57, p=0.04).

Strategies to improve skin health

Each of the three studies aimed at improving skin health compared different types of preparations for the skin; none looked at a skin preparation versus no treatment. Compared to a placebo treatment, hyperoxygenated fatty acid preparation was more effective in reducing pressure ulcer incidence (7 vs 17%, p<0.06).

Take home message: There were surprisingly few good quality studies investigating strategies to prevent pressure ulcers, especially considering the cost associated with treating deep pressure ulcers where muscle and bone are exposed. This is estimated at between AU\$61,230 and AU\$100,000 per patient (Young, 1997).

Mattress overlays on operating theatres are a good idea. Overlays or specialised sheepskins are better than relying on a standard hospital mattress alone. There is also no good evidence that they are any less effective than the more expensive dynamic beds. Optimising nutritional status is important and moisturisers are unlikely to cause harm.

MET Teams - what's the evidence?

Winters BD, Pham J, Pronovost PJ. *Rapid Response Team - Walk, don't run. JAMA 2006; 296 (13): 1645-1647.*



There has been widespread introduction of rapid response teams within hospitals, largely as a result of strategies such as the 100,000 lives campaign initiated by the Institute of Healthcare Innovation (IHI). The concept is that if a person is deteriorating on the ward, a team of specialised personnel are deployed to provide early intervention. The assumption is that this will lead to better outcomes. Ten studies have evaluated the effectiveness of rapid response teams: eight observational studies and two randomised controlled trials (RCTs).

With regard to the observational studies: two of five studies showed a reduced mortality rate and three of five showed reduction in cardiac arrests when comparing rapid response teams with normal practice.

Of the two RCTs conducted, one single-institution study showed reduced mortality rate (cardiac arrest was not evaluated) however the other multi-institution study showed no significant difference for any outcomes studied, including mortality and cardiac arrest (OR=1.03 95%CI=0.79-1.13).

The equivocal evidence for introduction of rapid response teams suggests that more research is required before implementation of rapid response teams should be made mandatory, or even strongly recommended. It may be that other strategies such as enhanced training of staff to recognise deteriorating patients (a component of the rapid response team program), employment of ward educators, and having both intensivists in all ICUs and hospitalists⁴ to staff wards, are as effective and cost-effective as having rapid response teams in each hospital.

Take home message: Rapid response teams, or MET teams as we know them in Australia, are gaining popularity as a tool to reduce preventable error. The Safer Systems Saving Lives campaign, being introduced across Australia, incorporates the implementation of a rapid response team as one of its six key interventions to facilitate improvement in health outcomes (see <<http://www.health.vic.gov.au/sssl/>>).

One of the most significant issues with MET teams appears to be getting staff to follow implementation guidelines. As discussed by Grol and Buchan in the following editorial, difficulty achieving adherence to guidelines is a pervasive issue in healthcare. A second, unresolved issue is whether it is the MET team or the educational / training package that goes with it, that is important. A third issue is what form of ward cover is appropriate for after hours emergencies, if there is no MET team in place?

Clinical guidelines - getting them into practice

Grol R and Buchan H. Clinical guidelines: what can we do to increase their use? MJA 2006; 185(6): 301-2.

Clinical guidelines are expensive to produce and have often been shown to result in little widespread impact on clinical care. This editorial comments on two articles published in the MJA: one relating to evidence that diabetes is not well managed in a tertiary outpatients department⁵ and the other relating to variability in control of iron levels in patients receiving dialysis.⁶ In both cases evidence-based guidelines were in place.

The authors make the point that rather than assuming that guidelines are ineffective because they are so poorly adhered to, more effort needs to be made to:

- format guidelines in such a way that promotes their use;

- identify the best implementation strategies taking into account the complex nature of care delivery;
- identify how we can best achieve sustainable practice change.

Simply developing the guideline will not ensure that it is implemented. Many guidelines are developed by people who have no understanding of the environment in which they will be used and without appropriate consultation with clinicians. Guidelines, of course, need to be useful to clinicians.

Strategies such as incorporating clinical indicators into guidelines to enable clinicians to assess how well they are performing in relation to meeting targets would likely encourage participation. Guidelines need well developed, well executed and sustained implementation programs. Consideration needs to be given to how teams work, how people interact, the organisational culture, resources, economic and legal issues.

Take home message: To improve guideline use, we need to look beyond the development and more closely at the implementation phase. Developing them is the easiest part. The key is to ensure that they offer more to clinicians than is currently available.

Mobile phones in hospitals - what's the risk?

Derbyshire S, Burgess A. Use of mobile phones in hospitals. BMJ 2006; 333: 3337-8.

The use of mobile phones in hospitals is controversial. On one hand, there is evidence that mobile phone use can cause interference when used within one metre of medical devices (e.g. triggers alarms and causes interference when ECGs are being conducted). Another concern relates to the possibility of people using cameras installed in phones to compromise patient confidentiality.

However, on the other hand, there is no evidence that mobile phone use has resulted in serious consequences for patients. In addition, mobile phones enable clinicians to be easily contactable thereby reducing likelihood of communication delays.

Guidelines developed by the Medicines and Healthcare products Regulatory Agency (MHRA) in the UK do not support a total ban of mobile phones in hospitals. The guidelines instead suggest that phones should not be used in critical care areas, such as ICUs and special care nurseries.



Mobile phones prohibited

Handwashing - where does system failure end and personal accountability begin?



Goldmann D. *System Failure versus Personal Accountability - The Case for Clean Hands*. *N Engl J Med*. 2006 Jul 13;355(2):121-3.

This article provides a poignant perspective on hand washing and accountability. A case study is documented about a mother who watches as doctors and nurses touch her premature baby in the Neonatal Intensive Care Unit repeatedly without washing their hands. The baby contracts methicillin resistant *Staphylococcus aureus* (MRSA) septicaemia and dies.

If every caregiver reliably practiced simple hand hygiene when leaving the bedside of every patient and before touching the next patient, there would be an immediate and profound reduction in the spread of resistant bacteria. Figures estimate that between 40-50% of healthcare workers comply with hand hygiene processes. The largely preventable death, reported in this article is not uncommon and such cases bring to the fore the need for continued quality improvement programs.

The current approach to reducing medical error focuses largely on identifying the systems issues which led to the error, such as inadequate staffing levels, lack of education, inadequate access to solutions and issues surrounding blame and culpability.

However, the author argues that while taking a systems approach is important, it is equally crucial to hold healthcare workers accountable for their practices.

If a hospital has a good hand hygiene system in place and monitors it regularly, then neglecting to wash one's hands should constitute a violation, not a system failure. Repeated violations in health care, as in any industry, should have consequences. If an employee working in a computer chip factory failed to follow protocol in maintaining a sterile environment, then it would be reasonable to initiate disciplinary action. Why does healthcare continue to take a more tolerant stance when lives are at stake?

Take home message: Hand washing reduces spread of infection and saves lives. Yet, it is only practiced appropriately less than half the time. The perspective of Goldman is that we should stop blaming the system and hold people who breach protocol responsible for their actions.

Strategies to improve the accuracy of indicators which aim to measure patient safety

Pronovost PJ, Miller MR, Wachter RM. *Tracking Progress in Patient Safety: An Elusive Target*. *JAMA* 2006 Aug 9; 296(6):696-699.

Inherent biases involved in both the identification and reporting of medical errors result in measures of patient safety that are often inappropriately presented as valid rates. This US-based work, piloted in nearly 200 ICUs, identifies a number of issues which hospitals need to tackle in order to ensure that more accurate indicators of patient safety reach the public domain. Issues include the need for:

- dedicated resources for standardised surveillance systems;
- future research into evidence-based interventions;
- research into if and how to more explicitly link process changes to safety outcomes;
- the use of error/incident data to be limited to the identification of wider system defects;
- the identification and selection of alternative indicators to incidents (i.e. appropriate use of policy); and,
- the use of validated safety culture tools (e.g. the Safety Attitudes Questionnaire) to assist in a more holistic safety assessment.

Set against these issues are a number of obvious barriers to implementation, which include limited resource to invest in technology (including robust IT systems) and in establishing the expertise needed to develop new measures and improve data collection / reporting.

Take Home Message: Safety in healthcare, as opposed to its quality counterpart, is notoriously difficult to measure. The irregular nature of errors and the reliance on self-report of such errors are among a number of factors that makes patient safety more ambiguous to accurately track. Consequently, error 'rates' associated with patient care should be approached with caution and improvement actions taken.

Moreover, there is no guarantee, even if given the necessary resources, that the steps put forward in this article will make a difference. The jury is still out over whether the IOM has fully grasped the challenge of measuring safety in healthcare. This research seeks to help tackle the problem but has no real answers.

Should ‘responsible’ patients get better healthcare?

Steinbrook R. *Imposing Personal Responsibility for Health. NEJM 2006 Aug 24; 355(8): 753-756.*

The first of two commentaries in the New England Medical Journal on this subject defines ‘personal responsibility for health’ as the principle that if we follow a healthy lifestyle and adhere to professional advice we will reap both physical and financial benefits. On the healthcare side, it is postulated that care processes can be both streamlined and better coordinated, with benefits tailored to specific groups. The West Virginia Medicaid program is cited as an example of the concept put into practice. To remain in the ‘enhanced’ plan, members must follow four responsibilities.

They must:

- keep their medical appointments;
- receive screenings;
- take their medications; and,
- follow health improvement plans.

Although intuitively this seems constructive, there are currently no metrics (or comparative schemes) to test whether health is improved or if money can be saved. The question of unintended consequences - the worst of which being patients being deemed illegible for justifiable non-adherence – also remain unexplored.

There are many varied, and valid, reasons why patients may not meet these expectations (i.e. poor physician-patient communication and medication side effects). The authors propose that such plans should be rigorously evaluated in a controlled trial, crucially conducted by an independent group prior to implementation.

Spotlight on the West Virginia Medicaid Plan

Bishop G, Brodkey AC. *Personal Responsibility and Physician Responsibility – West Virginia’s Medicaid Plan. NEJM 2006 Aug 24; 355(8): 756-758.*

This second article investigates the specifics of the West Virginia Medicaid Plan, using a test case to illustrate the problems inherent in managing such a “catch all” plan.

The fictional 53 year old patient with diabetes and obesity, would quickly become illegible for the West Virginia Medicaid Plan because of low income (no bus fare for an appointment), poor education (she doesn’t understand educational material) and other psychosocial factors (she is too paranoid to continue her prescribed weight loss class).

Bishop is clearly at odds with the idea that benefits should be reduced or eliminated in such cases and, further, that these kinds of issues will be widespread and may lead to discrimination. He believes it is purely an economic exercise to control Medicaid costs and urges physicians to get involved in the debate on behalf of their patients’ welfare.

Take Home Message: There remains a lack of evidence that healthcare incentive schemes actually improve health-related behaviour and, in turn, patient outcomes. Moreover, such schemes do not yet have specified standards for determining successful adherence to the criteria giving patients the right to enhanced care.

Thus, what constitutes a ‘responsible patient’ remains undetermined. It would seem that much more research is necessary to ensure that the most vulnerable parts of our community (i.e. those with mental health difficulties) are not excluded from much needed treatment because of their inability to both understand and comply with pre-defined and inflexible indicators. The promotion of healthful behaviours is a noble aim but not when it is dependent on adherence to “one size fits all” rules and may be at the expense of equitable care.

Implementing bar code technology in pharmacy



Poon EG, Cina JL, Churchill W, et al. *Medication Dispensing Errors and Potential Adverse Drug Events before and after Implementing Bar Code Technology in the Pharmacy. Ann Intern Med 2006; 145: 426-434.*

The ease of use and high degree of reliability that bar code technology has provided other high-risk industries has made its potential application to the problem of errors in the dispensing and administration of medicines, within healthcare, very attractive. Indeed, this before and after observational study, evaluating the effect of a recent installation of a storage and retrieval system that used bar codes to label medication in a large (735-bed) hospital pharmacy, showed an 85% decrease in dispensing errors and a 60% in potential adverse drug events. These results compare favourably with the implementation of other healthcare information technologies, such as computerised physician order entry. However, the present study also demonstrated that the efficacy of such healthcare information technologies relies heavily on its configuration.

It was found that bar code technology only made a positive effect on patient safety in the pharmacy when the system required scanning of all dispensed doses (e.g. in the two day and carousel fill conditions). When it did not require scanning of all doses (i.e. in the alternate zone fill) the rate of dispensing errors was actually seen to increase from the pre-barcode period. Although these results may not be generalisable to other settings, particularly in light of the idiosyncratic nature of such healthcare information technology configurations, they speak powerfully to the need to evaluate bar coding and other similar technologies in the real-world context so that changes to workflow and attendant human factors considerations can be incorporated for the benefit of patient safety.

Take Home Message: In this hospital pharmacy example, the introduction of bar code technology was only part of an entirely re-designed medication storage and dispensing system. It appears that to consistently reduce the incidence of error and harm when introducing new health information technology the wider implications (e.g. changes to workflow) and unintended consequences (e.g. importing new errors) need to be carefully considered. In situ human factors analyses, which examine risk both pre and post healthcare innovation technology implementation, may be a useful way to control inadvertent safety impacts.

Reducing ICU adverse events through culture change

Jain M, Miller L, Belt D, et al. *Decline in ICU Adverse Events, Nosocomial Infections and Cost through a Quality Improvement Initiative focusing on Teamwork and Culture Change. Qual Saf Health Care 2006; 15: 235-239.*



As part of the Institute of Healthcare Improvement's (IHI) "IMPACT" initiative for quality improvement, this study sought to improve patient safety by promoting a culture of teamwork and healing in its 28-bed ICU.

The key indicators measured for improvement were:

- nosocomial urinary tract infection rate;
- ventilator associated pneumonia;
- blood stream infection rate;
- adverse events per ICU day;
- average length of stay; and,
- average cost per ICU episode

The key strategies for change instigated were:

- physician-led multidisciplinary rounds (setting daily goals using "trigger tools");
- daily bed flow meetings (twice daily consultations to assess patient status and intervention priority)
- "bundles" (i.e. sets of evidence-based practices designed to optimise treatment);
- culture change efforts (supporting participatory management of decisions in the unit).

A significant improvement in selected indicators and a reduction in the cost and length of stay coincident resulted, although no decline in the mortality rate was found even with a dramatic decrease in ventilator associated pneumonia.

The authors suggest that this was probably due to a problem with the way that mortality was defined, alongside case mix considerations. Based on the run charts, it seems the most important intervention was the multidisciplinary rounds (although this could be due to the Hawthorne effect).

However, distinguishing between the impact/s and relative importance of changes is in fact, impossible. Moreover, it is unknown how and whether these ICU improvements can be sustained and, therefore, if they can ever be shown to reduce mortality.

Take Home Message: Endeavouring to promote patient safety by tackling culture within healthcare organisations is an important aim. However, it relies on objective measures of change and the genuine and sustained commitment of front-line staff in adapting their practice. Strong leadership is also essential in terms of providing incentives, support and resources to such staff. Attempts to control confounding variables are also crucial. It remains to be seen whether ICU mortality can be significantly reduced from these types of initiatives that hope to change unit culture.

A systematic review of physician self assessment

Davis D, Maazmanian PE, Fordis M. *Accuracy of Physician Self-Assessment Compared With Observed Measures of Competence: A Systematic Review. JAMA 2006 Sep 6; 296(9): 1094-1102.*

An electronic database search yielded 725 articles from which the authors sought to determine how accurately physicians self assess compared with external observations of their competence.

Studies were included if they:

- compared physician's self-rated assessments with external observations;
- used quantifiable and replicable measures;
- included a study population of at least 50% practicing physicians or similar health professionals; and,
- were conducted in the UK, NZ, USA or Canada.

Consequently, 17 studies met all inclusion criteria, three of which used two external comparisons each resulting in 20 comparisons between self- and external reports.

These 20 comparisons were divided into three constructs of self-assessment:

- *Predictive* self-assessment, which is the ability of the physician to predict his/her performance on a future competency-based assessment;
- *Summative* and *retrospective* self-assessment, which is the ability of the physician to rate or provide a mental representation of his / her performance of a recently completed simulation exercise; and,
- *Concurrent* self-assessment, which is the ability of the physician to reflect on performance, knowledge and skills of familiar situations in order to self-identify current learning needs. The included studies compared such physician self-ratings with stable external objective measures such as objective structured clinical examinations (OSCEs), standardised patients, simulations, performance on in-training or other examinations, chart audit, or the ability to explain concepts of evidence-based medicine to a blinded interviewer.

Of the 20 comparisons between self-and external assessment, 13 demonstrated little, or no, or an inverse relationship between self-assessment measures and other indicators.

The authors conclude that physicians do not appear to accurately self assess and that new initiatives and formats need to be developed. Although there are a relatively small number of studies in this review, which revealed considerable methodological and conceptual variability, they nonetheless confirmed evidence of physicians' limited ability to independently assess their performance.

Take Home Message: Further research into the structure and practice of self-directed learning is required, which may include simulation and other promising approaches such as appraisal of perceived self-efficacy or examining the role that age and experience might play in the process.

Ultimately, it appears that a focus on externally determined self-assessments to guide the physician in the use of educational and other activities designed to improve performance could be the best way to alleviate current discrepancies in physician self-assessment and assist in appropriate skill development.

Upcoming Seminar: Clinical Handover Friday 23rd February 2007

The focus of the next Centre of Research Excellence in Patient Safety seminar will be *Clinical Handover*. The seminar will be held in Brisbane and will be run in conjunction with Queensland Health and Princess Alexandra Hospital.

More details and a finalised seminar program will be available on our website in the upcoming weeks.

Venue

Royal Brisbane and Women's Hospital, Cnr Butterfield St and Bowen Bridge Rd, Herston, Queensland 4029
To express interest in attending the seminar, please register on the website: www.crepatientsafety.org.au.

What's in the News?

HealthInsite: This Australian Government initiative, funded by the Department of Health and Ageing contains loads of interesting articles. The aim of Health Insite is to improve the health of Australians by providing easy access to quality information about human health. It can be accessed via <http://www.healthinsite.gov.au>. It is well worth a look and a bookmark.

Victorian Institute of Forensic Medicine: Every three months the VIFM releases a publication outlining selected cases that have been reported to the State Coroner's Office and are of interest to healthcare workers. They can be viewed via: <http://www.vifm.org/communiqué.html>. The most recent Coronal Communiqué discusses cases relating to overriding a patient's wishes, nasogastric tube misplacement and a tragic case of morphine intoxication. You can subscribe and get it emailed to you when it is released, free of charge.

Patient Safety: A comparative analysis of eight Inquiries in six countries: The Clinical Excellence Commission released this informative report last month. It provides an overview of the Australian Inquiries (King Edward Memorial Hospital, Royal Melbourne Hospital, Cambelltown-Camden Hospitals) and those from England (Bristol Royal Infirmary), Glasgow (Victoria Infirmary), Slovenia (Celje Hospital), New Zealand (Southern DHB) and Canada (Winnipeg Health Sciences Centre). The report summarises key recommendations and findings, including commonalities and differences. It can be accessed via: <http://www.cec.health.nsw.gov.au/pubsnews.htm>

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