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ORIGINAL ARTICLES

Patient and Family Engagement

495  Patient and Family Complaints in Cancer Care: What Can We Learn From the Tip of the Iceberg?
K.A. Fisher, K.M. Mazor
A systematic approach to analyzing complaints to identify processes in need of improvement, the authors state, "is an important contribution to the science of using patient complaints to make health care more patient centered."

498  Evaluation of Patient and Family Outpatient Complaints as a Strategy to Prioritize Efforts to Improve Cancer Care Delivery
Two years’ data on outpatient complaints at a large academic cancer center suggest that patients and their family members prioritize high-quality relationships and communication. These findings differ from prior work in other settings, where quality and safety concerns are more prominent. This suggests that longitudinal care for life-threatening illness engenders special priorities for relational care.

Diagnostic Errors

508  Missed Diagnosis of Cardiovascular Disease in Outpatient General Medicine: Insights from Malpractice Claims Data
G.R. Quinn, D. Ranum, E. Song, M. Linets, C. Keohane, H. Riah, P. Greenberg
A retrospective analysis was conducted of 3,407 closed malpractice claims (3,073 non-cardiovascular disease [CVD] cases and 334 CVD cases). The CVD cases occurred predominately in patients with typical risk factors of cardiac disease rather than in low-risk patients, suggesting that these patients may be high-yield targets for preventing diagnostic errors in the ambulatory setting.

Timeliness and Efficiency

517  Clinician Perspectives on the Management of Abnormal Subcritical Tests in an Urban Academic Safety-Net Health Care System
C. Clarity, U. Sarkar, J. Lee, M.A. Handley, L.E. Goldman
Safety-net health systems with limited resources and socially complex patients are vulnerable to safety gaps resulting from delayed management. In focus groups, clinicians cited the challenges of tests pending at discharge and tests requiring delayed follow-up. Proposed solutions involved protocols to aid in assigning responsibility, reliable paths of communication, and systems to track the status of tests.

Care Processes

524  Optimizing an Enhanced Recovery Pathway Program: Development of a Postimplementation Audit Strategy
M.C. Grant, D.J. Galante, D.B. Hobson, A. Lavezza, M. Friedman, C.L. Wu, E.C. Wick
Enhanced recovery pathways (ERPs) are bundled best-practice process measures associated with reduction of preventable harm, decreased length of stay, and increased overall value of care. An auditing strategy, which was developed to assess compliance with 18 ERP process measures and establish a system for identifying and addressing defects in measure implementation, provided a comprehensive process for ongoing improvement of an ERP for colorectal surgery.

Methods, Tools, and Strategies

534  Psychometric Evaluation of the Hospital Culture of Transitions Survey
M. McClelland, J. Bena, N.M. Albert, J.M. Pines
Ineffective or inefficient transitions threaten patient safety, hinder communication, and worsen patient outcomes. Findings suggest that the Hospital Culture of Transitions survey, which was designed to assess a hospital’s organizational culture related to within-hospital transitions in care involving patient movement, is psychometrically sound and practical.

COMMENTARY

540  Toward More Proactive Approaches to Safety in the Electronic Health Record Era
D.F. Sittig, H. Singh
This article summarizes how quality and safety leaders can use the recently revised SAFER (Safety Assurance Factors for EHR Resilience) Guides, published by the Office of the National Coordinator for Health Information Technology, to help their health care organizations conduct proactive risk assessments to assess whether they are using health information technology (HIT) safely and to optimize use of HIT to monitor and improve patient safety.

RESEARCH LETTER

548  Quality of Septic Shock Care in the Emergency Department: Perceptions Versus Reality
When clinician perceptions of septic shock care performance were examined at two urban emergency departments in comparison to actual performance on eight sepsis care quality metrics, all clinical disciplines overestimated the quality of septic shock care quality.

550  INFORMATION FOR AUTHORS