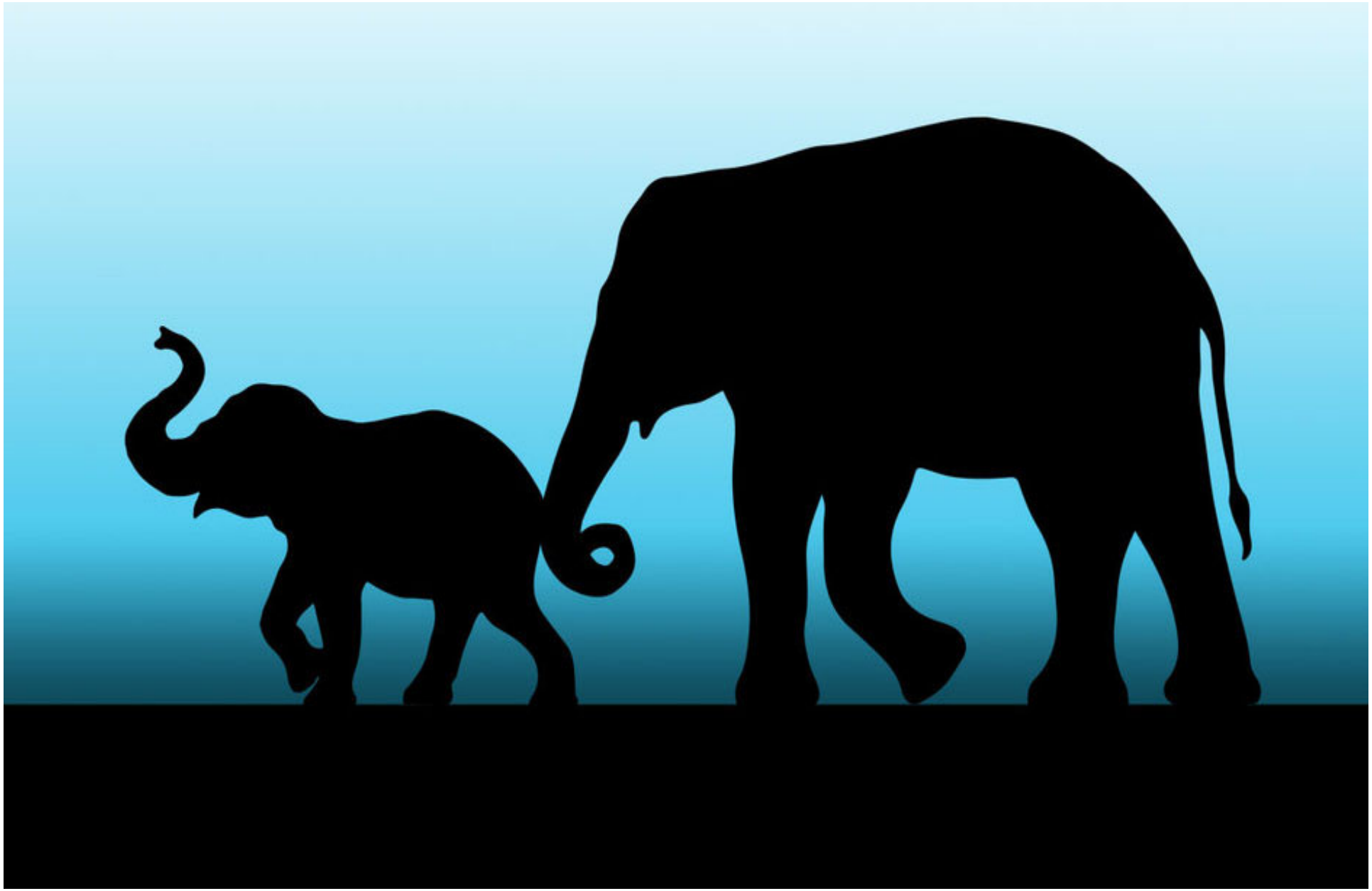
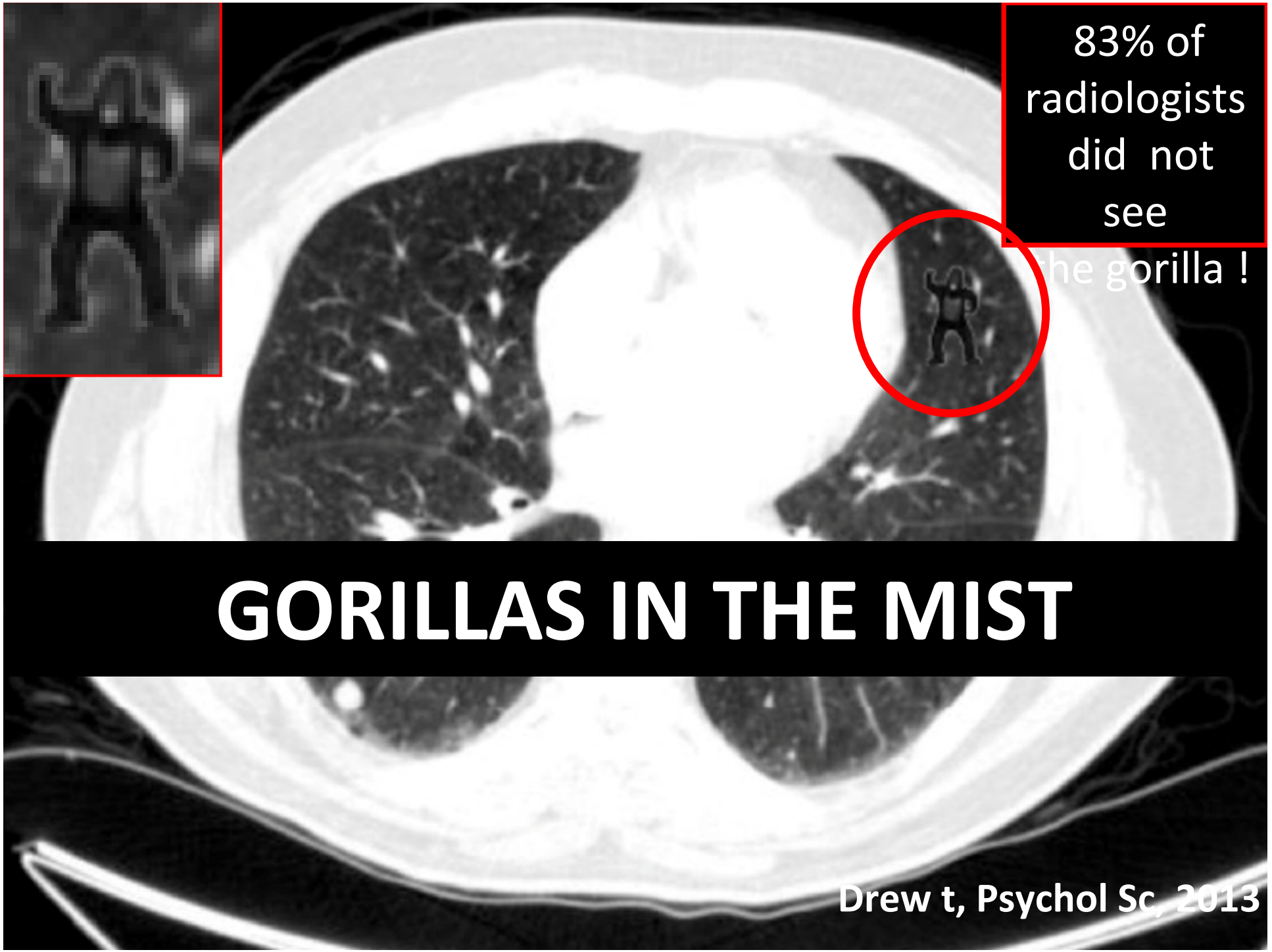
Dalle check-list alle spinte gentili

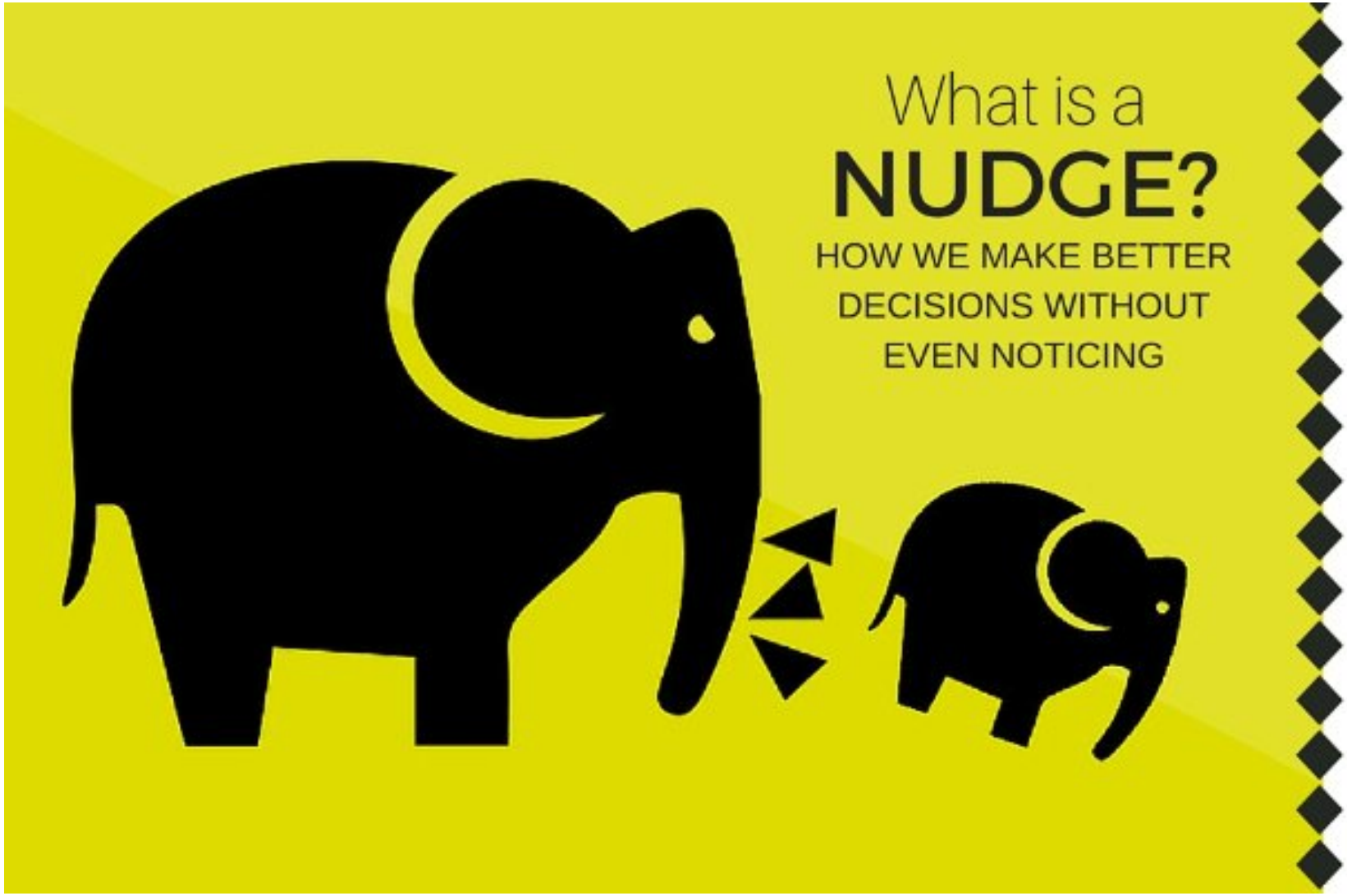


PHILOSOPHER

PHYSICIAN

LIKELY AND UNLIKELY


83% of radiologists did not see
the gorilla !
GORILLAS IN THE MIST
Drew t, Psychol Sc, 2013


What is a
NUDGE?
HOW WE MAKE BETTER
DECISIONS WITHOUT
EVEN NOTICING


DF

APPROVED B-17F and G CHECKLIST

REVISED 3-1-44

PILOT'S DUTIES IN RED

COPILOT'S DUTIES IN BLACK

BEFORE STARTING

1. Pilot's Preflight—COMPLETE
2. Form 1A—CHECKED
3. Controls and Seats—CHECKED
4. Fuel Transfer Valves & Switch—OFF
5. Intercoolers—Cold
6. Gyros—UNCAGED
7. Fuel Shut-off Switches—OPEN
8. Gear Switch—NEUTRAL
9. Cowl Flaps—Open Right—OPEN LEFT—Locked
10. Turbos—OFF
11. Idle cut-off—CHECKED
12. Throttles—CLOSED
13. High RPM—CHECKED
14. Autopilot—OFF
15. De-icers and Anti-icers, Wing and Prop—OFF
16. Cabin Heat—OFF
17. Generators—OFF

STARTING ENGINES

1. Fire Guard and Call Clear—LEFT Right
2. Master Switch—ON
3. Battery switches and inverters—ON & CHECKED
4. Parking Brakes—Hydraulic Check—On-CHECKED
5. Booster Pumps—Pressure—ON & CHECKED
6. Carburetor Filters—Open
7. Fuel Quantity—Gallons per tank
8. Start Engines: both magnetos on after one revolution
9. Flight Indicator & Vacuum Pressures CHECKED
10. Radio—On
11. Check Instruments—CHECKED
12. Crew Report
13. Radio Call & Altimeter—SET

ENGINE RUN-UP

1. Brakes—Locked
2. Trim Tabs—SET
3. Exercise Turbos and Props
4. Check Generators—CHECKED & OFF
5. Run up Engines

BEFORE TAKEOFF

1. Tailwheel—Locked
2. Gyro—Set
3. Generators—ON

AFTER TAKEOFF

1. Wheel—PILOT'S SIGNAL
2. Power Reduction
3. Cowl Flaps
4. Wheel Check—OK right—OK LEFT

BEFORE LANDING

1. Radio Call, Altimeter—SET
2. Crew Positions—OK
3. Autopilot—OFF
4. Booster Pumps—On
5. Mixture Controls—AUTO-RICH
6. Intercooler—Set
7. Carburetor Filters—Open
8. Wing De-icers—Off
9. Landing Gear
   a. Visual—Down Right—DOWN LEFT Tailwheel Down, Antenna in, Ball Turret Checked
   b. Light—OK
   c. Switch Off—Neutral
10. Hydraulic Pressure—OK Valve closed
11. RPM 2100—Set
12. Turbos—Set
13. Flaps ⅓—⅓ Down

FINAL APPROACH

14. Flaps—PILOT'S SIGNAL
15. RPM 2200—PILOT'S SIGNAL


MS
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L
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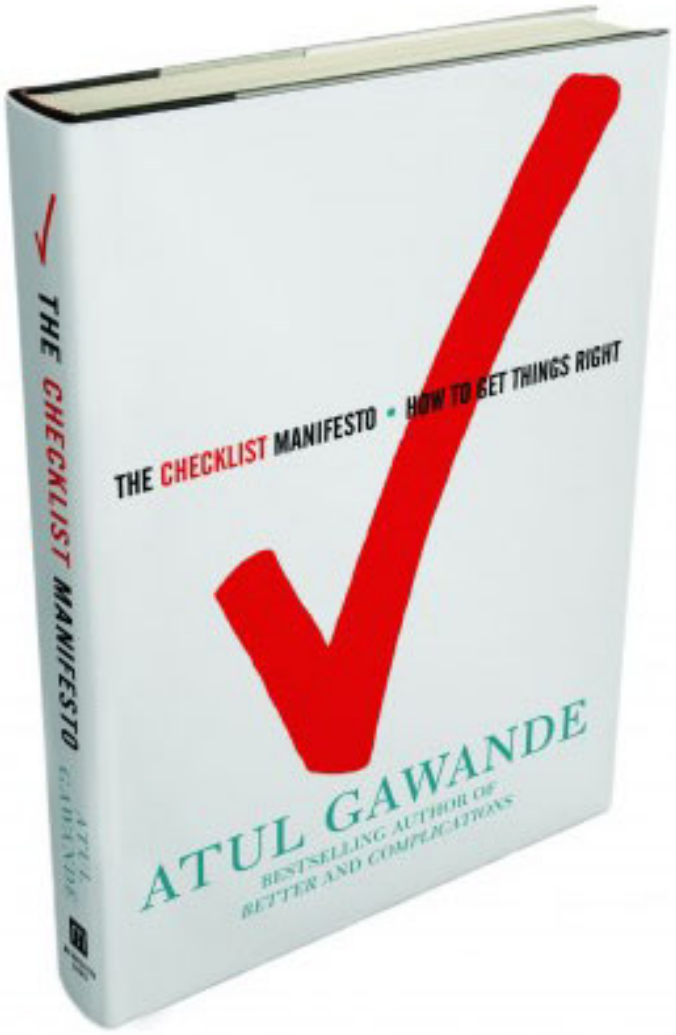
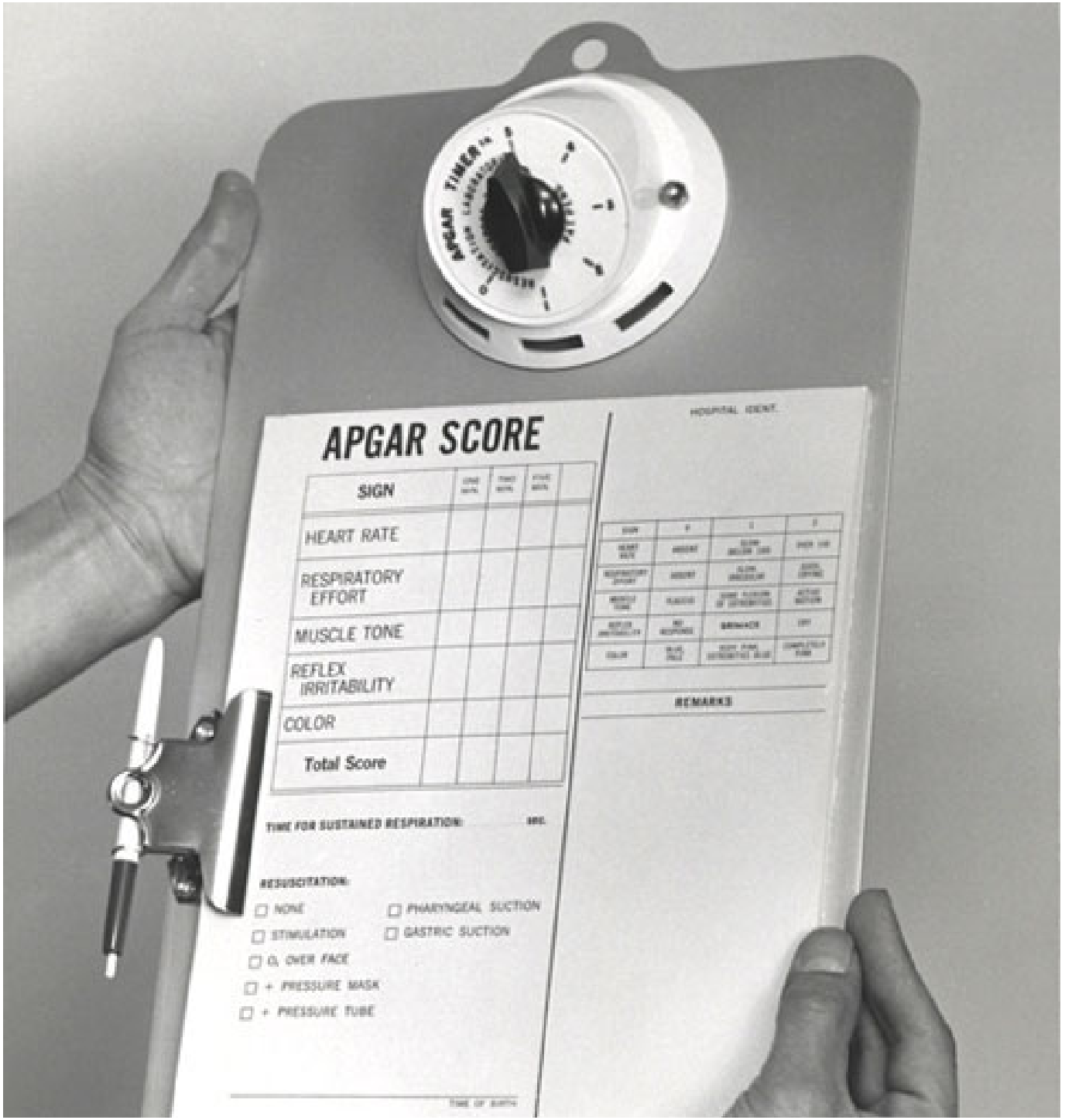
M
VL


BRIGHAM
AND
WOMEN'S
HOSPITAL


THE CHECKLIST MANIFESTO
HOW TO GET THINGS RIGHT
ATUL GAWANDE
BESTSELLING AUTHOR OF
BETTER AND COMPLICATIONS


APGAR TIMER
APGAR SCORE
SIGN
HEART RATE
RESPIRATORY EFFORT
MUSCLE TONE
REFLEX IRRITABILITY
COLOR
Total Score
HOSPITAL IDENT.
REMARKS
TIME FOR SUSTAINED RESPIRATION:
sec.
RESUSCITATION:
NONE
STIMULATION
O2 OVER FACE
+ PRESSURE MASK
+ PRESSURE TUBE
PHARYNGEAL SUCTION
GASTRIC SUCTION
TIME OF BIRTH


TIME-OUT!
Regions Hospital

Surgical Safety Checklist

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

Before induction of anaesthesia

(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision

(with nurse, anaesthetist and surgeon)

- ☐ **Confirm all team members have introduced themselves by name and role.**
- ☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient?

50 % REDUCTION IN MORTALITY RATE !

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Haynes NEJM 2009

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 28, 2006 VOL. 355 NO. 26

An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

Peter Pronovost, M.D., Ph.D., Dale Needham, M.D., Ph.D., Sean Berenholtz, M.D., David Sinopoli, M.P.H., M.B.A., Haitao Chu, M.D., Ph.D., Sara Cosgrove, M.D., Bryan Sexton, Ph.D., Robert Hyzy, M.D., Robert Welsh, M.D., Gary Roth, M.D., Joseph Bander, M.D., John Kepros, M.D., and Christine Goeschel, R.N., M.P.A.

66 % REDUCTION IN CATHETER-RELATED INFECTIONS !

1. **Wash hands** with soap and water or an alcohol cleanser
2. **Wear sterile clothing**—a mask, gloves, and hair covering—and cover patient with a sterile drape, except for a very small hole where the line goes in
3. **Clean patient's skin** with chlorhexidine (a type of soap) when the line is put in
4. **Avoid veins in arm and leg,** which are more likely to get infected than veins in chest
5. **Check the line for infection** each day and remove when no longer needed

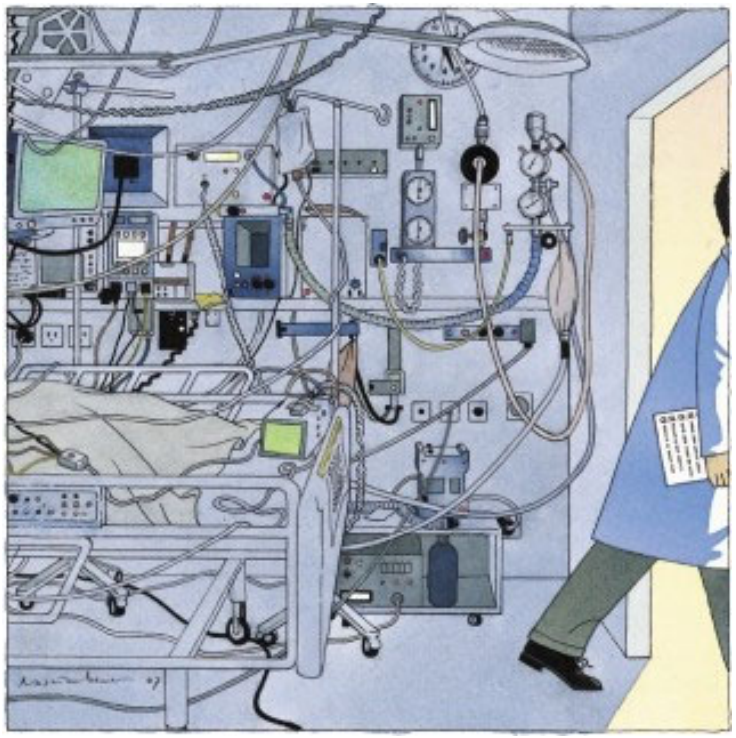
Source: Dr. Peter Pronovost

Provonost NEJM 2006


DOUBLE ISSUE
MAY 12, 2008
TIME
The Time
100
The Most Influential People in The World
www.time.com


TIME
TIME
TIME

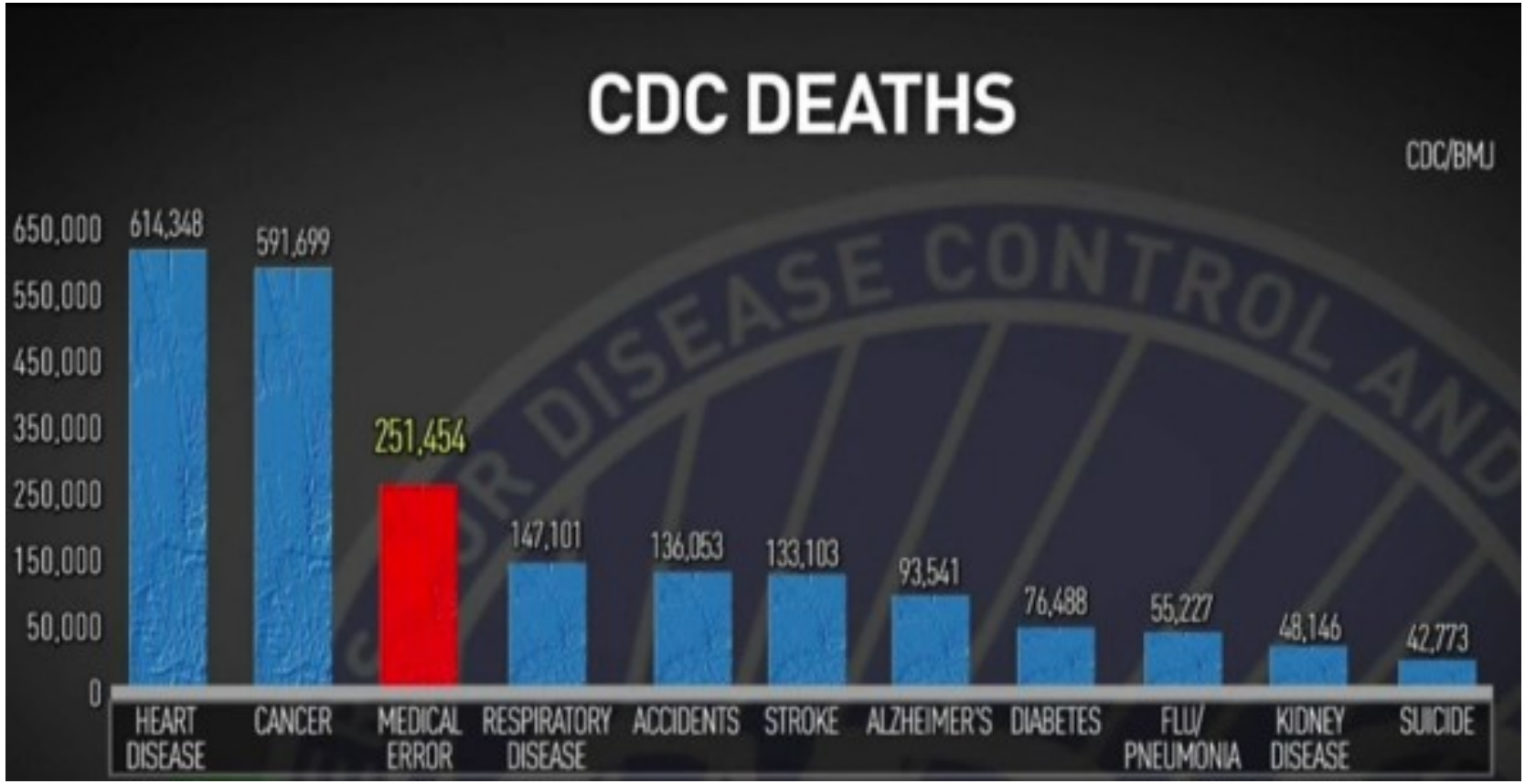
THE NEW YORKER



ANNALS OF MEDICINE DECEMBER 10, 2007 ISSUE

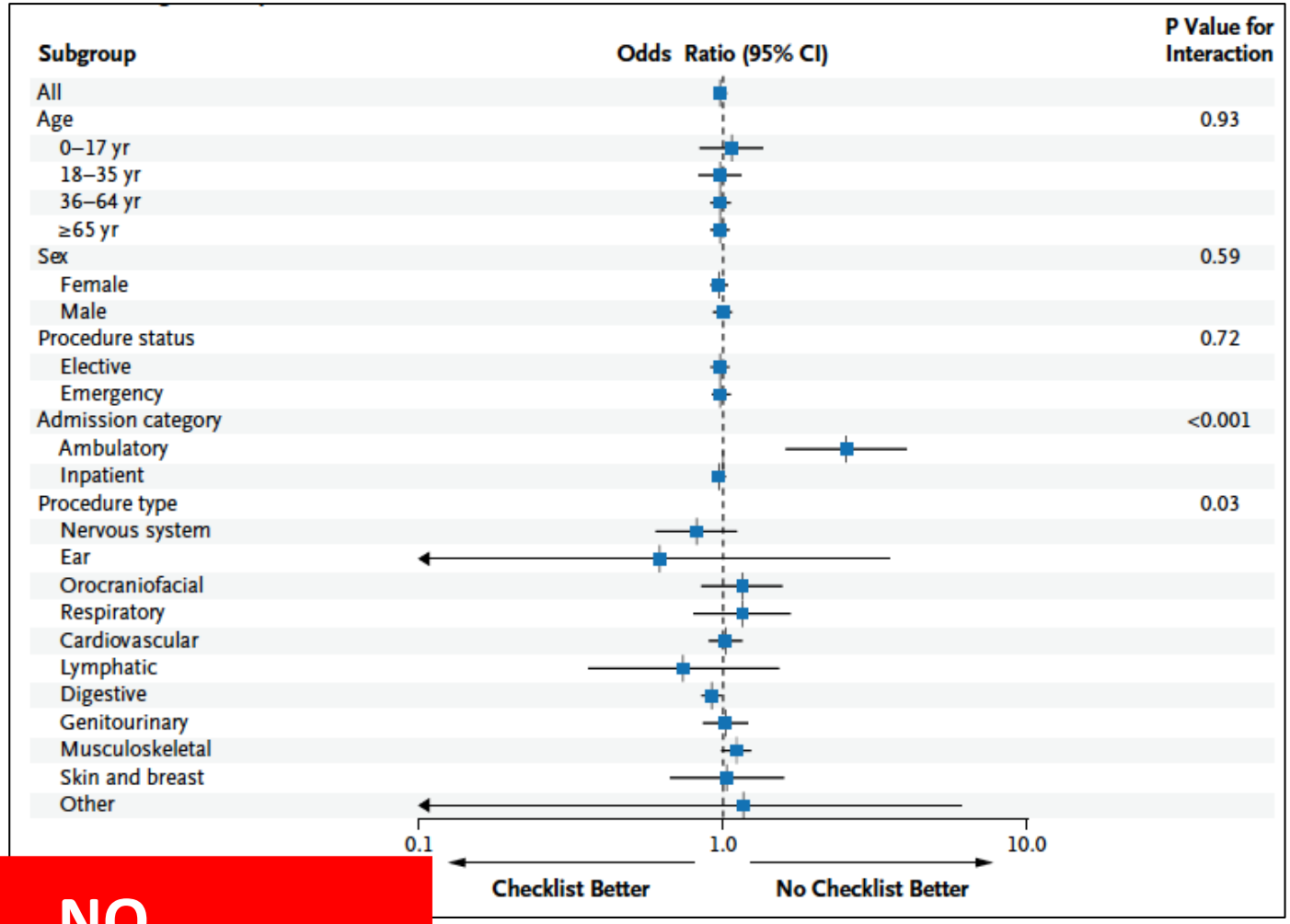
THE CHECKLIST

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


CDC DEATHS
CDC/BMJ
650,000
550,000
450,000
350,000
250,000
150,000
50,000
0
614,348
591,699
251,454
147,101
136,053
133,103
93,541
76,488
55,227
48,146
42,773
HEART DISEASE
CANCER
MEDICAL ERROR
RESPIRATORY DISEASE
ACCIDENTS
STROKE
ALZHEIMER'S
DIABETES
FLU/ PNEUMONIA
KIDNEY DISEASE
SUICIDE

The problem with checklists, lost in translation

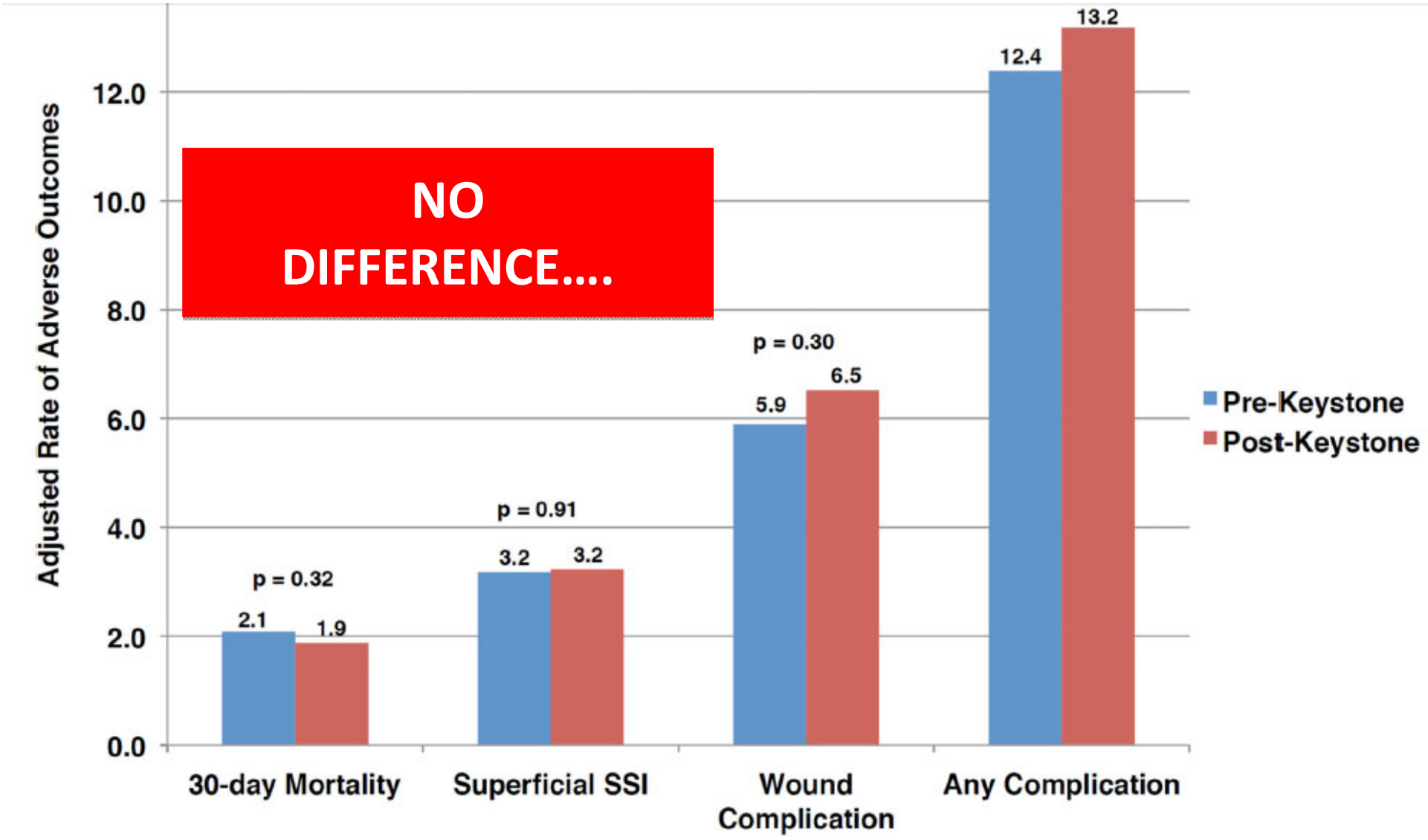
Introduction of Surgical Safety Checklists in Ontario, Canada



NO DIFFERENCE….

Urbacht NEJM 2010

A Checklist-based Intervention to Improve Surgical Outcomes in Michigan: Evaluation of the Keystone Surgery Program



Reames JAMA Surg 2015

The trouble with CHECKLISTS

An easy method that promised to save lives in hospitals worldwide may not be so simple after all.

Anthes Nature 2015

From clinical trials .....

….. to real life

“There is no question that the right checklist, in the right place, with the right design and implementation, can be used enthusiastically by the right people with the right skills and can be highly effective”

ANNALS OF MEDICINE DECEMBER 10, 2007 ISSUE

THE CHECKLIST

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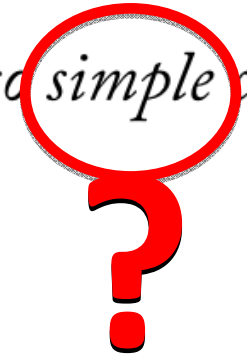

pit crew vs cawboys

Come spingere gli individui verso comportamenti virtuosi ?

Briefing Room

- Your Weekly Address
- Speeches & Remarks
- Press Briefings
- Statements & Releases
- White House Schedule
- Presidential Actions
  - Executive Orders
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  - Proclamations
- Legislation
- Nominations & Appointments
- Disclosures

The White House
Office of the Press Secretary

For Immediate Release September 15, 2015

Executive Order -- Using Behavioral Science Insights to Better Serve the American People

EXECUTIVE ORDER

- - - - - - -

USING BEHAVIORAL SCIENCE INSIGHTS TO

BETTER SERVE THE AMERICAN PEOPLE

A growing body of evidence demonstrates that behavioral science insights -- research findings from fields such as behavioral economics and psychology about how people make decisions and act on them -- can be used to design government policies to better serve the American people.

Where Federal policies have been designed to reflect behavioral science insights, they have substantially improved outcomes for the individuals, families, communities, and businesses those policies serve. For example, automatic enrollment and automatic escalation

THE BEHAVIOURAL INSIGHTS TEAM

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Who we are

Penn Medicine Nudge Unit

Open Access Research

BMJ Open

Increasing compliance with low tidal volume ventilation in the ICU with two nudge-based interventions: evaluation through intervention time-series analyses

Christopher P Bourdeaux,[1] Matthew JC Thomas,[1] Timothy H Gould,[1] Gaurav Malhotra,[2] Andreas Jarvstad,[2] Timothy Jones,[3] Iain D Gilchrist[2]

The JAMA Network

JAMA Pediatrics | JAMA Network | Enter Search Term

This Issue | Views 1,639 | Citations 0 | Altmetric 105

Editorial

May 2015

More

Nudging Students Toward Healthier Food Choices—Applying Insights From Behavioral Economics

Mitesh S. Patel, MD, MBA, MS[1,2,3,4]; Kevin G. Volpp, MD, PhD[1,2,3,4,5]

Author Affiliations

JAMA Pediatr. 2015;169(5):425-426. doi:10.1001/jamapediatrics.2015.0217

The JAMA Network

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Original Investigation

FREE

February 9, 2016

Effect of Behavioral Interventions on Inappropriate Antibiotic Prescribing Among Primary Care Practices

A Randomized Clinical Trial

Daniella Meeker, PhD[1,2]; Jeffrey A. Linder, MD, MPH[3,4]; Craig R. Fox, PhD[5,6]; et al

Author Affiliations | Article Information

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[2]RAND Corporation, Santa Monica, California

[3]Division of General Internal Medicine and Primary Care, Brigham and Women's Hospital, Boston, Massachusetts

[4]Harvard Medical School, Boston, Massachusetts

[5]Anderson School of Management, University of California, Los Angeles

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DEBATE | OPEN ACCESS | OPEN PEER REVIEW

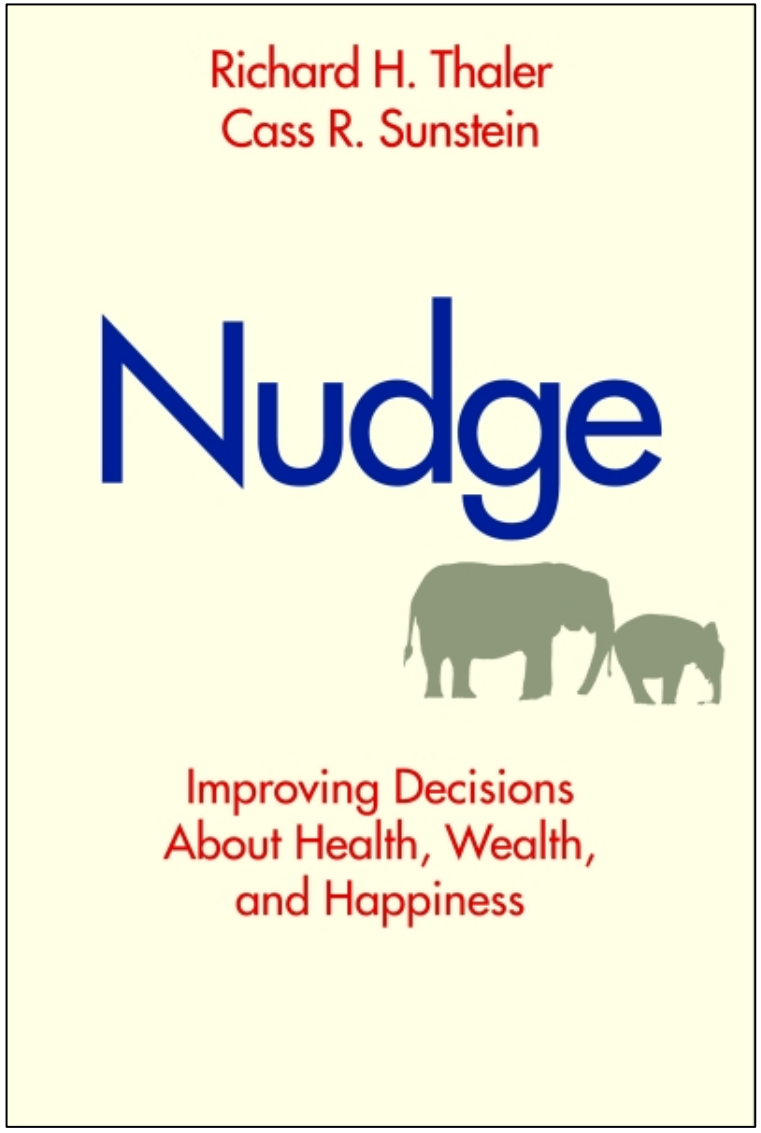
"Nudge" in the clinical consultation – an acceptable form of medical paternalism?

Ajay Aggarwal, Joanna Davies and Richard Sullivan

BMC Medical Ethics 2014 15:31 | DOI: 10.1186/1472-6939-15-31

Received: 28 May 2013 | Accepted: 11 April 2014 | Published: 17 April 2014

Open Peer Review reports


Richard H. Thaler
Cass R. Sunstein
Nudge
Improving Decisions
About Health, Wealth,
and Happiness


RICHARD H. THALER
CASS R. SUNSTEIN
Nudge
Serie Bianca Feltrinelli
LA SPINTA
GENTILE
La nuova strategia per migliorare
le nostre decisioni su denaro, salute, felicità

«Ci sono tanti bei libri sulla razionalità
e l'irrazionalità umana, ma soltanto uno è un capolavoro.
Questo capolavoro si chiama *PENSIERI LENTI E VELOCI*,
di Daniel Kahneman.»
FINANCIAL TIMES

PENSIERI LENTI E *VELOCI*

DANIEL
KAHNEMAN

— PREMIO NOBEL PER L'ECONOMIA —

MONDADORI


ABC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ABC


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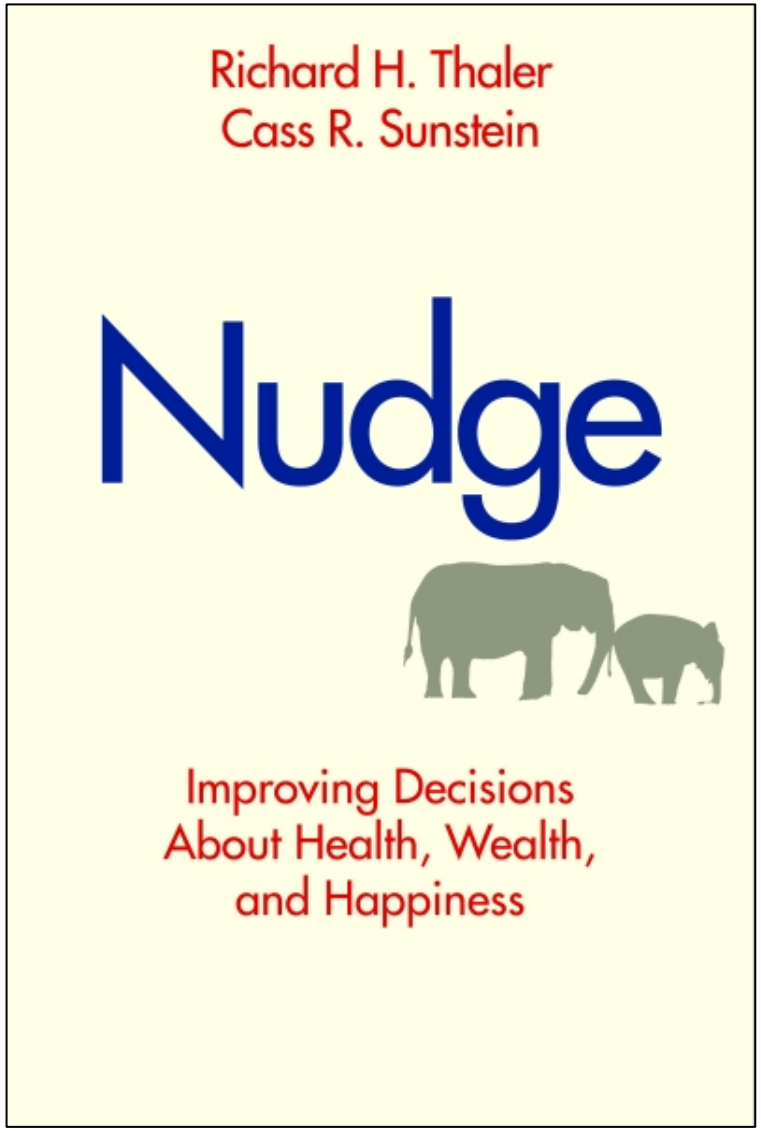
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La nuova strategia per migliorare
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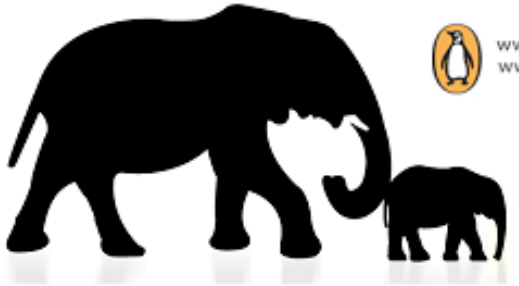
"If you go to the men's washrooms at the Schiphol airport in Amsterdam, you may notice there's a fly in the urinals. So what do you think most men do? That's right, they aim at the fly when they urinate. They don't even think about it, and they don't need to read
a user's manual; it's just an instinctive reaction. The interesting feature
of these urinals is that they're deliberately designed to take advantage of this inherent human male tendency.”

Nudge



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Improving Decisions About
Health, Wealth, and Happiness

Richard H. Thaler and Cass R. Sunstein

Excuse me, how much did you exercise this week?

May 18, 2010 in Blog posts by nudgeblog | 1 Comment

The Wall Street Journal reports on another study showing that reminding (some call it nagging) has its virtues – this time for exercising. As part of the study, one group of people received a weekly phone call from a human asking them how much exercise they'd gotten that week and congratulating them if they had met a personal goal. Another group got a similar call from an automated system. A third group got no call.

> After 12 months, participants receiving calls from a live person were exercising, as a mean, about 178 minutes a week, above government recommendations for 150 minutes a week. That represented a 78% jump from about 100 minutes a week at the start of the study. Exercise levels for the group receiving computerized calls doubled to 157 minutes a week. A control group of participants, who received no phone calls, exercised 118 minutes a week, up 28% from the study's start. "When you knew you were going to have to report back on what you had done, it motivated you," says Ms. Lowe.

Richard H. Thaler
and Cass R. Sunstein

Improving Decisions About
Health, Wealth, and Happiness

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The Amsterdam urinals

The recent piece "Easy Does it" about choice architecture in the New Republic by Cass Sunstein and Richard Thaler opened with the example of bathroom urinals. Bathroom urinals in the Amsterdam airport, more specifically.

> As all women who have ever shared a toilet with a man can attest, men can be especially spacey when it comes to their, er, aim. In the privacy of a home, that may be a mere annoyance. But, in a busy airport restroom used by throngs of travelers each day, the unpleasant effects of bad aim can add up rather quickly. Enter an ingenious economist who worked for Schiphol International Airport in Amsterdam. His idea was to etch an image of a black house fly onto the bowls of the airport's urinals, just to the left of the drain. The result: Spillage declined 80 percent. It turns out that, if you give men a target, they can't help but aim at it.

Richard H. Thaler
and Cass R. Sunstein

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Health, Wealth, and Happiness

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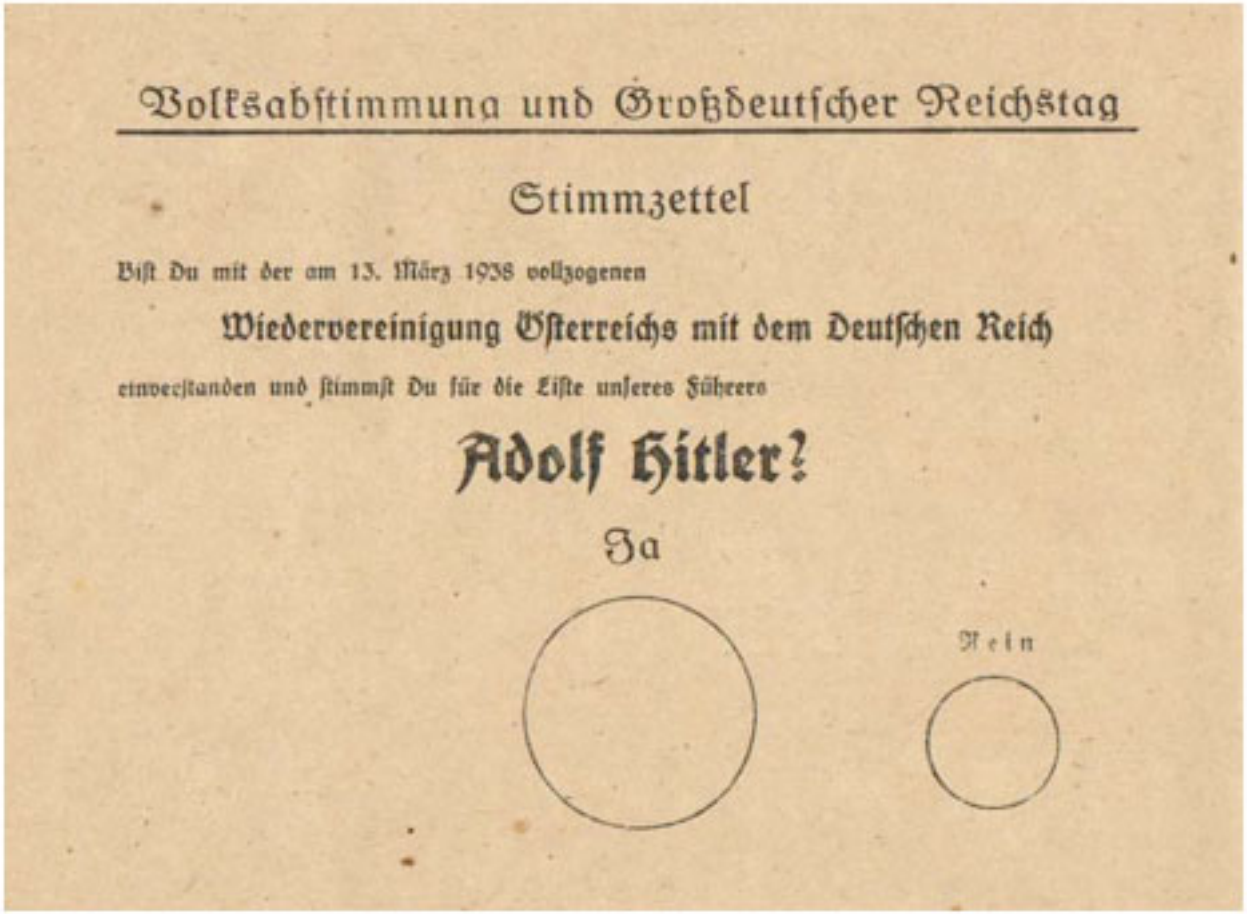
Monaco di Baviera,
2016

aeroporto Charles De Gaulle, Parigi, campionati europei di calcio 2016



Volksabstimmung und Großdeutscher Reichstag

Stimmzettel

Bist Du mit der am 13. März 1938 vollzogenen

Wiedervereinigung Österreichs mit dem Deutschen Reich

einverstanden und stimmst Du für die Liste unseres Führers

Adolf Hitler?

Ja

Nein

Translation: "Referendum and Großdeutscher Reichstag; Ballot; Do you agree with the reunification of Austria with the German Reich that was enacted on 13 March 1938 and do you vote for the party of our leader; Adolf Hitler?; Yes; No"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PLUS
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NCR
Desidera la stampa dello scontrino?
Sì
No

MEDICINE

Do Defaults Save Lives?

Eric J. Johnson* and Daniel Goldstein

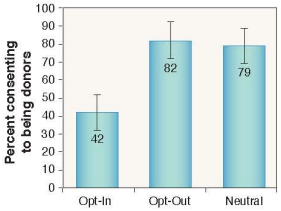
Since 1995, more than 45,000 people in the United States have died waiting for a suitable donor organ. Although an oft-cited poll (*1*) showed that 85% of Americans approve of organ donation, less than half had made a decision about donating, and fewer still (28%) had granted permission by signing a donor card, a pattern also observed in Germany, Spain, and Sweden (*2*–*4*). Given the shortage of donors, the gap between approval and action is a matter of life and death.

What drives the decision to become a potential donor? Within the European Union, donation rates vary by nearly an order of magnitude across countries and these differences are stable from year to year. Even when controlling for variables such as transplant infrastructure, economic and educational status, and religion (*5*), large differences in donation rates persist. Why?

Most public policy choices have a no-action default, that is, a condition is imposed when an individual fails to make a decision (*6*, *7*). In the case of organ donation, European countries have one of two default policies. In presumed-consent states, people are organ donors unless they register not to be, and in explicit-consent countries, nobody is an organ donor without registering to be one.

According to a classical economics view, preferences exist and are available to the decision-maker—people simply find too little value in organ donation. This view has led to calls for the establishment of a regulated market for the organs of the deceased (*8*, *9*), for the payment of donors or donors' families (*10*, *11*), and even for suggestions that organs should become public property upon death (*12*). Calls for campaigns to change public attitudes (*13*) are widespread. In classical economics, defaults should have a limited effect: when defaults are not consistent with preferences, people would choose an appropriate alternative.

A different hypothesis arises from research depicting preferences as constructed, that is, not yet articulated in the minds of those who have not been asked (*14*–*16*). If preferences for being an organ donor are constructed, defaults can influence choices in three ways: First, decision-makers might believe that defaults are suggestions by the policy-maker, which imply a recommended action. Second, making a decision often involves effort, whereas accepting the default is effortless. Many people would rather avoid making an active decision about donation, because it can be unpleasant and stressful (*17*). Physical effort such as filling out a form may also increase acceptance of the default (*18*). Finally, defaults often represent the existing state or status quo, and change usually involves a trade-off. Psychologists have shown that losses loom larger than the equivalent gains, a phenomenon known as loss aversion (*19*). Thus, changes in the default may result in a change of choice.



Effective consent rates, online experiment, as a function of default.

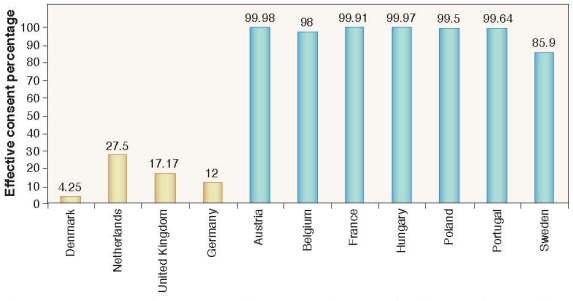
Governments, companies, and public agencies inadvertently run "natural experiments" testing the power of defaults. Studies of insurance choice (*20*), selection of Internet privacy policies (*21*, *22*), and the level of pension savings (*23*) all show large effects, often with substantial financial consequences.

Defaults and Organ Donations

We investigated the effect of defaults on donation agreement rates in three studies. The first used an online experiment (*24*): 161 respondents were asked whether they would be donors on the basis of one of three questions with varying defaults. In the opt-in condition, participants were told to assume that they had just moved to a new state where the default was not to be an organ donor, and they were given a choice to confirm or change that status. The opt-out condition was identical, except the default was to be a donor. The third, neutral condition simply required them to choose with no prior default. Respondents could at a mouse click change their choice, largely eliminating effort explanations.

The form of the question had a dramatic impact (see figure, left): Revealed donation rates were about twice as high when opting-out as when opting-in. The opt-out condition did not differ significantly from the neutral condition (without a default option). Only the opt-in condition, the current practice in the United States, was significantly lower.

In the last two decades, a number of European countries have had opt-in or opt-out default options for individuals' decisions to become organ donors. Actual decisions about organ donation may be affected by governmental educational programs, the



Effective consent rates, by country. Explicit consent (opt-in, gold) and presumed consent (opt-out, blue).

The authors are at the Center for Decision Sciences, Columbia University, New York, NY 10027, USA.

*To whom all correspondence should be addressed: ejj3@columbia.edu

MEDICINE

Do Defaults Save Lives?

Eric J. Johnson* and Daniel Goldstein

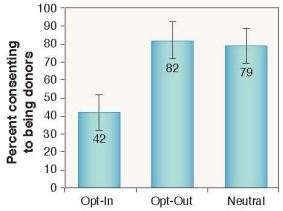
Since 1995, more than 45,000 people in the United States have died waiting for a suitable donor organ. Although an oft-cited poll (*1*) showed that 85% of Americans approve of organ donation, less than half had made a decision about donating, and fewer still (28%) had granted permission by signing a donor card, a pattern also observed in Germany, Spain, and Sweden (*2*–*4*). Given the shortage of donors, the gap between approval and action is a matter of life and death.

What drives the decision to become a potential donor? Within the European Union, donation rates vary by nearly an order of magnitude across countries and these differences are stable from year to year. Even when controlling for variables such as transplant infrastructure, economic and educational status, and religion (*5*), large differences in donation rates persist. Why?

Most public policy choices have a no-action default, that is, a condition is imposed when an individual fails to make a decision (*6*, *7*). In the case of organ donation, European countries have one of two default policies. In presumed-consent states, people are organ donors unless they register not to be, and in explicit-consent countries, nobody is an organ donor without registering to be one.

According to a classical economics view, preferences exist and are available to the decision-maker—people simply find too little value in organ donation. This view has led to calls for the establishment of a regulated market for the organs of the deceased (*8*, *9*), for the payment of donors or donors' families (*10*, *11*), and even for suggestions that organs should become public property upon death (*12*). Calls for campaigns to change public attitudes (*13*) are widespread. In classical economics, defaults should have a limited effect: when defaults are not consistent with preferences, people would choose an appropriate alternative.

A different hypothesis arises from research depicting preferences as constructed, that is, not yet articulated in the minds of those who have not been asked (*14*–*16*). If preferences for being an organ donor are constructed, defaults can influence choices in three ways: First, decision-makers might believe that defaults are suggestions by the policy-maker, which imply a recommended action. Second, making a decision often involves effort, whereas accepting the default is effortless. Many people would rather avoid making an active decision about donation, because it can be unpleasant and stressful (*17*). Physical effort such as filling out a form may also increase acceptance of the default (*18*). Finally, defaults often represent the existing state or status quo, and change usually involves a trade-off. Psychologists have shown that losses loom larger than the equivalent gains, a phenomenon known as loss aversion (*19*). Thus, changes in the default may result in a change of choice.



Effective consent rates, online experiment, as a function of default.

Governments, companies, and public agencies inadvertently run "natural experiments" testing the power of defaults. Studies of insurance choice (*20*), selection of Internet privacy policies (*21*, *22*), and the level of pension savings (*23*) all show large effects, often with substantial financial consequences.

Defaults and Organ Donations

We investigated the effect of defaults on donation agreement rates in three studies. The first used an online experiment (*24*): 161 respondents were asked whether they would be donors on the basis of one of three questions with varying defaults. In the opt-in condition, participants were told to assume that they had just moved to a new state where the default was not to be an organ donor, and they were given a choice to confirm or change that status. The opt-out condition was identical, except the default was to be a donor. The third, neutral condition simply required them to choose with no prior default. Respondents could at a mouse click change their choice, largely eliminating effort explanations.

The form of the question had a dramatic impact (see figure, left): Revealed donation rates were about twice as high when opting-out as when opting-in. The opt-out condition did not differ significantly from the neutral condition (without a default option). Only the opt-in condition, the current practice in the United States, was significantly lower.

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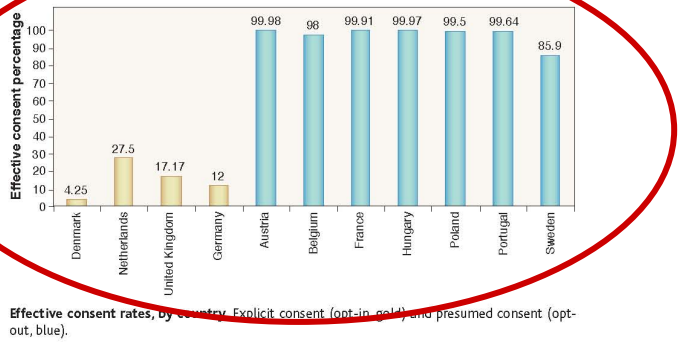

Effective consent rates, by country. Explicit consent (opt-in, gold) and presumed consent (opt-out, blue).

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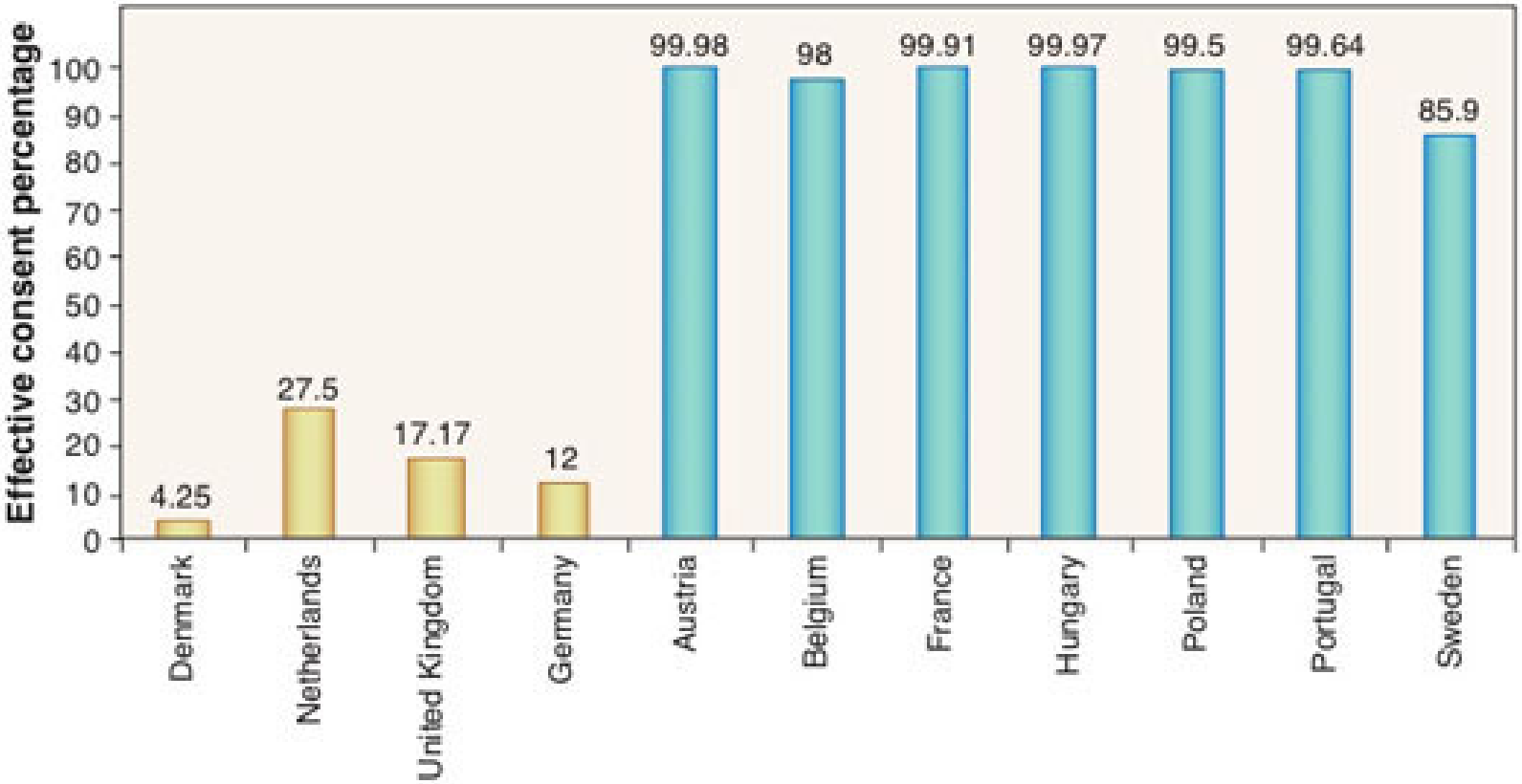
Effective consent percentage
100
90
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99.64
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Denmark
Netherlands
United Kingdom
Germany
Austria
Belgium
France
Hungary
Poland
Portugal
Sweden

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Increasing compliance with low tidal volume ventilation in the ICU with two nudge-based interventions: evaluation through intervention time-series analyses

Christopher P Bourdeaux,[1] Matthew JC Thomas,[1] Timothy H Gould,[1] Gaurav Malhotra,[2] Andreas Jarvstad,[2] Timothy Jones,[3] Iain D Gilchrist[2]

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Editorial

May 2015

More

Nudging Students Toward Healthier Food Choices—Applying Insights From Behavioral Economics

Mitesh S. Patel, MD, MBA, MS[1,2,3,4]; Kevin G. Volpp, MD, PhD[1,2,3,4,5]

Author Affiliations

JAMA Pediatr. 2015;169(5):425-426. doi:10.1001/jamapediatrics.2015.0217

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Original Investigation

FREE

February 9, 2016

Effect of Behavioral Interventions on Inappropriate Antibiotic Prescribing Among Primary Care Practices

A Randomized Clinical Trial

Daniella Meeker, PhD[1,2]; Jeffrey A. Linder, MD, MPH[3,4]; Craig R. Fox, PhD[5,6]; et al

Author Affiliations | Article Information

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"Nudge" in the clinical consultation – an acceptable form of medical paternalism?

Ajay Aggarwal, Joanna Davies and Richard Sullivan

BMC Medical Ethics 2014 15:31 | DOI: 10.1186/1472-6939-15-31

Received: 28 May 2013 | Accepted: 11 April 2014 | Published: 17 April 2014

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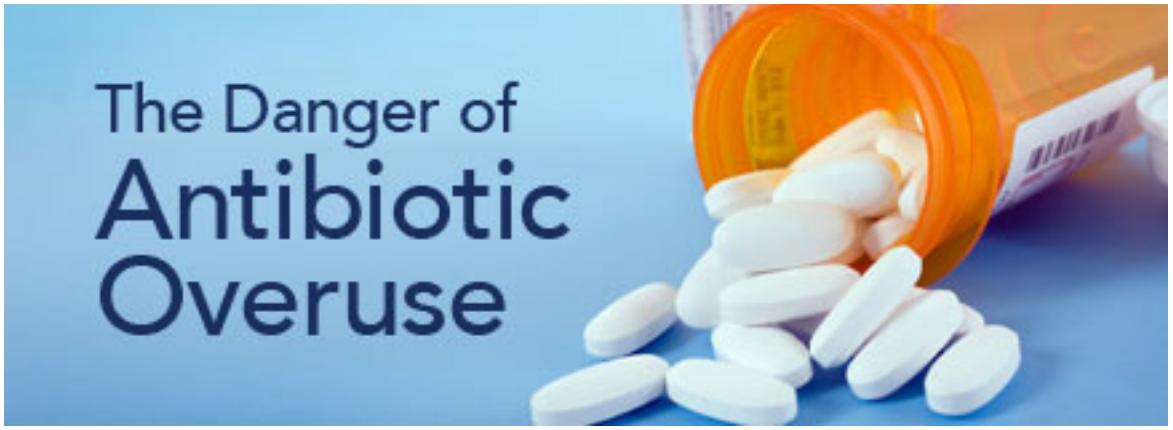

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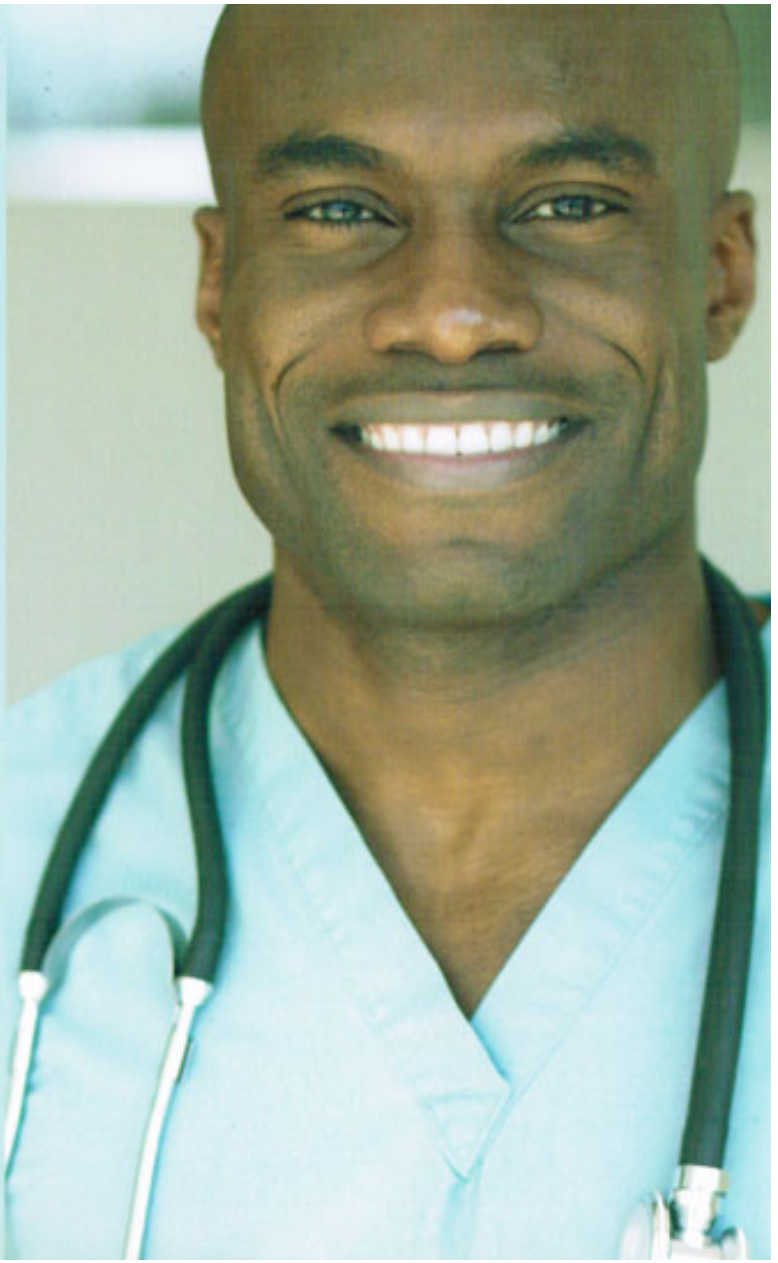

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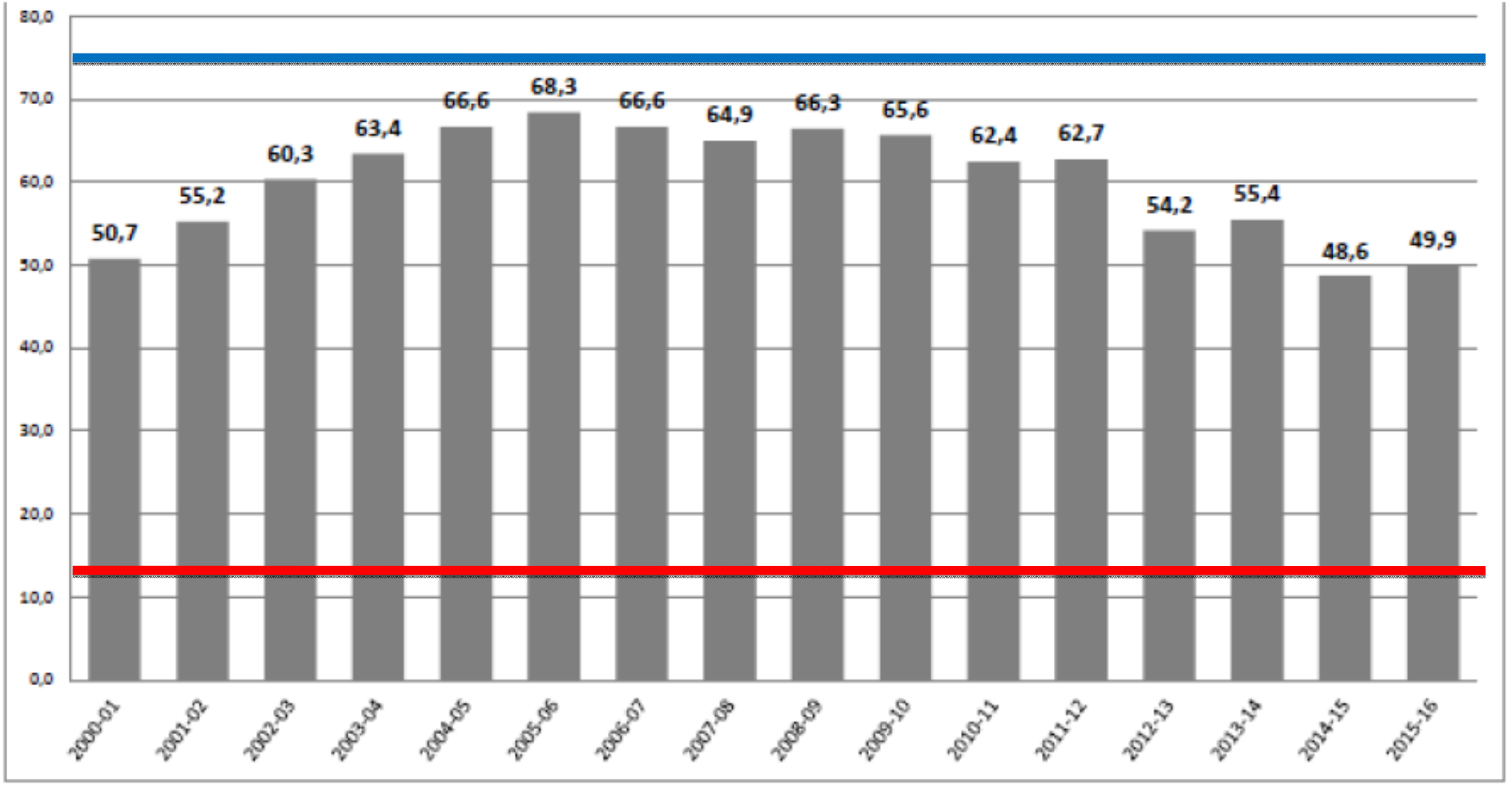
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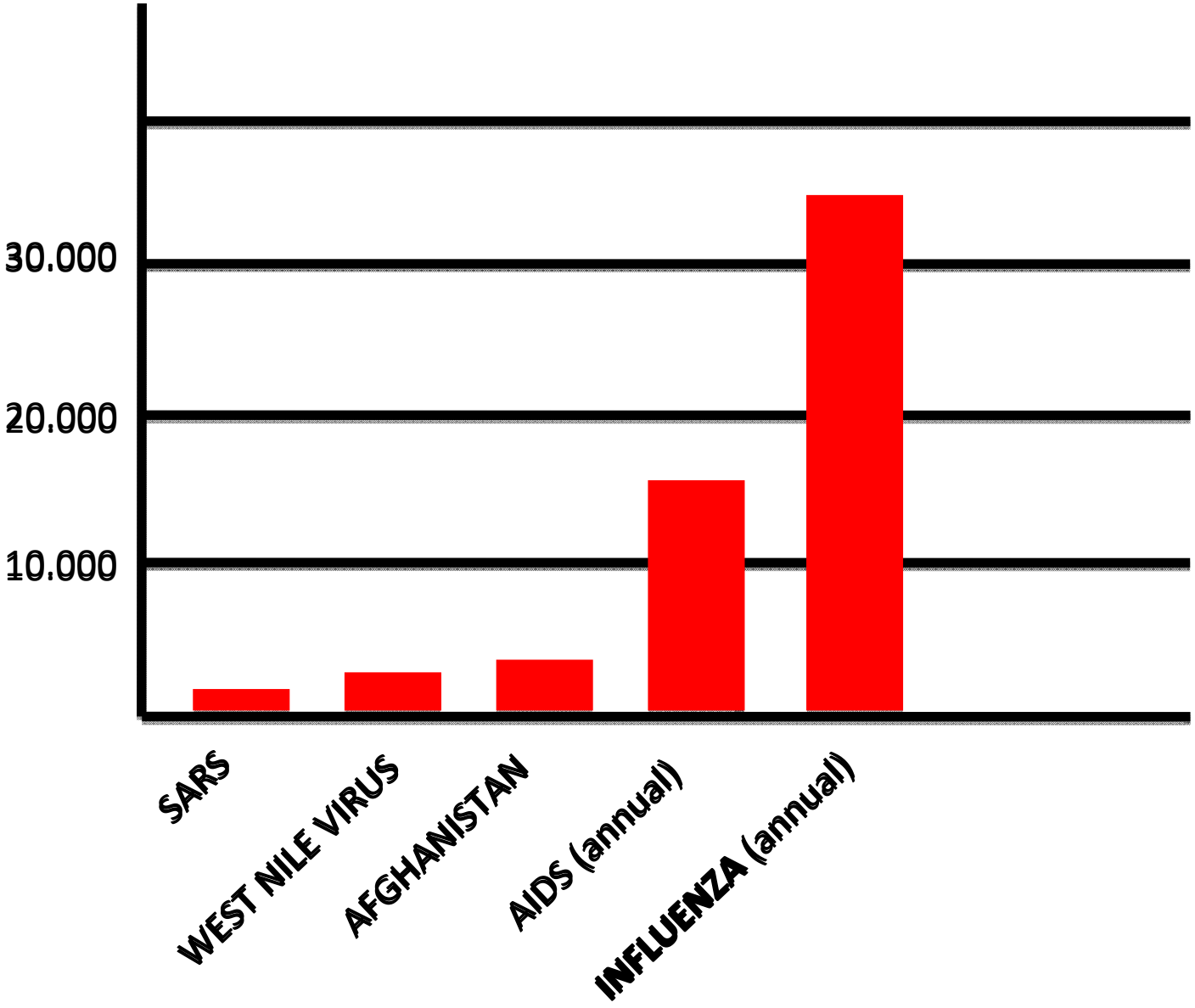
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10.000
SARS
WEST NILE VIRUS
AFGHANISTAN
AIDS (annual)
INFLUENZA (annual)

the **benefits** of **flu vaccination** 2014-2015

The estimated number of influenza-associated **illnesses prevented** by flu vaccination during the 2014-2015 season:

1.9 million

greater than the population of the city of Philadelphia

The estimated number of flu-associated **medical visits prevented** by vaccination during the 2014-2015 season:

966,000

as many people as can fit in Manhattan's Times Square

The estimated number of flu **hospitalizations prevented** during the 2014-2015 season:

67,000

as many people as Seattle's Seahawks stadium can seat

get **vaccinated**

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

DATA: www.cdc.gov/flu/about/disease/2014-15.htm
Morbidity and Mortality Weekly Report (MMWR). October 4–November 28, 2015: Vol. 64, No. 46
NCIRDdg-529 | 12.10.2015

www.cdc.gov/flu

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I am Fine !

COPERTURA VACCINALE TRA I DIPENDENTI INFERIORE AL 10 %

CONTROLLO

Gentile……,

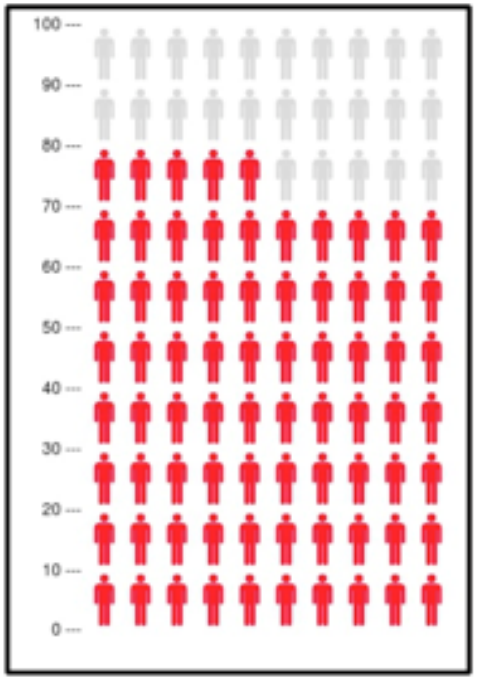
ti ricordiamo che dal giorno 7 novembre 2016 è disponibile il **VACCINO ANTI-INFLUENZALE STAGIONALE**.

La vaccinazione è gratuita. Per vaccinarti, puoi presentarti presso la SoSD Medico Competente Area Est (Ospedale San Giovanni Bosco, I piano) dal lunedì al venerdì dalle ore 8.00 alle ore 14.00. Per orari differenti è possibile contattare gli operatori all'interno 2408.

INTERVENTO 1

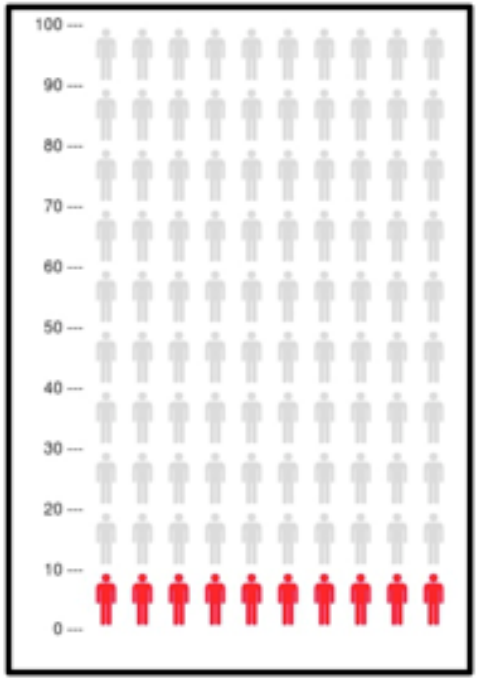
Gentile ……,

ti segnaliamo che dal giorno 7 novembre 2016 è disponibile il **VACCINO ANTI-INFLUENZALE STAGIONALE**.



L'obiettivo minimo per l'OMS e il Ministero della Sanità è la vaccinazione di almeno 75 operatori ospedalieri su 100

Negli USA la media di dipendenti ospedalieri vaccinati è di 60 su 100



<u>Nel nostro Ospedale</u> lo scorso anno solo 10 dipendenti ogni 100 hanno scelto di vaccinarsi

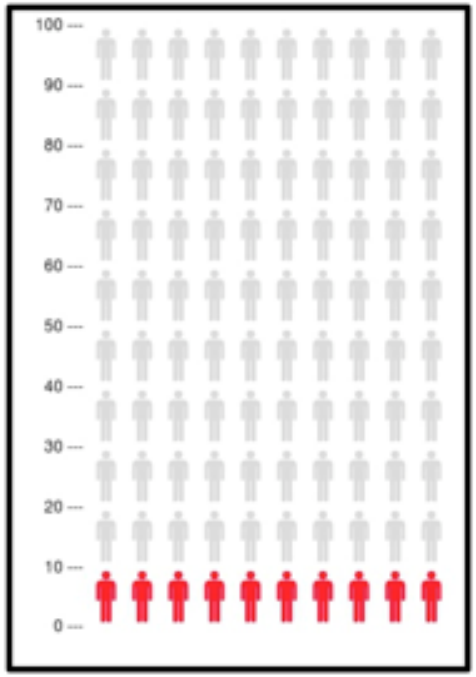
INTERVENTO 2

Gentile……,

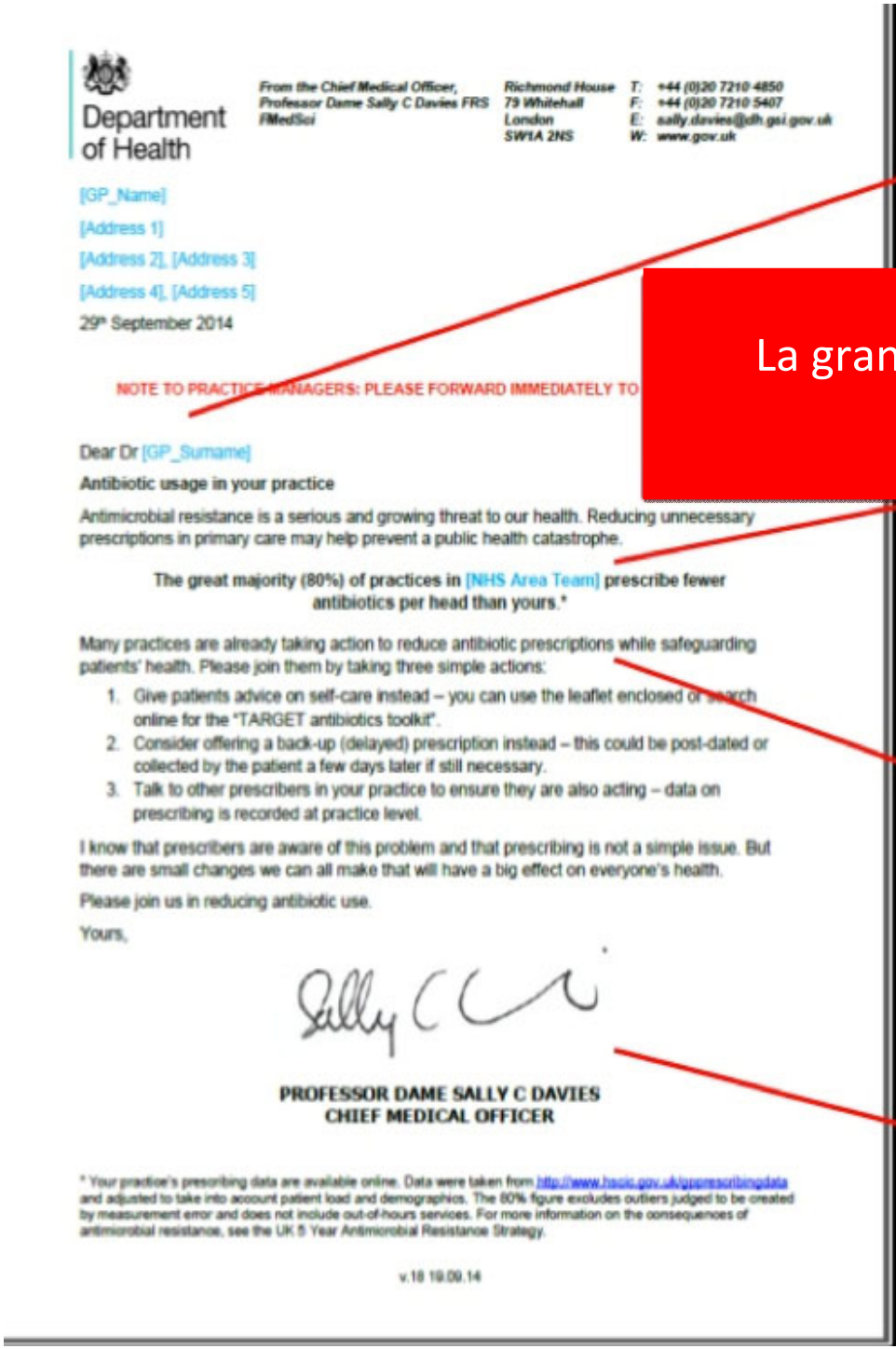
ti segnaliamo che dal giorno 7 novembre 2016 è disponibile il **VACCINO ANTI-INFLUENZALE STAGIONALE**.

L'obiettivo minimo per l'OMS e il Ministero della Sanità è la vaccinazione di almeno 75 operatori ospedalieri su 100

In Italia nella scorsa stagione 50 adulti su 100 sopra i 65 anni hanno scelto di vaccinarsi



<u>Nel nostro Ospedale</u> lo scorso anno solo 10 dipendenti ogni 100 hanno scelto di vaccinarsi



Department of Health

From the Chief Medical Officer,
Professor Dame Sally C Davies FRS
FMedSci

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79 Whitehall
London
SW1A 2NS

T: +44 (0)20 7210 4850
F: +44 (0)20 7210 5407
E: sally.davies@dh.gsi.gov.uk
W: www.gov.uk

[GP_Name]
[Address 1]
[Address 2], [Address 3]
[Address 4], [Address 5]

29th September 2014

NOTE TO PRACTICE MANAGERS: PLEASE FORWARD IMMEDIATELY TO

Dear Dr [GP_Surname]

Antibiotic usage in your practice

Antimicrobial resistance is a serious and growing threat to our health. Reducing unnecessary prescriptions in primary care may help prevent a public health catastrophe.

The great majority (80%) of practices in [NHS Area Team] prescribe fewer antibiotics per head than yours.*

Many practices are already taking action to reduce antibiotic prescriptions while safeguarding patients' health. Please join them by taking three simple actions:

1. Give patients advice on self-care instead – you can use the leaflet enclosed or search online for the "TARGET antibiotics toolkit".
2. Consider offering a back-up (delayed) prescription instead – this could be post-dated or collected by the patient a few days later if still necessary.
3. Talk to other prescribers in your practice to ensure they are also acting – data on prescribing is recorded at practice level.

I know that prescribers are aware of this problem and that prescribing is not a simple issue. But there are small changes we can all make that will have a big effect on everyone's health.

Please join us in reducing antibiotic use.

Yours,

PROFESSOR DAME SALLY C DAVIES
CHIEF MEDICAL OFFICER

* Your practice's prescribing data are available online. Data were taken from http://www.hscic.gov.uk/gpprescribingdata and adjusted to take into account patient load and demographics. The 80% figure excludes outliers judged to be created by measurement error and does not include out-of-hours services. For more information on the consequences of antimicrobial resistance, see the UK 5 Year Antimicrobial Resistance Strategy.

v.18 19.09.14

Indirizzata personalmente al medico di famiglia

La grande maggioranza dei tuoi colleghi (80%) prescrive meno antibiotici di te

3 semplici azioni

Firmata da un'autorità

Provision of social norm feedback to high prescribers of antibiotics in general practice: a pragmatic national randomised controlled trial

Michael Hallsworth, Tim Chadborn, Anna Sallis, Michael Sanders, Daniel Berry, Felix Greaves, Lara Clements, Sally C Davies

Summary

Background Unnecessary antibiotic prescribing contributes to antimicrobial resistance. In this trial, we aimed to reduce unnecessary prescriptions of antibiotics by general practitioners (GPs) in England.

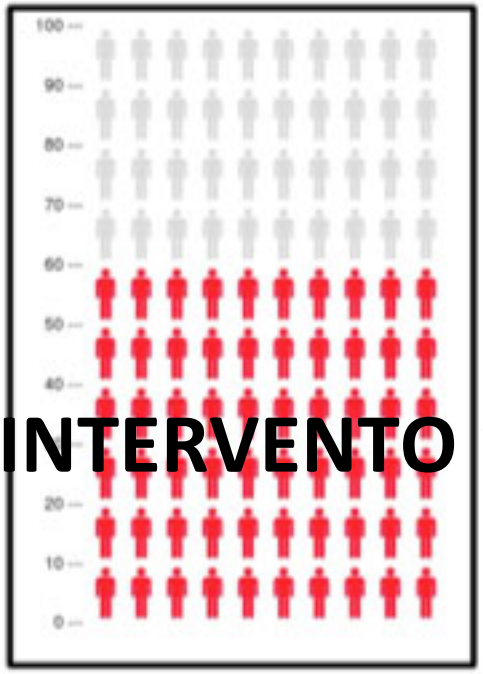
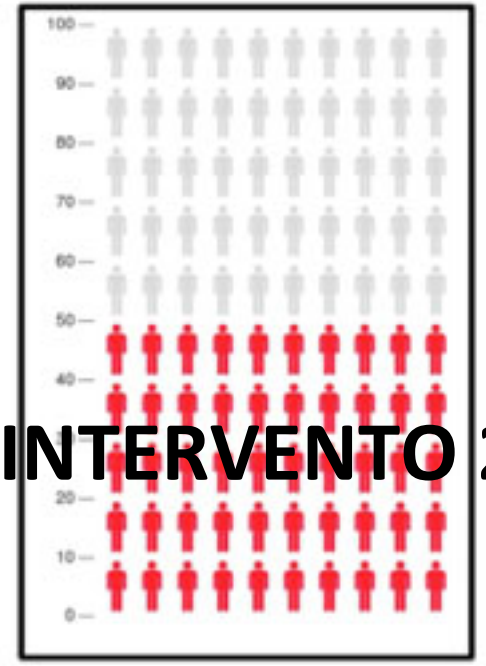
Methods In this randomised, 2×2 factorial trial, publicly available databases were used to identify GP practices whose prescribing rate for antibiotics was in the top 20% for their National Health Service (NHS) Local Area Team. Eligible practices were randomly assigned (1:1) into two groups by computer-generated allocation sequence, stratified by NHS Local Area Team. Participants, but not investigators, were blinded to group assignment. On Sept 29, 2014, every GP in the feedback intervention group was sent a letter from England's Chief Medical Officer and a leaflet on antibiotics for use with patients. The letter stated that the practice was prescribing antibiotics at a higher rate than 80% of practices in its NHS Local Area Team. GPs in the control group received no communication. The sample was re-randomised into two groups, and in December, 2014, GP practices were either sent patient-focused information that promoted reduced use of antibiotics or received no communication. The primary outcome measure was the rate of antibiotic items dispensed per 1000 weighted population, controlling for past prescribing. Analysis was by intention to treat. This trial is registered with the ISRCTN registry, number ISRCTN32349954, and has been completed.

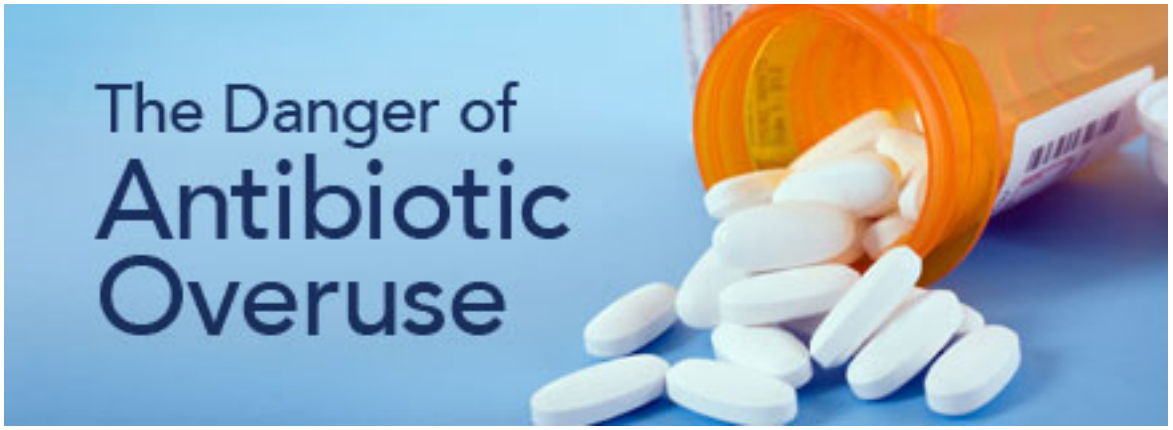
Findings Between Sept 8 and Sept 26, 2014, we recruited and assigned 1581 GP practices to feedback intervention (n=791) or control (n=790) groups. Letters were sent to 3227 GPs in the intervention group. Between October, 2014, and March, 2015, the rate of antibiotic items dispensed per 1000 population was 126·98 (95% CI 125·68–128·27) in the feedback intervention group and 131·25 (130·33–132·16) in the control group, a difference of 4·27 (3·3%; incidence rate ratio [IRR] 0·967 [95% CI 0·957–0·977]; p<0·0001), representing an estimated 73 406 fewer antibiotic items dispensed. In December, 2014, GP practices were re-assigned to patient-focused intervention (n=777) or control (n=804) groups. The patient-focused intervention did not significantly affect the primary outcome measure between December, 2014, and March, 2015 (antibiotic items dispensed per 1000 population: 135·00 [95% CI 133·77–136·22] in the patient-focused intervention group and 133·98 [133·06–134·90] in the control group; IRR for difference between groups 1·01, 95% CI 1·00–1·02; p=0·105).

Interpretation Social norm feedback from a high-profile messenger can substantially reduce antibiotic prescribing at low cost and at national scale; this outcome makes it a worthwhile addition to antimicrobial stewardship programmes.

THE LANCET

INCREMENTO DEL 63% DELLA COPERTURA VACCINALE

CONTROLLO	INTERVENTO 1	INTERVENTO 2
		
	Negli USA la media di dipendenti ospedalieri vaccinati è di 60 su 100	In Italia nella scorsa stagione 50 adulti su 100 sopra i 65 anni hanno scelto di vaccinarsi
28 %	40 %	30 %



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