Welcome to Patient Safety Picks an electronic newsletter of the University of Manitoba Health Sciences Libraries in partnership with the Winnipeg Regional Health Authority. This free electronic newsletter is designed to alert you to recent information about patient safety including new books, websites, articles, and audiovisual resources. Nine times a year, we will feature some of the best local, national and international resources that we can find. By way of introduction, the first edition of the newsletter is being broadly distributed to healthcare professionals throughout the University of Manitoba and the WRHA. If you are interested in continuing to receive this newsletter, please subscribe now. You will be sent an email when new content is available for you to view. Please take a minute to fill out a brief survey so we can gauge the value of this newsletter to you and the Winnipeg healthcare community. You are also welcome to make comments and join a discussion on patient safety in our forums section.

WRHA Features Speaker on Patient Safety at AGM

If you missed the WRHA AGM, the notes from speaker Dr. G. Ross Baker on "Patient Safety: Raising the Bar" are available online

Manitoba Announces New Institute for Patient Safety

In case you missed the announcement, Manitoba is in the process of setting up a new Patient Safety Institute

Halifax 4: Canadian Healthcare Safety Symposium

Many of the recent presentations from the October 14-16, 2004 presentation are available online

Sixteenth Annual National Forum on Quality Improvement in Health Care

WRHA announced that they will be hosting a satellite broadcast of the Institute for Health Care Improvement (IHI) 16th Annual National Forum on Quality Improvement in Healthcare on December 14 and 15, 2004

Nature of Things Features Patient Safety

The CBC television show the Nature of Things features a special on medical error titled "Killed by Care: Making Medicine Safe"

Forums

Nature of Things Program Oct 29, 2004 Tania Gottschalk

Publication Information

Patient Safety Picks is an electronic newsletter of the University of Manitoba Health Sciences Libraries in partnership with the Winnipeg Regional Health Authority. Its purpose is to alert those in the Winnipeg health community to new information resources
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of Patient Safety; Ryan Sidorchuk, WRHA Patient Safety Officer

**About the Health Sciences Libraries**

The Health Sciences Libraries support the teaching, research, and patient care activities
of the staff and students of the Faculties of Dentistry, Medicine, and the Schools of
Dental Hygiene and Medical Rehabilitation.

Working with the Winnipeg Regional Health Authority, the University of Manitoba
provides library services to six Winnipeg hospitals. The Health Sciences Libraries now
include the Neil John Maclean Health Sciences Library (Health Sciences Centre), and the
hospital libraries of Concordia, Grace, Seven Oaks, St. Boniface, and Victoria.

The Health Sciences Libraries offer a wide range of services — including document
delivery, literature searches, and training — and provide access to an extensive
collection of monographs, journals, videos, and health databases.

**About the WRHA**

Established in December 1999, the Winnipeg Regional Health Authority is one of 12
Regional Health Authorities in Manitoba responsible for coordinating health services in
designated regions. The WRHA is comprised of health care providers and management
professionals who coordinate, manage, deliver, allocate funds to and evaluate health
care and health promotion in Winnipeg. While they report through a Board of Directors
directly to the Minister of Health, they are equally accountable to the public.

The Winnipeg Regional Health Authority is working to provide services that promote
independence, wellness, treatment and care and doing it with respect. For more
information about the Winnipeg Regional Health Authority, search their website or
contact them at: 1800-155 Carlton Street, Winnipeg, MB R3C 4Y1
Ph. 204.926.7000 Fax. 204.926.7007
WRHA FEATURES SPEAKER on PATIENT SAFETY AT AGM

Dr. G. Ross Baker of the Department of Health Policy, Management, and Evaluation was the featured speaker at the Winnipeg Regional Health Authority Annual General Meeting on October 5, 2004. The title of his talk was "Patient Safety: Raising the Bar" and the speaker notes are available on the WRHA website at:


MANITOBA ANNOUNCES NEW INSTITUTE FOR PATIENT SAFETY

This press release from May 20, 2004 from the Minister of Health alerts the medical community to the creation of a Manitoba Institute for Patient Safety.


HALIFAX 4: CANADIAN HEALTHCARE SAFETY SYMPOSIUM

Many of the presentations made at the October 14 -16, 2004 in Edmonton are available online at

https://secure.interbaun.com/buksa/htdocs/Halifax4/Presentations.htm

Speakers included:

Keynote Presentation: Building a Culture of Safety

James P. Bagian MD PE
Director, US Vetrans Affairs National Centre for Patient Safety

Dr. Bagian understands very well the link between safety focused policies and procedures, and healthy outcomes – as a former NASA astronaut, he relied on other people and effective systems to ensure his personal safety during two space flights. As the first, and current, Director of the US Veterans Affairs (VA) National Center for Patient Safety (NCPS), Dr. Bagian is now responsible for overseeing the safety of thousands of clients by managing this comprehensive program designed to assist in reducing errors. He will speak about the NCPS system’s approach to error measurement, and the techniques that have resulted in reducing avoidable injuries and deaths throughout VA’s 173 medical centres and over 771 outpatient facilities.

The Latest From the Canadian Patient Safety Institute (CPSI)

John Wade MD FRCPC
Chair, Founding Board, Canadian Patient Safety Institute

The recently created Canadian Patient Safety Institute is responsible for addressing the following five aspects of patient safety: system issues, legal/regulatory issues, measurement/evaluation, education/professional development and information/communication. Dr. Wade will discuss the structure and mandate of the Institute, and its action plan for the coming year.

Decision-Making In Healthcare

Pat Croskerry MD PhD
Clinical Consultant in Patient Safety-CDHA, Dalhousie University

Dr. Croskerry will discuss pitfalls when making decisions and suggest some ways to avoid them, with emphasis on processes involved and common mistakes
SIXTEENTH ANNUAL NATIONAL FORUM on QUALITY IMPROVEMENT in HEALTH CARE

INVITATION TO 16TH ANNUAL NATIONAL FORUM ON QUALITY IMPROVEMENT IN HEALTH CARE

SATELLITE BROADCAST

DATES: December 14-15, 2004

LOCATION: Winnipeg Convention Centre, 2nd Floor Presentation Theatre

The WRHA will be hosting a satellite broadcast of the Institute for Health Care Improvement (IHI) 16th Annual National Forum on Quality Improvement in Healthcare on December 14 and 15, 2004.

The theme of the 16th National Forum on Quality Improvement in Health Care is: "But … How?"

· How do we identify and change habits that do not support good care?

· How do we use lessons from other industries to improve care systems?

· How do we improve our ability to reduce suffering and improve health?

· How do we revitalize our workforce?

· How do we create a culture of change that leads to continuous improvement?

The schedule of Plenary and Miniplenary Presentations for this year's National Forum is as follows:

December 14, 2004:

- 7:00-8:00 am: Plenary - Dr. Donald Berwick

- 8:30-9:45 am: Miniplenary - Dr. Jonathan Perlin, Sam Shekar & Lloyd Provost (Increasing Access, Increasing Quality - Lessons Learned from Two US National Health Care Systems)

- 10:15-11:30 pm: Miniplenary - Lillee Gelinas & Joan Ellis Beglinger (Nursing Care in the 21st Century: Closing the Gap)

- 12:30 - 1:45 pm: Miniplenary - Dr. Peter Pronovost, Linda Kenney & Dr. Frederick vanPelt, Dr. Mark Rosenberg and Sorrel King (Victims and Healing: Three Reactions to Medical Errors)

- 2:15-3:15 pm: Plenary - Sir John Oldham

December 15, 2004:

- 7:00-8:00 am: Plenary - Sister May Jean Ryan

- 8:30-9:45 am: Miniplenary - Dr. Gary Kaplan and J. Michael Rona (Toyota Production System: Virginia Mason's Quality Strategy)

- 10:15-11:30 pm: Miniplenary - Maureen Bisognano and Paul Plsek (Top Ten Improvement Ideas for 2005)
- 12:30-1:30 pm: Plenary - Uwe Reinhardt

Please note that the Institute for Healthcare Improvement will be offering CEU and CME credits for physicians, nurses, and Human Resources. For more information (topic details, CEU and CME credits) of the broadcast information, go to the Institute for Healthcare Improvement's website - www.ihi.org.

Registration:

To register for this conference, please contact Darlene Gosselin at 926-8033 or by e-mail at dgosselin@wrha.mb.ca. Please provide your full name, WRHA facility, address, phone number and e-mail address when registering. Please indicate which days you will be attending. There is no charge to attend this conference however registration is limited.

NATURE of THINGS FEATURES PATIENT SAFETY

In Canada alone it's estimated that between 9,000 and 24,000 people die every year as a result of medical error. The Nature of Things produced a recent program titled Killed By Care: Making Medicine Safe a one hour documentary that explores the tragic consequences of medical error and the devastating impact it can have on patients, their families and on health care workers as well. The video features prominently features Manitoba families affected by medical error and some of WRHA staff that are working to improve patient safety.

A description of the program is available at:

http://www.cbc.ca/natureofthings/newsletter/20041025_article_medicalerror.html

The Health Sciences Libraries have ordered copies of this video for their collections and they should be available to borrow shortly.

WEBSITE of the MONTH

posted by Tania Gottschalk, WRHA Librarian
Neil John Maclean Health Sciences Library

The Institute for Healthcare Improvement (IHI) website is a non-profit, online resource available free of charge and designed to enable health care professionals around the world to collaborate on the latest strategies and techniques for health care improvement. The Patient Safety section is hosted by renowned expert Lucian Leape, MD. Dr. Leape, Adjunct Professor of Health Policy at the Harvard School of Public Health, is a leading authority on the prevention of medical errors.

Useful features of this website include a free electronic newsletter, Continuous Improvement, to which you can subscribe. It features information on quality improvement and patient care. As well, on the IHI website you can join an online discussion groups about patient safety. Unique to the site are two free online interactive tools:

FMEA Tool - Use the Interactive Failure Modes and Effects Analysis (FMEA) Tool to assess the likelihood of failure in different parts of a process; to see how changes you are considering would affect the safety of the process; and to track changes in the "risk profile number," or RPN, of the process over time.

Trigger Tool for ADEs - Use the Interactive Trigger Tool for Measuring Adverse Drug Events (ADEs) to measure the number of ADEs in your organization and track changes over time.
BOOK of the MONTH

Patient Safety Handbook


Copies of this book are available for loan at:

Grace General Hospital Library
NJM Health Sciences Library
St. Boniface General Hospital Library

You may also purchase a copy by contacting the University of Manitoba Health Sciences Bookstore

This review appeared in JAMA. 2004;291:3015.

Truly a compendium on medical accident, The Patient Safety Handbook touches on nearly every appropriate facet of accident, error, patient harm, organizational culture, ethics, accountability, safety, industrial hygiene, and legality. Perhaps it is too inclusive.

Taking its theme and direction from the notable 1999 Institute of Medicine Report To Err Is Human: Building a Safe Health Care System, the many authors of the 49 chapters explore the roles and responsibilities of all the stakeholders—even patients—in US health care.

Many of the chapters mention and reflect understanding of accident theory as it is expressed by James Reason and Charles Vincent in England and by Charles Perrow. Perrow is cited for his views on the complexity of accident coming from his study of the Three Mile Island nuclear failure. Reason is cited in several chapters for his views on systemic organizational failure as a common prelude to active error. Vincent in chapter 8 describes the application of Reason's "organizational framework for the analysis of risk and safety in medicine" to the study of clinical hazard events in his University College London Clinical Risk Unit, all applicable to analysis of mishaps in the course of care.

Intrinsic to several chapters dealing with organizational culture is the inference that in such intricately developed institutions as hospitals and managed care facilities, it is a necessity that interest in safety be a primary concern of the highest leaders. Furthermore, in the conventional hospital, split between professional function in monitoring quality of care and managerial function of design, maintenance, and facility operation, both professionals and managers must invest deeply in hazard prevention.

From the sad beginning of this book—its foreword memorial to the preventable hospital death of a young woman—one can look forward with some optimism, thanks to the concerted efforts at improvement of care that this book exemplifies and to the support being developed by government, particularly since the book's publication by several state governments and by industry, professional associations, and others. Such efforts seek the success in controlling error and preventable injury that has been reached in several high reliability situations in such hazardous fields as aviation function on aircraft carriers. These efforts will be enhanced by understanding and application of the suggestions made by Perrow, Reason, and Vincent.

It is useful for experts to be gathered together to give advice and counsel to individual physicians and hospital managers on the ground floor in studying hazardous events, injuries, and deaths in the course of care. Hundreds of such physicians and perhaps thousands of nurse coordinators are active in the day-to-day monitoring of patient status, crises in care, hazardous events, episodes of patient harm, and death. They deal with questions of reporting; interact with patients, families, and perplexed colleagues; confront issues of professional credentialing; and cooperate with the Joint Commission on Accreditation of Health Care Organizations. Their voices, missing from this book, would have been a useful addition. Their presence is best noted in the National Patient Safety Forum computer listwatch, in which physicians, nurse risk and quality coordinators, and others exchange care problems and solutions over a national communications network.

Sanford E. Feldman, MD, Reviewer
UCSF–Mount Zion Medical Center
RECOMMENDED FOR PATIENTS

Agency for Healthcare Research and Quality
20 Tips to Help Prevent Medical Errors
posted by Ryan Sidorchuk, WRHA Patient Safety Officer

I thought I would begin this feature by giving you the opportunity to encounter something that you may not have thought of before, and that might very well save your life or the life of one of your loved ones. The idea has been variously labelled, but for our purposes I will refer to it as “patient empowerment”. Patient empowerment seeks to ensure that patients contribute to the decision-making process of their care in order to become healthy from an injury or illness. For too long, patients have been passive members of the team trying to return them to a state of health. Industry has recognized the need for “empowered employees” in order to get the job done, provide quality customer service, and balance the various factors involved in the day-to-day operations of a high-paced customer service industry. In the same manner, an empowered patient will ask meaningful questions or engage in conversations regarding new technologies, contraindications of various pharmaceutical, over-the-counter, or “natural” remedies, or the meaning of various lab tests and reports.

This month, I am recommending a website created by the Agency for Healthcare Research and Quality, a department of the U.S. Department of Health and human Services. “20 Tips to Help Prevent Medical Errors” briefly describes what medical error is and then lists some very practical suggestions for helping patients work with their healthcare team to avoid error. The same actions a patient can take in order to empower themselves regarding the knowledge of their disease and its treatment will concurrently help them to significantly reduce their chance of being exposed to a medical error.

Remember your physician knows best regarding disease, injury and treatment, but no one knows you better than you!

http://www.ahrq.gov/consumer/20tips.htm

FEATURED ARTICLE of the MONTH

Posted by Rob Robson, Director Patient Safety for the WRHA

To request this articles, please register for the Loansome Doc service. If already registered, click journal title to request a copy of the article

To request this articles, please register for the Loansome Doc service. If already registered, click journal title to request a copy of the article

A consistent feature of articles in the Joint Commission Journal on Quality and Safety is the combination of practical advice with a clear theoretical framework. These two articles about the experience at Missouri Baptist Medical Centre do not disappoint.
It is well recognized that changing the existing professional cultures in healthcare represents the major challenge in moving the patient safety agenda forward. The first article describes the key role played by the leadership in this 489 bed community hospital. The concrete efforts to influence the five key realities concerning quality improvement and leadership are outlined.

Starting from the assumption that the leadership must help to “unfreeze” the preference of individual staff members for the status quo, the article the activities of the leadership. The obvious ones (such as executive walk-arounds) were included as well as some innovative ones (providing cash awards for suggestions that are shown to be effective in improving quality and safety).

As part of the commitment to measure and evaluate efforts the leadership undertook several focus groups to understand factors influencing the reporting of errors. The results were challenging in that they showed a consistent fear of negative consequences following reporting as well as an attitude that minimized the value of reporting errors that did not reach the patient. Not surprisingly, there was also consensus that the reporting forms and mechanisms were not user friendly.

The second article describes the efforts made to address these questions and to shift the culture to one that would encourage reporting. After encountering significant pushback from middle managers about the promotion of a “non-punitive” culture the leadership began to promote the concept of a fair and just culture.

Several interventions were undertaken and two critical success factors were identified. The first was demonstration of commitment of senior leadership in the form of highly visible behaviour. The second was the development of patient safety champions at all levels of the organization, reflecting the concept that everyone must be accountable for safety.

One important element was the involvement of patients who were considered to be “partners” in the maintenance of their own health as well as promoting the success of several initiatives.

The article provides evidence of the various parameters that were tracked and measured to gauge the success of various interventions. For instance they demonstrated a significant increases in the reporting of medication events/10,000 doses as well as medical events/errors/1,000 patient days. There was also a significant shift in staff attitudes as measured by surveys and an increase in the number of calls to a patient safety hotline.

These articles provide concrete guidance about ways to tackle the patient safety culture issue as well as evidence that consistent efforts can be successful in producing change. To say that this is both thought provoking and inspiring is an understatement.

To obtain copies of these articles, contact your nearest Health Sciences Library.

JOURNAL ARTICLES FOR OCTOBER-NOVEMBER

October - November 2004
Compiled by Tania Gottschalk, WRHA Librarian
Neil John Maclean Health Sciences Library

The following is a select bibliography of articles appeared in Pubmed/Medline in October and November 2004 on the topic of Patient Safety. If you have a current University of Manitoba Library card or University of Manitoba staff, student or staff card, you can link to the full-text of articles online by clicking on UM Links.

To request articles from this list that are not available electronically, you must be a staff, student, or faculty or member of the University of Manitoba or, a staff member of the WRHA. To request articles, please register for the Loansome Doc service. If you have questions or need help to register please contact the Neil John Maclean Health Sciences Library at 789-3464 or via email at njm_ref@umanitoba.ca

This item is not available online through the Library. Request a print version through Loansome Doc
Patient safety culture and leadership within Canada's Academic Health Science Centres: towards the development of a collaborative position paper.
Currently, the Academy of Canadian Executive Nurses (ACEN) is working with the Association of Canadian Academic Healthcare Organizations (ACAHO) to develop a joint position paper on patient safety cultures and leadership within
Academic Health Science Centres (AHSCs). As a primer, ACEN provides an overview of current patient safety initiatives in AHSCs to date. In addition, the following six key areas for action are identified to ensure that AHSCs continue to be leaders in delivering quality, safe healthcare in Canada. These include: (1) strategic orientation to safety culture and quality improvement, (2) open and transparent disclosure policies, (3) health human resources integral to ensuring patient safety practices, (4) effective linkages between AHSCs and academic institutions, (5) national patient safety accountability initiatives and (6) collaborative team practice.

PMID: 15503913

This item is not available online through the Library. Request a print version through Loansome Doc

In-hospital hip fractures in Canada: using information to improve patient safety.
Pulcins I, Wan E.
Health Indicators, Canadian Institute for Health Information.
PMID: 15540397


5 years after IOM ... the evolving state of patient safety
Scalise D.
How much progress has the health care field made in its patient safety endeavors in the five years since "To Err Is Human" sparked major headlines and soul-searching? This article the author interviews some hospital leaders and other experts about a number of issues related to improving patient safety.
PMID: 15536738

This item is not available online through the Library. Request a print version through Loansome Doc

Advocate health care: a systemwide approach to quality and safety.
Willeumier D.
To implement and sustain a culture of safety, Advocate addressed three challenges: complexity of the system, underreporting of patient safety events, and medical staffs acceptance of the disclosure policy. For example, strategies to address the underreporting challenge include creating a standardized patient safety event form, integrating disparate databases for patient safety event reporting, and providing ongoing education to reinforce the need to report events. Advocate's most significant area for improvement is to become less reliant on risk reduction strategies that may result only in short-term improvements.
PMID: 15518360

This item is not available online through the Library. Request a print version through Loansome Doc

The Johns Hopkins Hospital: identifying and addressing risks and safety issues.
Paine LA, Baker DR, Rosenstein B, Pronovost PJ.
JHH encountered three major hurdles in implementing and sustaining a culture of safety. First, JHH's decentralized organizational structure contributes to a silo effect that limits the spread of ideas, practices, and culture. JHH intends to create an internal collaborative of departmental safety initiatives to foster opportunities for units to share ideas and results. Second, in response to the challenge of encouraging teams to think and act in an interdisciplinary fashion, communication and teamwork training are being used to enhance the effectiveness of interdisciplinary teams. Further development of valid and meaningful safety-related measurement and data collection methodologies is JHH's largest remaining challenge.
PMID: 15518358

This item is not available online through the Library. Request a print version through Loansome Doc

Using focus groups to understand physicians' and nurses' perspectives on error reporting in hospitals.
Jeffe DB, Dunagan WC, Garbutt J, Burroughs TE, Gallagher TH, Hill PR, Harris CB, Bommarito K, Fraser VJ.
BACKGROUND: To increase error reporting, a better understanding of physicians' and nurses' perspectives regarding medical error reporting in hospitals, barriers to reporting, and possible ways to increase reporting is necessary.

METHODS: Nine focus groups--four with 49 staff nurses, two with 10 nurse managers, and three with 30 physicians--from 20 academic and community hospitals were conducted in May-June 2002 in the St. Louis metropolitan area. Qualitative analysis of focus group transcripts characterized participants' perspectives. RESULTS: Although participants knew they should report errors associated with serious adverse events, there was much uncertainty about reporting less serious errors or near misses. Nurses were more knowledgeable than physicians about how to report errors. All groups mentioned barriers to reporting, such as fear of reprisals and lack of confidentiality, time, and feedback after an error is reported. Some physicians doubted the benefit of reporting errors, but, generally, both physicians and nurses agreed that reporting was intended to change practice and policy to promote patient safety. CONCLUSIONS: A culture characterized by anonymous reporting, freedom from repercussions, and feedback about error reports should promote error reporting.

PMID: 15469124


Patient safety systems for case management.
Greenberg L.
Patient safety is an important concern of many healthcare stakeholders, including patients, providers, employers, health plans, and insurers. In 2003, URAC conducted a qualitative study to examine the role of utilization management programs as part of a systemic approach to promoting patient safety. Many of URAC's findings are applicable to case management as well. URAC found that most medical management companies address patient safety indirectly, as part of a global quality management program. Even so, the study identified a number of strengths that could be deployed by medical management organizations to more systematically promote patient safety. For example, case management organizations use decision support tools to assist frontline practitioners in conducting assessments and tracking interventions. Such systems could be programmed to flag safety concerns and guide interventions. The study also found that commonly used case management assessment protocols could be adapted to routinely assess for high priority safety concerns. URAC concluded that each stage of the medical management process offers opportunities for data collection and clinical interface to promote patient safety. Case managers have key positions interfacing between patients, providers, and the healthcare system. Development of safety indicators and training of staff are key elements needed to effectuate a safety program in medical management. Case management leaders in each organization and at the national level should make patient safety a priority, and define the processes for implementing safety systems wherever case management is practiced.

PMID: 15540075

8: Mod Healthc. 2004 Nov 1;34(44):6-7, 24, 30 passim.

Patient safety proves elusive. Five years after publication of the IOM's 'To Err is Human,' there's plenty of activity on patient safety, but progress is another matter.

Morrisey J.
Five years after the Institute of Medicine shook up the industry with its To Err is Human report, patient safety is a hot topic, but few hospitals have reached the IOM's goal of halving mistakes by 2004. "We've only begun," says Donald Berwick, president and CEO of the Institute for Healthcare Improvement.

PMID: 15554333


NY's best not good enough. Despite being a leader in adverse-event reporting, audit reveals some shortcomings, need for reform in N.Y.'s tracking system.
Becker C.
A New York audit of its well-regarded tracking system for adverse-event reporting drew fire when it revealed some problems with oversight. But state health officials defend the system, which is a model for other states. New Jersey official Marilyn Dahl, left, says New York has "been considered a national leader.

PMID: 15510878

Effect of reducing interns' work hours on serious medical errors in intensive care units.
CONCLUSIONS: Interns made substantially more serious medical errors when they worked frequent shifts of 24 hours or more than when they worked shorter shifts. Eliminating extended work shifts and reducing the number of hours interns work per week can reduce serious medical errors in the intensive care unit.
Publication Types:
   Clinical Trial
   Randomized Controlled Trial
PMID: 15509817


Improving patient safety and incident reporting.
Milligan F, Dennis S.
Patient safety is currently an international priority in health care, as it is widely accepted that the quality of healthcare provision, in terms of reducing errors and other forms of unnecessary patient harm, needs to be improved significantly. This article describes the work and position of the National Patient Safety Agency (NPSA) in NHS-funded care. It outlines the contribution made by two nurses who, as clinical specialty advisers (CSAs) in the organisation, are charged with helping to ensure that nursing issues are considered as an integral part of developing solutions to patient safety issues.
PMID: 15551915

12: Prof Nurse. 2004 Nov;20(3):10-4
This item is not available online through the Library. Request a print version through Loansome Doc
Seven steps to patient safety.
Chamberlain-Webber J.
Nurses have a fundamental role in ensuring the safety of patients in their care. Judith Chamberlain-Webber outlines current policy measures aimed at removing the blame culture and encouraging the reporting of incidents and near misses without fear of reprimand, so that lessons can be learned.
PMID: 15552432