

Patient Safety Picks

February 2005

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Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

From the Editor

Welcome to the second edition of *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.



We are also interested in receiving information about any patient safety projects, initiatives, or workshops that are occurring in Manitoba. If you would like to share with others, please contact the editor so that your information can be included in the next edition.

The newsletter is currently distributed to a broad list of emails. However, this will continue only for a few more issues. If you wish to continue receiving the information, please subscribe by going to:
<http://lists.umanitoba.ca/mailman/listinfo/patient-safety>

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.

News

CPSI Root Cause Analysis Workshop page 3

Canadian Patient Safety Institute and Manitoba Health in cooperation with regional health authorities offers special workshop on Root Cause Analysis in Winnipeg on March 18th

7th Annual Patient Safety Congress page 4

"Let's Get On With It ~ Round 2!" is the theme chosen by National Patient Safety Foundation for their annual congress from May 4-6 in Orlando, Florida.

Ethics in Dementia Care - First Do No Harm: A Workshop Dealing with Frontline Issues page 4

"Ethics in Dementia Care - First Do No Harm: A Workshop Dealing with Frontline Issues" will be offered by Geriatric Education and Consultation Services in Winnipeg and Brandon in April.

IHI 16th National Forum on Quality in Improvement in Health Care page 5

Some of the presentations that were made at the IHI Forum are available online.

IHI 100,000 Lives Campaign page 5

The IHI is spearheading a drive to enlist thousands of U.S. hospitals across the country in a commitment to implement changes in care that prevent avoidable deaths.

Website of the Month

Canadian Patient Safety Institute page 6

Book of the Month

Measuring Patient Safety page 6

E-Book of the Month

Best Practices in Patient Safety Education page 7

Recommended For Patients

Ryan Sidorchuk, Patient Safety Officer for the WRHA, recommends the website of the Canadian Pharmacists Association page 7

Featured Article

Rob Robson, Director of Patient Safety for WRHA, reviews Patient Safety – how much is enough?, Health Policy, Vol. 71, 2005, page 223-232 page 8

Journal Articles for Dec - Feb

A select bibliography of articles appearing in PubMed/Medline for December through February on patient safety page 9

Publication Information

Patient Safety Picks is a 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 in print, audiovisual, or electronic format about patient safety. *Patient Safety Picks* is published nine times per year.

Subscriptions are free and anyone is welcome to receive the newsletter. Please go to:

<http://lists.umanitoba.ca/mailman/listinfo/patient-safety> to supply your email so that you can receive future editions.

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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

CPSI Root Cause Analysis Workshop

by Linda Smyrski
Manitoba Health

Manitoba Health in collaboration with the health authorities continue to address the ongoing commitment to provide health care professionals ongoing access to the latest developments and information available on patient safety. Emphasized is the need to continue to promote a culture of learning to foster and support a shared environment that encourages the reduction and/or prevention of errors. A key component in improving quality of care and patient safety is moving to a culture that views care quality and patient safety as a systems issue that requires evaluation, inter-disciplinary cooperation and commitment to change.

Manitoba has been chosen to be the first province to offer the Canadian Patient Safety Institute's (CPSI) workshop ***Canadian Root Cause Analysis Framework - A Team Approach to Improving Patient Safety.***

Root Cause Analysis (RCA) is a *tool* for identifying prevention strategies. It is a process that is part of the effort to build a *culture of safety* and move beyond the culture of blame. In RCA, basic and contributing causes are discovered in a process similar to diagnosis of disease - with the goal always in mind of preventing recurrence.

Root Cause Analysis is:

- inter-disciplinary, involving experts from the frontline services;
- involving those who are the most familiar with the situation;
- continually digging deeper by asking why, why, why at each level of cause and effect;
- a process that identifies changes that need to be made to systems; and
- a process that is as impartial as possible.

To be thorough a Root Cause Analysis must involve:

- principles of human factors;
- identification of potential problems related to processes and systems;
- analysis of underlying cause and effect systems through a series of ***why*** questions;
- identification of risks & their potential contributions to the event;
- development of actions aimed at improving processes and systems; and,
- measurement and evaluation of implementation of these actions.

To be credible a Root Cause Analysis must:

- include participation by the leadership of the organization & those most closely involved in the processes & systems;
- be internally consistent; and,
- include consideration of relevant literature.

This Root Cause Analysis Workshop is planned for March 18, 2005. **Due to the facilitative and participative nature of the workshop – registration has been limited to select participants identified by each region.** It is expected that future workshops will be offered either in collaboration or individually by regions. Stay tuned to this site for details.

7th Annual Patient Safety Congress

Posted by Tania Gottschalk
WRHA Librarian

The [National Patient Safety Foundation](#) is a U.S. nonprofit organization dedicated to improving patient safety and reducing medical errors by funding research and raising awareness with hospitals, healthcare systems, doctors, and nurses and the patients and families they serve. Having worked to make patient safety a national priority, the NPSF is working with the healthcare industry to find affordable ways through research and education to reduce medical errors and to improve the quality of the nation's healthcare. The NPSF was founded in 1996 and incorporated in 1997 by the American Medical Association, CNA HealthPro, and 3M, with significant support from the Schering-Plough Corporation. Of particular merit on the NPSF website is the [Patient Safety Bibliography](#) which is an excellent listing of articles, books, and videos on the topic of patient safety collected by the organization.

The [Seventh Annual National Patient Safety Foundation Congress](#) will focus on critical improvements that save lives and reduce harm each and every day, with a specific concentration on high risk/high impact areas of medical care. Leaders and organizations who have made quantum leaps will present successful strategies that promote patient safety across the continuum of the healthcare system. The plenary sessions and workshops will highlight effective implementations of policies and programs that result in cultural change and sustained improvement of clinician behavioral patterns. The Congress will be May 4-6, 2005 in Orlando, Florida. Registration details are available at <http://www.npsf.org/congress/>. Ryan Sidorchuk, WRHA Patient Safety Officer, will be attending the conference and will be able to share what he learns there when he returns.

Ethics in Dementia Care – First Do No Harm: A Workshop Dealing with Frontline Issues

Behavioural Therapy for Dementia Care Treatment for Yelling, Sexual Aggression & Wandering

Brandon April 11 & 12, 2005
Winnipeg April 14 & 15, 2005

For more information call or write to:
Geriatric Education & Consultation Services
Box 543, Winkler, MB, Canada, R6W 4A7

Phone: 204-325-5755
Fax: 204-325-5762

Email: mail@geriatricservices.ca

URL: www.geriatricservices.ca

IHI 16th National Forum on Quality in Improvement in Health Care

Posted by Tania Gottschalk
WRHA Librarian

If you missed the satellite broadcast sponsored by the Winnipeg Regional Health Authority at the Winnipeg Convention Centre of the *IHI 16th National Forum on Quality in Improvement in Health Care*, many of the presentations are available online at:

<http://www.ihl.org/IHI/Programs/ConferencesAndTraining/16thNationalForum.htm?TabId=11>

Notable presentations related to patient safety include:

Top Ten Improvement Ideas from 2004: Emerging and Promising Approaches by Maureen Bisognano, Executive Vice President & COO, Institute for Healthcare Improvement - http://www.ihl.org/ihl/files/forum/2004/handouts/E1-FORUM_2004.pdf outlines some of practices which may lead to improved patient safety and outcomes

Seeking Zero Defects: Applying the Toyota Production System to Health Care by Virginia Mason Medical Centre - <http://www.ihl.org/ihl/files/forum/2004/handouts/D01.pdf> outlines the use of the Toyota production model to reduce error.

IHI 100,000 Lives Campaign

Posted by Tania Gottschalk
WRHA Librarian

If you missed the IHI's 16th National Forum on Quality Improvement in Health Care, [Donald Berwick made a major announcement](#) regarding a new campaign, the 100,000 Lives Campaign.

The 100,000 Lives Campaign aims to enlist hospitals across the United States in a commitment to implement changes in care that prevent avoidable deaths. Details of the campaign can be found at <http://www.ihl.org/IHI/Programs/Campaign/>

The six interventions that have been chosen for emphasis in this campaign are:

- Deploy Rapid Response Teams
- Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction
- Prevent Adverse Drug Events (ADEs)
- Prevent Central Line Infections
- Prevent Surgical Site Infections
- Prevent Ventilator-Associated Pneumonia

Some information on the value of these interventions has been compiled by the IHI at <http://www.ihl.org/NR/rdonlyres/4032A1F3-B368-4D0A-B7DB-34F86D86C706/0/AllSheets.pdf>

As of the posting of this information, no Canadian hospitals are listed as participants. However, if you are aware of any Canadian hospitals that are joining this campaign, I would like to hear from you. This would be interesting information to share with others in Manitoba and across Canada.

Website of the Month

Canadian Patient Safety Institute

by Tania Gottschalk
WRHA Librarian

The [Canadian Patient Safety Institute](http://www.cpsi-icsp.ca/) (CPSI) is an independent not-for-profit corporation, at arm's length from governments, system stakeholders and regulatory bodies. The CPSI is committed to providing a leadership role with respect to patient safety issues in the context of improving health care quality. Formed in 2003, the CPSI is still developing its website. Currently the most useful portion of this page for those looking for information on patient safety in the Canadian context is the [publications page](#). It includes links to a number of key documents that have been produced in Canada and in several other countries. Similarly the [links page](#) provides list of the national and international groups and agencies concerned with patient safety. While still an evolving resource, it is worthwhile to check this page from time to time to see if new information has been posted.

<http://www.cpsi-icsp.ca/>

Book of the Month

Measuring Patient Safety

Measuring Patient Safety

by Robin Purdy Newhouse
Sudbury, Mass: Jones and Bartlett Publishers; 2005.
ISBN 0-7637-2841-1

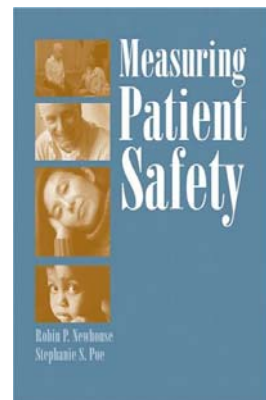
Copies of this book are available for loan at:

[Grace General Hospital Library](#)
[Concordia Hospital Library](#)

Contact your nearest [Health Sciences Library](#) if you would like to borrow this book

You may also purchase a copy by contacting the [University of Manitoba Health Sciences Bookstore](#)

Based on a series of presentations at John's Hopkins hospital, this book examines each of the steps necessary to identify, create, develop, implement, and disseminate the results of measurable patient safety projects. Sample forms, available resources, and four case studies focusing on mechanical ventilation, medication reconciliation, chemotherapy safety, and preventing patient aggression respectively are included.



E-Book of the Month
Best Practices in Patient Safety: Module Handbook
University of Washington, May 2004

Posted by Tania Gottschalk, WRHA Librarian

Learning to understand the issue surrounding patient safety is a challenge. This resource developed by the University of Washington's Center for Health Sciences is an excellent and freely accessible document. Designed as a modularized workshop, it covers the following: the principles and tenets of patient safety; taking an educational and leadership role in patient safety ; assessing the culture of practice in your institution; and writing an action plan for implementing and evaluating interprofessional educational experience around patient safety. Each module contains an extensive list of the core books and papers for further reading.

http://interprofessional.washington.edu/flipeps/Documents%20for%20the%20FLI%20EPPS%20Website/Handbook_Jan_05.pdf



Recommended for Patients
Canadian Pharmacists Association Website

Ryan Sidorchuk
WRHA Patient Safety Officer

While we Canadians consistently rank healthcare as the most important priority to which our tax dollars should be spent, the Patient Safety movement, and resources towards such initiatives, continue to lag behind such countries as the U.S., Australia, and the U.K. There are, however, many encouraging signs that, as a nation, and especially as a Region here in the city of Winnipeg, we are beginning to move towards elevating Patient Safety as a significant goal of our strategic planning and resource allocation for improving the overall quality and safety of our healthcare system.

For this issue, I recommend the Consumer/Patients page of the [Canadian Pharmacists Association](http://www.pharmacists.ca). Pharmacists are a group of professionals who I consider to be essential partners with physicians, nurses, allied health professionals, and of course, we the patients, in creating effectively communicating partnerships to keep patients safe while maximizing the efficacy of current medical interventions to improve the health and overall livelihood of the citizens of Canada. On this website, you will find links to all sorts of specific health areas such as managing arthritis to keeping your skin healthy during the long, cold, dry Manitoba winters. In addition, there are links to other organizational websites in Canada committed to improving the health of all Canadians, while doing so in a safe manner. I welcome your comments, suggestions, and questions regarding the Patient Safety movement here in Winnipeg and across the country. I can be reached at 926-7164, or email me at rsidorchuk@wrha.mb.ca.

Take care, and be safe!

http://www.pharmacists.ca/content/consumer_patient/index.cfm

Featured Article

Patient Safety – how much is enough?

Warburton, R.N., Health Policy, Vol. 71, 2005, page 223-232

Review by Rob Robson, Director of Patient Safety, WRHA

"*Patient Safety – how much is enough?*" is a clearly written article that is essential reading for all those interested in promoting patient safety in the era of fiscal restraint and budget limitations.

The article asks the question "How do we prioritize our patient safety interventions?" It makes us appreciate that doing one thing often means we are unable to do another.

The fundamental message is that we should develop tools to perform appropriate economic analysis. The solution proposed (EEL – economic evaluation loop) is a good start.

The author indicates that economic analysis involves calculating both the cost of the intervention as well as the savings that result from adverse events prevented by a given initiative. As well, both the frequency and severity of risk associated with a given adverse event must be factored into the analysis.

This results in the concept of the "total cost to society" and indicates that there are limits to what can be done – we can make our healthcare system *safer* but we will never have the resources or ability to make it completely safe.

The author questions the use of evidence-based evaluations to determine which patient safety interventions should be recommended. Such an approach excludes many of the human factors and systems changes that are felt to be key to long term success in patient safety programs.

"Soft" interventions such as promoting safety culture, improving reporting systems, improving team communications, etc. are more difficult to evaluate than "hard" technological matters involving drugs and devices. Since there is little evidence at this time to support such practices, they are not recommended nor are they deemed valid for further research, using the evidence-based paradigm.

This sets up a delightful "Catch-22". The author points out "rigorous research will never be warranted, until sufficient rigorous research has been performed to make a case for it!"

Several interesting examples are presented; using QALY's to assist in the economic analysis. I would strongly recommend this article to colleagues interested in developing sustainable patient safety programs in their region.

To access the full-text of article click on the UM Links button.



You will require your Library Card Number and PIN.

[Abstract information](#) is also available for this article

Journal Articles for December 2004 - February 2005

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

The following is a select bibliography of articles appeared in Pubmed/Medline from December 2004 to February 2005 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



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

1: Acad Emerg Med. 2004 Dec;11(12):1341-5.



Profiles in patient safety: authority gradients in medical error.

Cosby KS, Croskerry P.

Department of Emergency Medicine, The John H. Stroger, Jr., Hospital of Cook County/Rush Medical College, 1900 West Polk Street, Chicago, IL 60612, USA.
kcosby@ccbh.org

The term "authority gradient" was first defined in aviation when it was noted that pilots and copilots may not communicate effectively in stressful situations if there is a significant difference in their experience, perceived expertise, or authority. A number of unintentional aviation, aerospace, and industrial incidents have been attributed, in part, to authority gradients. The concept of authority gradient was introduced to medicine in the Institute of Medicine report *To Err Is Human*, yet little has been written or acknowledged in the medical literature regarding its role in medical error. The practice of medicine and medical training programs are highly organized, hierarchical structures that depend on supervision by authority figures. The concept that authority gradients might contribute to medical error is largely unrecognized. This article presents one case and a series of examples to detail how authority gradients can contribute to medical error, and describes methods used in other disciplines to avoid their potentially negative impact.

Publication Types:

- Case Reports
- Review
- Review, Tutorial

PMID: [15576526](#) [PubMed - indexed for MEDLINE]

2: Am Heart Hosp J. 2004 Winter;2(1):42-8.

This item is not available online through the Library. [Request a print version through Loansome Doc](#)

The science of Six Sigma in hospitals.

Guinane CS, Davis NH.

Division of Applied Business Science and Education, MedCath, Inc., Brentwood, TN, USA. carole.guinane@medcath.com

Six Sigma applied to hospital processes and services can lead to breakthrough improvements, near-perfect outcomes, and zero defects. It is wise to consider this aspect of quality science as part of an overall Total Quality Management program. Senior leadership support and involvement is critical to the success of this strategy.

Publication Types:

Review
Review, Tutorial

PMID: [15604839](#) [PubMed - indexed for MEDLINE]

3: Ann Intern Med. 2005 Jan 18;142(2):115-20.



Improving patient care. The cognitive psychology of missed diagnoses.

Redelmeier DA.

University of Toronto, Institute for Clinical Evaluative Sciences, and Sunnybrook and Women's College Health Sciences Centre, Toronto, Ontario, Canada. dar@ices.on.ca

Cognitive psychology is the science that examines how people reason, formulate judgments, and make decisions. This case involves a patient given a diagnosis of pharyngitis, whose ultimate diagnosis of osteomyelitis was missed through a series of cognitive shortcuts. These errors include the availability heuristic (in which people judge likelihood by how easily examples spring to mind), the anchoring heuristic (in which people stick with initial impressions), framing effects (in which people make different decisions depending on how information is presented), blind obedience (in which people stop thinking when confronted with authority), and premature closure (in which several alternatives are not pursued). Rather than trying to completely eliminate cognitive shortcuts (which often serve clinicians well), becoming aware of common errors might lead to sustained improvement in patient care.

Publication Types:

Case Reports

PMID: [15657159](#) [PubMed - indexed for MEDLINE]

4: BMJ. 2005 Jan 22;330(7484):182. Epub 2004 Nov 25.



How doctors discuss major interventions with high risk patients: an observational study.

Corke CF, Stow PJ, Green DT, Agar JW, Henry MJ.

Intensive Care Unit, Geelong Hospital, Barwon Health, Geelong, Victoria, Australia 3220. charliec@barwonhealth.org.au

OBJECTIVE: To investigate the difficulties doctors face in discussing treatment options with patients with acute, life threatening illness and major comorbidities. **DESIGN:** Observational study of doctor-patient interviews based on a standardised clinical scenario involving high risk surgery in a hypothetical patient (played by an actor) with serious comorbidities. **PARTICIPANTS:** 30 trainee doctors 3-5 years after graduation. **MAIN OUTCOME MEASURES:** Adequacy of coverage of various aspects was scored from 3 (good) to 0 (not discussed). **RESULTS:** The medical situation was considered to be well described (median score 2.7 (interquartile range 2.1-3.0)), whereas the patient's functional status, values, and fears were poorly or minimally addressed (scores 0.5 (0.0-1.0), 0.5 (0.0-1.0), and 0.0 (0.0-1.5), respectively; all $P < 0.001$ v score for describing the medical situation). Twenty nine of the doctors indicated that they wished to include the patient's family in the discussion, but none identified a preferred surrogate decision maker. Six doctors suggested that the patient alone should speak with his family to reach a decision without the doctor being present. The doctors were reluctant to give advice, despite it being directly requested: two doctors stated that a doctor could not give advice, while 17 simply restated the medical risks, without advocating any particular course. Of the 11 who did offer advice, eight advocated intervention. **CONCLUSIONS:** Doctors focused on technical medical issues and placed much less emphasis on patient issues such as functional status, values, wishes, and fears. This limits doctors' ability to offer suitable advice about treatment options. Doctors need to improve their communication skills in this difficult but common clinical situation.

PMID: [15564228](#) [PubMed - indexed for MEDLINE]

5: Bull World Health Organ. 2004 Dec;82(12):892. Epub 2005 Jan 05.



Patient safety: a global priority.

Donaldson L, Philip P.

Publication Types:
Editorial

PMID: [15654400](#) [PubMed - in process]

6: Bull World Health Organ. 2004 Nov;82(11):889. Epub 2004 Dec 14.



WHO launches global patient safety campaign.

[No authors listed]

Publication Types:
News

PMID: [15640931](#) [PubMed - in process]

7: Clin Leadersh Manag Rev. 2004 Nov-Dec;18(6):378-80.

This item is not available online through the Library. [Request a print version through Loansome Doc](#)

The key to patient safety-quality communication.

[No authors listed]

The outcome for the patient in the study could have become a serious issue for this facility. The patient was still in the facility and was able to provide another sample. As it turned out, the patient had not taken any medication that could have interfered with the culture and sensitivity testing. As we have discussed, patient safety issues are part of the laboratorian's and health-care professional's daily routine. Errors and incidents can be reduced by having clear and simple communication between patients and staff. In addition, open, honest, and direct quality communication without judgment or blame between each person involved in the patient service system is the key to guaranteeing patient safety issues won't occur in your patient practice.

Publication Types:
Case Reports

PMID: [15597565](#) [PubMed - indexed for MEDLINE]

8: Clin Leadersh Manag Rev. 2004 Nov-Dec;18(6):328-34.

This item is not available online through the Library. [Request a print version through Loansome Doc](#)

Reducing medical errors through barcoding at the point of care.

Nichols JH, Bartholomew C, Brunton M, Cintron C, Elliott S, McGirr J, Morsi D, Scott S, Seipel J, Sinha D.

Tufts University School of Medicine, USA.

Medical errors are a major concern in health care today. Errors in point-of-care testing (POCT) are particularly problematic because the test is conducted by clinical operators at the site of patient care and immediate medical action is taken on the results prior to review by the laboratory. The Performance Improvement Program at Baystate Health System, Springfield, Massachusetts, noted a number of identification errors occurring with glucose and blood gas POCT devices. Incorrect patient account numbers that were attached to POCT results prevented the results from being transmitted to the patient's medical record and appropriately billed. In the worst case, they could lead to results being transferred to the wrong patient's chart and inappropriate medical treatment. Our first action was to lock-out operators who repeatedly made identification errors (3-Strike Rule), requiring operators to be counseled and retrained after their third error. The 3-Strike Rule significantly decreased our glucose meter errors ($p = 0.014$) but did not have an impact on the rate of our blood gas errors ($p = 0.378$). Neither device approached our ultimate goal of zero tolerance. A Failure Mode and Effects Analysis (FMEA) was conducted to determine the various processes that could lead to an identification error. A primary source of system failure was the manual entry of 14 digits for each test, five numbers for operator and nine numbers for patient account identification. Patient barcoding was implemented to automate the data entry process, and after an initial familiarization period, resulted in significant improvements in error rates for both the glucose ($p = 0.0007$) and blood gas devices ($p = 0.048$). Despite the improvements, error rates with barcoding still did not achieve zero errors. Operators continued to utilize manual data entry when the barcode scan was unsuccessful or unavailable, and some patients were found to have incorrect patient account numbers due to hospital transfer, multiple wristbands on a single patient, and selection of expired account numbers from previous hospitalizations when printing the barcoded wristbands. Barcoding can thus

improve the incidence of identification errors, but hospitals need to take additional steps to ensure successful barcode scanning and to verify that patient wristbands contain correct information. Implementation of patient barcoding was successful in significantly reducing identification errors with POCT, improving patient care, and enhancing interdisciplinary communication.

PMID: [15597554](#) [PubMed - indexed for MEDLINE]

9: Clin Leadersh Manag Rev. 2004 Nov-Dec;18(6):316-21.

This item is not available online through the Library. [Request a print version through Loansome Doc](#)

The cost of patient safety.

Hoeltge GA.

Department of Clinical Pathology, The Cleveland Clinic Foundation, Cleveland, Ohio 44195, USA.

To ensure patient safety, it costs an organization time, money, and commitment. The clinical laboratory may promote patient safety or may contribute to medical error. Laboratory errors put a patient at risk at any point along the path of workflow. The cost of an initiative in patient safety may be considered from four perspectives: compliance, feasibility, present risk, and financial. Three examples are offered to illustrate the use of these approaches. Most patient-safety strategies in laboratory medicine are not expensive. They are affordable with a structured outlay of existing resources and a willingness to follow defined work practices without exception. More extensive projects, especially those that cross jurisdictional lines within an organization, do require comprehensive project management. Management of both kinds of initiatives is addressed by NCCLS' documents on quality practice.

PMID: [15597552](#) [PubMed - indexed for MEDLINE]

10: Clin Leadersh Manag Rev. 2004 Nov-Dec;18(6):311-5.

This item is not available online through the Library. [Request a print version through Loansome Doc](#)

Patient safety: getting there from here--quality management is the best patient safety program.

Berte LM.

Historical management activities such as quality control (QC) and quality assurance (QA) have not prevented medical errors or patient safety problems related to the laboratory. Reports of laboratory quality assurance activities provide evidence of the need for significant improvement in the total laboratory path of workflow when measured on the Six Sigma scale. The old paradigm has been: people are the cause of medical errors and the solution is to name, blame, and shame them. This bias is being replaced by a new awareness that system failures cause medical errors and that a systematic process management approach to improving patient safety can prevent these hazards.

PMID: [15597551](#) [PubMed - indexed for MEDLINE]

11: Crit Care Clin. 2005 Jan;21(1):21-30, vii.



Failure mode and effects analysis application to critical care medicine.

Duwe B, Fuchs BD, Hansen-Flaschen J.

Department of Medicine, Hospital of the University of Pennsylvania, 873 Maloney Building, 3400 Spruce Street, Philadelphia, PA 19104, USA.

In July 2001, the United States Joint Commission on Accreditation of Health care Organizations adopted a new leadership standard that requires department heads in health care organizations to perform at least one Failure Mode and Effects Analysis (FMEA) every year. This proactive approach to error prevention has proven to be highly effective in other industries, notably aerospace, but remains untested in acute care hospitals. For several reasons, the intensive care unit (ICU) potentially is an attractive setting for early adoption of FMEA; however, successful implementation of FMEA in ICUs is likely to require strong, effective leadership and a sustained commitment to prevent errors that may have occurred rarely or never before in the local setting. This article describes FMEA in relation to critical care medicine and reviews some of the attractive features together with several potential pitfalls that are associated with this approach to error prevention in ICUs.

Publication Types:

Review

PMID: [15579350](#) [PubMed - indexed for MEDLINE]

12: Crit Care Clin. 2005 Jan;21(1):1-19, vii.



Defining and measuring patient safety.

Pronovost PJ, Thompson DA, Holzmueller CG, Lubomski LH, Morlock LL.

Department of Anesthesiology & Critical Care Medicine, Surgery and Health Policy & Management, The Johns Hopkins University School of Medicine, 901 South Bond Street, Suite 318, Baltimore, MD 21231, USA. ppronovo@jhmi.edu

Despite the growing demand for improved safety in health care, debate remains regarding the magnitude of the problem and the degree to which harm is preventable. To a great extent, this debate stems from variation in the definition and methods for measuring safety, its "shadow" error, and the degree of preventability. This article reviews the definition of safety and error, discusses approaches to measuring safety, and provides a framework for investigating incidents that unveils how the systems under which care is delivered may contribute to adverse incidents.

Publication Types:

Case Reports

Review

PMID: [15579349](#) [PubMed - indexed for MEDLINE]

13: Health Care Manag (Frederick). 2004 Oct-Dec;23(4):329-33.

Reducing medical errors through better documentation.



Edwards M, Moczygemba J.

Health Information Management Program, Texas State University-San Marcos, USA.

Preventable medical errors occur with alarming frequency in US hospitals. Questions to address include what is a medical error, what errors occur most often, and what solutions can health information technologies offer with better documentation. Preventable injuries caused by mismanagement of treatment happen in all areas of care. Some result from human fallibility and some from system failures. Most errors stem from a combination of the two. Examples of combination errors include wrong-site surgeries, scrambled laboratory results, medication mishaps, misidentification of patients, and equipment failures. Unavailable patient information and illegible handwriting lead to diagnosing and ordering errors. Recent technology offers viable solutions to many of these medical errors. Computer-based medical records, integration with the pharmacy, decision support software, Computerized Physician Order Entry Systems, and bar coding all offer ways to avoid tragic treatment outcomes. Persuading and training hospital staff to use the technology poses a problem, as does budgeting for the new equipment. However, the technology would prove its worth in time. The Institute of Medicine and coalition groups such as Leapfrog Group have recognized the problem that permeates the health care industry, manifests in many ways, and requires the many solutions that information technology offer.

Publication Types:

Review

Review, Tutorial

PMID: [15638340](#) [PubMed - indexed for MEDLINE]

14: Health Devices. 2004 Dec;33(12):430-5.

This item is not available online through the Library. [Request a print version through Loansome Doc](#)

JCAHO's National Patient Safety Goal for infusion pump free-flow protection: ECRI's assessment of the protection offered by general-purpose, PCA, and ambulatory pumps.

[No authors listed]

One of the U.S. National Patient Safety Goals promulgated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is to "improve the safety of using infusion pumps" by ensuring that pumps are protected against free-flow. In this Guidance Article, we provide ECRI's updated guidance for achieving this goal. Free-flow refers to the uncontrolled delivery of an infusion to a patient when a controlled or metered delivery was intended. For more than 20 years--in numerous articles presented in Health Devices and its sister publication Health Devices Alerts--ECRI has offered guidance to help hospitals avoid the dangers of free-flow. The current article is the latest in a series of reports addressing JCAHO's goal; it describes the dangers, provides updated guidance for interpreting JCAHO's goal, and categorizes the available pump models according to the level of free-flow protection offered. This report supersedes Health Devices Alerts Special Reports S0008 (August 23, 2002), S0018 (March 21, 2003), and S0029 (November 14, 2003).

PMID: [15675739](#) [PubMed - in process]

15: Health Policy. 2005 Feb;71(2):223-32.



Patient safety - how much is enough?

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Awareness of errors in health care has skyrocketed in recent years, and huge resources have been mobilised to measure and reduce the harm. This is a good thing, and long overdue. But current improvement recommendations have ignored the costs of prevention and have prioritized improvements by the rigour with which they have been studied. The current proliferation of safety goals and required or recommended safe practices threatens to overwhelm the capacity of hospitals to safely implement change, yet the cost-effectiveness of most proposed improvements remains unknown. Unless we collect information on cost-effectiveness, and use it to prioritize both improvement initiatives and new safety research, society will not gain the maximum return (in terms of safety) for whatever resources are put into error reduction. This would be a bad thing. Hospitals are complex systems, largely dependent on human performance, so improving hospital safety is not simple. Every change must be implemented with an understanding of human factors engineering and safety science, and even good changes can create unexpected new hazards. Increased safety precautions reduce preventable adverse events but generally impose both direct costs (to implement the safety precautions) and hidden costs (in the form of delays, new errors, or lost opportunities elsewhere). Perfect safety is not always possible and near-perfect-safety may impose unacceptably high costs. The goal of minimizing the total cost of both accidents and accident-prevention requires information on both costs and effects of specific safety improvements. Such information is also needed to prioritize suggested safety improvements, when all cannot be implemented immediately. This evidence can best be produced using the economic evaluation loop, an iterative process involving routine, periodic, assessment of costs and effects, and targeted original research where initial estimates reveal uncertainty in key values.

PMID: [15607384](#) [PubMed - in process]

16: Home Healthc Nurse. 2005 Jan;23(1):29-36; quiz 37-8.



Strategies to improve the patient safety outcome indicator: preventing or reducing falls.

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In response to our agency exceeding the national benchmark rates for "Emergent Care for Injury Caused by Fall or Accident at Home," Alliance Visiting Nurse Association & Hospice developed a program to assess, prevent, or decrease the risk of falls in our mostly elderly and/or chronically ill population. Using the

Tinetti Assessment score as the starting point, we developed a program of assessment, education, and follow-up that significantly reduced the number of patients requiring care for fall-related injuries.

PMID: [15632504](#) [PubMed - in process]

17: J AHIMA. 2005 Jan;76(1):56A-56G.

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The HIM role in patient safety and quality of care.

Hjort B.

IOM reminds us that technology is only part of the initiative to make the nation's health system a safer one. Another significant factor is the human element. Change will occur when the culture and commitment to patient safety shift. According to IOM, change will "require a culture of safety and the active participation of all health care professionals, organizations and patients themselves." It is up to all of us to create a trusting, safe environment to look at the truth around patient safety and ensure open, blameless dealing with findings. We are letting go of a culture that no longer works. The efforts we make at a local level will play into safety in the larger environment. It is a journey--we will make patient care safer over time by taking action on what we learn from accurate and complete aggregate data. And it is a balance, with patient safety getting the greatest weight in commitments and difficult resource decisions. Patient safety will come from universal cooperation to uncover the truth--letting go of blame and finding resolution to problems, known and not yet uncovered.

PMID: [15675771](#) [PubMed - in process]

18: J Healthc Qual. 2004 Nov-Dec;26(6):39-44.

This item is not available online through the Library. [Request a print version through Loansome Doc](#)

Adoption factors associated with patient safety-related information technology.

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Information technology (IT) that positively affects both quality of care and patient safety currently exists but is not used widely. This study identifies organizational and external factors associated with the adoption of patient safety-related IT (PSIT) in acute care hospitals in Florida. Factors found to be positively correlated with PSIT use included physicians' active involvement in clinical IT planning, the placement of strategic importance on IT by the organization, CIO involvement in patient safety planning, and the perception of an adequate selection of products from vendors. Other factors and implications are discussed as well.

PMID: [15603094](#) [PubMed - in process]

19: J Healthc Qual. 2004 Nov-Dec;26(6):5-11.

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Using bar-code point-of-care technology for patient safety.

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Patient safety, in particular, medication safety, has become a major issue for healthcare providers, payers, and patients. Medication errors occur at an alarming rate, and the majority of non-intercepted medication errors originate at the point of care when a nurse mistakenly administers a medication. The 1999 Institute of Medicine report called for increasing the use of information technology to reduce medication errors. Realizing a 59% to 70% decrease in medication administration errors on individual nursing units, this hospital demonstrates how bar code point-of-care medication administration systems successfully track, reduce, and prevent bedside medication errors while having a positive effect on nursing satisfaction.

PMID: [15603088](#) [PubMed - in process]

20: J Natl Med Assoc. 2004 Dec;96(12):1558-64.

This item is not available online through the Library. [Request a print version through Loansome Doc](#)

Strategies to reduce medication errors in ambulatory practice.

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Medication errors generally refer to mistakes made in the processes of ordering, transcribing, dispensing, administering or monitoring of pharmaceutical agents used in clinical practice. The Institute of Medicine report, To Err Is Human: Building a Safer Health System, has helped raise public awareness surrounding the issue of patient safety within our hospitals. A number of legislative and regulatory steps have resulted in hospital authorities putting in place various systems to allow for error reporting and prevention. Medication errors are being closely scrutinized as part of these hospital-based efforts. Most Americans, however, receive their healthcare in the ambulatory primary care setting. Primary care physicians are involved in the writing of several million prescriptions annually. The steps underway in our hospitals to reduce medication errors should occur concurrently with steps to increase awareness of this problem in the out-patient setting. This article provides an overview of strategies that can be adopted by primary care physicians to decrease medication errors in ambulatory practice.

PMID: [15622685](#) [PubMed - indexed for MEDLINE]

21: J Nurs Adm. 2005 Feb;35(2):81-5.



Active Error Management: Use of a Web-based Reporting System to Support Patient Safety Initiatives.

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The authors examine the implementation of a Web-based reporting system in a rural academic medical center to support patient safety initiatives. Discussion centers on how an online support system can support active error management and help identify latent errors. This strategy can help administrators in their efforts to develop and institute improvements to prevent subsequent errors. By making changes in clinical process and refinement in policies and procedures, administrators can uncover trends and patterns across settings.

PMID: [15714100](#) [PubMed - in process]

22: J Nurs Scholarsh. 2004;36(4):366-70.



Lucian Leape on patient safety in U.S. hospitals. Interview by Peter I Buerhaus.

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PURPOSE: To describe and discuss the status of patient safety in U.S. hospitals.
METHODS: Personal interview. This report is part of a series of discussions with a leading expert on patient safety.
FINDINGS AND CONCLUSIONS: Some improvements have been made in the past 10 years. But changes have not been adequate. Continuing barriers include the punitive environment in hospitals, physicians' denial of the scope of the problem, lack of national leadership, and lack of systems thinking.

Publication Types:
Interview

PMID: [15636418](#) [PubMed - indexed for MEDLINE]

23: J Nurses Staff Dev. 2004 Nov-Dec;20(6):247-52; quiz 253-4.



Patient safety simulation: learning about safety never seemed more fun.

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While other industries have effectively used simulation as an educational strategy to improve safety and performance, nurse educators have not yet embraced this as an educational tool for safety initiatives. This article examines the benefit of using simulation exercises as an adjunct to didactic teaching and describes how one hospital's nurse educators adapted simulation methodology to educate the nurses on the complexity of safe medication administration and the importance of critical thinking in daily practice.

PMID: [15586086](#) [PubMed - in process]

24: J Surg Oncol. 2004 Dec 1;88(3):130-42.



The psychology of error in relation to medical practice.

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There is a broad effort underway to reduce the frequency of medical error. This effort will be facilitated by understanding the causes of human error and the methods that serve to reduce it in settings comparable to medical practice. To serve this end, this article is a review of cognitive psychology as it relates to the origins of human error and an application of that material to issues that arise in medical practice.

Publication Types:

Review

Review, Tutorial

PMID: [15562465](#) [PubMed - indexed for MEDLINE]

25: J Surg Oncol. 2004 Dec 1;88(3):115-21.



A systems approach to error prevention in medicine.

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Minimization of medical errors is at the core of all clinical medical practices. The first tenet of care is to do no harm. The enormous complexity of modern medical care has made error detection and management extremely difficult. Traditional deterministic methods of solving the "error issue" cannot cope with the huge number of potential errors that are possible. Systems thinking and approach to error reduction provides a different avenue for tackling this challenging dilemma. The intent of this article is to introduce a systems view of medical errors and to explain how it can provide new insights about dealing with massively complex organizations such as the healthcare system. Important features include an understanding of system relationships, sources of error, human components, optimization versus perfection in systems and the interrelationships between human and system processes.

PMID: [15562464](#) [PubMed - indexed for MEDLINE]

26: J Surg Oncol. 2004 Dec 1;88(3):153-60.



Errors in laparoscopic surgery.

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Laparoscopic surgery is the most significant advancement in the field of surgery over the past 15 years. This minimal access approach has been widely embraced and adopted to many common operations. Demonstrated benefits include decreased post-operative pain, shorter lengths of in-patient hospitalization, increased patient acceptance, and a more rapid return to gainful employment. With its ever-growing popularity, it has become fertile ground for civil litigation, ranking along with birth injuries and failure to diagnose cancer. A brief synopsis of the history of its evolution is presented along with general and specific comments concerning potential errors as they relate to specific common operations which are commonly done utilizing this technique.

PMID: [15562457](#) [PubMed - indexed for MEDLINE]

27: J Surg Oncol. 2004 Dec 1;88(3):143-52.



Nature and prevention of errors in anesthesiology.

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Publication Types:

Review

Review, Tutorial

PMID: [15562456](#) [PubMed - indexed for MEDLINE]

28: Jt Comm J Qual Saf. 2005 Jan;31(1):43-6, 1.

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Introducing the National Patient Safety Goals Department: sharing programs of
excellence from individual organizations.

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This new department will provide innovative ideas for meeting the Joint
Commission's National Patient Safety Goals as implemented in various health care
settings.

PMID: [15691209](#) [PubMed - in process]

29: Jt Comm J Qual Saf. 2004 Dec;30(12):671-5.

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Using a distance-learning program to educate staff on the Joint Commission National Patient Safety.

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BACKGROUND: A motion picture expert group (MPEG) distance-learning program was created in 2003 at Brooke Army Medical Center (BAMC; San Antonio, Texas) on the Joint Commission National Patient Safety Goals. The 34 2-4-minute scripted video productions addressed the 7 goals and 13 recommendations for 2003 and 2004. For each goal, three MPEGs respectively describe sentinel events pertaining to that goal, root causes and risk-reduction strategies, and Army Medical Department and BAMC recommendations and policies. **CREATING THE PROGRAM:** The program entailed creating the scripts, narrating video, editing the tapes, and compressing the videos into the MPEG format. **LAUNCHING THE PROGRAM:** A featured MPEG was emailed weekly to over 3,000 hospital staff with a scripted endorsement and photograph of a key BAMC leader and a link to the MPEG. In addition, the MPEGs were placed on the hospital's intranet site. **DISCUSSION:** As the National Patient Safety Goal MPEG distance-learning program gained more recognition, different branches of the Army used the program to educate their staff on the Joint Commission National Patient Safety Goals. The next step is to update the distance-learning program with new MPEGs that will provide guidance on the current National Patient Safety Goals.

PMID: [15646099](#) [PubMed - in process]

30: Jt Comm J Qual Saf. 2004 Dec;30(12):665-70.

This item is not available online through the Library. [Request a print version through Loansome Doc](#)

The faces of errors: a case-based approach to educating providers, policymakers, and the public about patient safety.

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BACKGROUND: When patient safety became a subject of policy and research, the question was how to engage clinicians-perhaps they would respond more to case studies of dramatic adverse events than to statistics. **THE CHRONOLOGY:** In 2001, we launched a case-based series in the Annals of Medicine which focused on diagnosing what ailed the system rather than the patient. For example, in "The Wrong Patient," 17 discrete errors resulted in a woman's receiving a cardiac electrophysiology procedure intended for another patient with a similar last name. The Web-based Agency for Healthcare Research and Quality (AHRQ) WebM&M was then developed as a forum that was part-reporting system and part-journal. Finally, we then applied this approach to writing a book for a popular audience. **LESSONS LEARNED:** We found that clinicians were willing to submit cases, assuming that anonymity was protected. Cases of errors that led to harm were generally more compelling than near misses. As in real life, many cases lacked complete information, but sufficient information was usually available to highlight the key lessons. All three vehicles generated substantial readerships and critical praise, indicating that there is a "market" for case-based education about patient safety. **CONCLUSION:** Presenting de-identified cases of medical mistakes

in a variety of public venues is an effective way to educate patients and providers about safety.

PMID: [15646098](#) [PubMed - in process]

31: Nurs Econ. 2004 Sep-Oct;22(5):266-72, 279.



The effect of workforce issues on patient safety.

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The workforce of any health care organization is vital to its continued survival, but a highly competent and committed workforce is vital to its success. The evidence is clear: employees influence not only the financial performance of the organization, but also the safety and quality of the clinical care provided to patients. Health care organizations must understand these important linkages and have in place corporate strategies to manage workforce issues with a systems focus that ensures excellent leadership and operational processes, a healthy culture, and optimum patient outcomes. New levels of knowledge, resources, and implementation are needed to move health care in the United States to the next level of quality performance. Staff satisfaction and retention should be at the heart of the clinical improvement strategies. Such an approach will allow organizations to cope and thrive in an environment of workforce shortages and increasing consumer demand for quality. To quote Robert Waller, MD, of the Mayo Clinic, "The goal is the best care for every patient, every day. Our patients deserve nothing less.

Publication Types:

Review

Review, Tutorial

PMID: [15586483](#) [PubMed - indexed for MEDLINE]

32: Nurs Ethics. 2004 Nov;11(6):568-76.



Always having to say you're sorry: an ethical response to making mistakes in professional practice.

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Efforts to decrease errors in health care are directed at prevention rather than at managing a situation when a mistake has occurred. Consequently, nurses and other health care providers may not know how to respond properly and may lack sufficient support to make a healthy recovery from the mental anguish and emotional suffering that often accompany making mistakes. This article explores the conceptualization of mistakes and the ethical response to making a mistake. There are three parts to an ethical response to error: disclosure, apology and amends. Honesty and humility are discussed as important virtues that facilitate

coping and personal growth for the health care provider who is involved in mistakes. In conclusion, a healthy view of nursing practice and mistake making is one that prevents error but, when prevention is not possible, accepts fallibility as part of the human condition and achieves the best possible outcome for all.

Publication Types:

Review

Review, Tutorial

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33: Qual Saf Health Care. 2004 Dec;13 Suppl 2:ii52-6.



Implications for practice: challenges for healthcare leaders in fostering patient safety.

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Although various government and regulatory organisations have identified practices that may enhance patient safety, there is little empirical or theoretical research to inform the decisions of healthcare leaders seeking to create patient safety programmes within their hospitals and clinics. In order to understand the challenges facing hospital and health system executives, we describe the experience of the Executive Session on Patient Safety. The executives identified five major problems in leading patient safety: 1) how should executives structure their organisations to deliver safe care? 2) how should executives monitor and measure their organisation's safety performance? 3) how should executives spread and sustain patient safety innovation? 4) how should executives manage the relationship with the external environment? and 5) how should executives manage their own behaviour in order to lead for safety? The organisational infrastructure needed for safer care is being developed by practitioners out in the field as a matter of necessity. Strengthening the scientific basis for organisational leadership in patient safety is a vital but neglected area of study.

PMID: [15576693](#) [PubMed - indexed for MEDLINE]

34: Qual Saf Health Care. 2004 Dec;13 Suppl 2:ii34-8.



Integrating patient safety into the clinical microsystem.

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Healthcare institutions continue to face challenges in providing safe patient care in increasingly complex organisational and regulatory environments while striving to maintain financial viability. The clinical microsystem provides a

conceptual and practical framework for approaching organisational learning and delivery of care. Tensions exist between the conceptual theory and the daily practical applications of providing safe and effective care within healthcare systems. Healthcare organisations are often complex, disorganised, and opaque systems to their users and their patients. This disorganisation may lead to patient discomfort and harm as well as much waste. Healthcare organisations are in some sense conglomerates of smaller systems, not coherent monolithic organisations. The microsystem unit allows organisational leaders to embed quality and safety into a microsystem's developmental journey. Leaders can set the stage for making safety a priority for the organisation while allowing individual microsystems to create innovative strategies for improvement.

PMID: [15576690](#) [PubMed - indexed for MEDLINE]

35: Qual Saf Health Care. 2004 Dec;13 Suppl 2:ii3-9.



Learning from failure in health care: frequent opportunities, pervasive barriers.

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The notion that hospitals and medical practices should learn from failures, both their own and others', has obvious appeal. Yet, healthcare organisations that systematically and effectively learn from the failures that occur in the care delivery process, especially from small mistakes and problems rather than from consequential adverse events, are rare. This article explores pervasive barriers embedded in healthcare's organisational systems that make shared or organisational learning from failure difficult and then recommends strategies for overcoming these barriers to learning from failure, emphasising the critical role of leadership. Firstly, leaders must create a compelling vision that motivates and communicates urgency for change; secondly, leaders must work to create an environment of psychological safety that fosters open reporting, active questioning, and frequent sharing of insights and concerns; and thirdly, case study research on one hospital's organisational learning initiative suggests that leaders can empower and support team learning throughout their organisations as a way of identifying, analysing, and removing hazards that threaten patient safety.

PMID: [15576689](#) [PubMed - indexed for MEDLINE]

36: Qual Saf Health Care. 2004 Dec;13 Suppl 2:ii28-33.



Beyond the organisational accident: the need for "error wisdom" on the frontline.

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Complex, well defended, high technology systems are subject to rare but usually

catastrophic organisational accidents in which a variety of contributing factors combine to breach the many barriers and safeguards. To the extent that healthcare institutions share these properties, they too are subject to organisational accidents. A detailed case study of such an accident is described. However, it is important to recognise that health care possesses a number of characteristics that set it apart from other hazardous domains. These include the diversity of activity and equipment, a high degree of uncertainty, the vulnerability of patients, and a one to one or few to one mode of delivery. Those in direct contact with patients, particularly nurses and junior doctors, often have little opportunity to reform the system's defences. It is argued that some organisational accident sequences could be thwarted at the last minute if those on the frontline had acquired some degree of error wisdom. Some mental skills are outlined that could alert junior doctors and nurses to situations likely to promote damaging errors.

PMID: [15576688](#) [PubMed - indexed for MEDLINE]

37: Rehabil Nurs. 2004 Nov-Dec;29(6):221-6.

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Effects of wheelchair posture on patient safety.

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Wheelchairs originally were designed to transport people from one place to another quickly and easily. They have evolved to rank among the most important therapeutic devices used in rehabilitation. Currently, an estimated 2.2 million people who use wheelchairs generally are living longer and moving about more. However, the increased use of wheelchairs has been accompanied by many types of adverse events and repetitive stress injuries. Wheelchair prescription, posture, training, and maintenance are critical components of safety in this population, and may be enhanced through increased awareness and education. Since nurses and nursing staff are most often involved directly with wheelchair users (particularly in long-term-care settings), providing specialized programs for adaptive wheelchair fitting allows for a proactive approach to seating problems.

Publication Types:

Review

Review, Tutorial

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