

Patient Safety Picks

April / May 2005
Volume 1, Issue 3



Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

Website of the Month

[AHRQ "Classics" on Patient Safety](#)

E-Book of the Month

[Making Health Care Safer: A Critical Analysis of Patient Safety Practices](#)

Recommended For Patients

Ryan Sidorchuk, Patient Safety Officer for the WRHA, recommends [Parents Charting Progress in Vancouver](#)

Featured Book

Rob Robson, Director of Patient Safety for WRHA, reviews [To Do No Harm: Ensuring Patient Safety in Health Care Organizations](#)

Journal Articles on Patient Safety

A [select bibliography](#) of articles appearing in PubMed/Medline for January to April on patient safety

From the Editor

Welcome to the third 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

[Patient Safety Picks](#)

Health Sciences Libraries

Patient Safety Picks Welcome to the third 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...

[Patients First: Safety Always](#)

The Viola Leadlay lecture at the Winnipeg Health Sciences Centre is focused on patient safety

[Canadian Hospitals Join 100,000 Lives Campaign](#)

A number of Canadian hospitals including several in Manitoba have joined the 100,000 lives campaign.

[MIPS Seeks Opinions of Stakeholders](#)

As a newly created organization, MIPS seeks opinion and input from stakeholders.

[MIPS Releases Strategic Directions Document](#)

MIPS releases "Moving Forward: Strategic Directions for 2005 and Beyond"

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.

Comments, questions, or letters to the editor should be addressed to:
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770 Bannatyne Avenue, Winnipeg, MB R3E 0W3
Email: tania_gottschalk@umanitoba.ca or tgottschalk@wrha.mb.ca
Phone: 789-3365 or 926-7093

Regular Contributors: Tania Gottschalk, WRHA Librarian; Rob Robson, WRHA
Director of Patient Safety; and 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

Patients First: Safety Always

Date: May 2, 2005

Location: Theatre A, Basic Medical Sciences Building, 730 William Ave., Winnipeg, MB

Time: 0730-1600 hours

Registration Fee: \$10

Contact: Elaine Molinski at 787-2888

This workshop discusses the origin of the current focus on patient safety and the requirements for applying the ideas for improvement, especially within the hospital sector.

Outline:

730-0800 Registration

0800-0810 Announcements and Introduction

810-940 The Challenges of Implementing a Patient Safety Agenda

940-1000 Break

1000-1200 Nursing, the Eyes for Safety

1200-1300 Lunch

1300-1400 Our Stories

1400-1420 Break

1420-1530 Accountability in Health Care

1530-1545 Closing Remarks

Speakers:

Paul Thomas, the Duff Roblin Professor of Government at the University of Manitoba and the [Chair of the Manitoba Patient Safety Institute](#)

Helga Bryant, VP and Chief Nursing Office of the Health Sciences Centre

Wendy Peppel, Director of Quality and Decision Support at the Health Sciences Centre

Canadian Hospitals Join 100,000 Lives Campaign

In the [last issue of Patient Safety Picks](#) we reported on the IHIs 100,000 Lives Campaign. The 100,000 Lives Campaign aims to enlist hospitals in a commitment to implement changes in care that prevent avoidable deaths. Details of the campaign can be found at <http://www.ihi.org/IHI/Programs/Campaign/>.

There is now a [list of hospitals and systems](#) participating in the Campaign. A number of Canadian hospitals have joined including several from Manitoba (Health Sciences Centre, St. Boniface General Hospital, and the Canadian Collaborative to Improve Patient Care and Safety in the ICU)

MIPS Seeks Opinions of Stakeholders

On March 14, 2005, the Manitoba Institute Patient Safety (MIPS) provided a video-link information session on patient safety and the role of the Manitoba Patient Safety Institute. As a follow-up to this video conference and information, MIPS is consulting with stakeholders across Manitoba including:

- public representatives drawn from Regional Health Authorities,
- First Nation representatives;
- Regional Health Authority front line health care providers;
- professional regulatory associations;
- representatives from health care provider unions;
- representatives from health educational programs/institutions; and
- Regional Health Authority and CancerCare Manitoba boards and management.

The purpose of the consultations is to seek opinions and input on:

- the strategic directions of the Institute;
- Manitoba Health's patient safety priorities and activities;
- priorities, challenges, and potential solutions related to patient safety; and, current local activities related to patient safety.

More information on the MIPS videoconference and stakeholder consultations is available at:

<http://www.mbips.ca/events.html#consult>

MIPS Releases Strategic Directions Document

The Manitoba Institute for Patient Safety (MIPS) releases Moving Forward: Strategic Directions for 2005 and Beyond. This document provides information on the mission, values, objectives, actions, and priorities of the MIPS. The document can be found at:

<http://www.mbips.ca/docs/movingforward.pdf>

Website of the Month

AHRQ "Classics" on Patient Safety

If you have ever wanted an a list of the most frequently cited articles and items on patient safety, the Agency for Healthcare Research and Quality is an excellent place to look. A bibliography of Audiovisual resources, books, reports, clinical practice guidelines, journal articles, magazine articles, web resources, and theme issues is available.

<http://psnet.ahrq.gov/classics.aspx>

E-Book of the Month

Making Health Care Safer: A Critical Analysis of Patient Safety Practices. Shojania KG, Duncan BW, McDonald KM, Wachter RM, eds. Evidence Report/Technology Assessment No. 43 from the Agency for Healthcare Research and Quality: AHRQ Publication No. 01-E058; 2001.

Most "evidence reports" are placed on shelves and gather dust. This one, which reviewed the state of the evidence behind nearly 80 different "safety practices" (including computerized order entry, use of pharmacists on rounds, methods to prevent falls and nosocomial infections, and interventions to create a culture of safety), became quite influential, in part because it was the first effort to subject safety practices to the same scrutiny as other clinical practices in terms of their evidence of effectiveness. Nearly 100,000 copies of the report have been obtained from the Agency for Healthcare Research and Quality (AHRQ), and its now-famous list of the "top 11 practices" became the focus of many a new patient safety program at hospitals around the nation. The report served as one of the intellectual underpinnings of subsequent rankings of practices such as those by the [National Quality Forum](#) and the [Leapfrog Group](#). It also engendered a spirited debate between [those who advocated a practical approach to the adoption of safety practices](#) and [those promoting a more evidence-based approach](#). Readers are cautioned that evidence reports have limited shelf-lives, and it is worth reviewing recent literature before adopting even the most highly rated practices in this report.

<http://www.ahrq.gov/clinic/ptsafety/>

Recommended for Patients

"Parents-Charting Progress in Vancouver", Linda Harteker, in *Advances in Family-Centred Care*, [Institute for Family-Centered Care](#), Summer 2004, Vol.10(1): .21-22.

Click [here](#) to request a copy of the article from the Library

by Ryan Sidorchuk, Patient Safety Officer

As the Patient Safety Officer for the Winnipeg Regional Health Authority, my main role is the creation and facilitation of a Patient/Family Advisory Council that will provide both opinions and feedback to the Director of Patient Safety on issues affecting the safety of patients from the perspective of the consumer of healthcare services. This initiative is based on the idea of patients and their family members as an untapped informational resource in the form of "24-hour quality control officers". It is fair to say that "layperson" participatory input into "complex-system" industries such as healthcare has been met over the years with a pathological dose of scepticism, at times bordering on complete cynicism for the validity of such potential knowledge contributions to the well being of the very people being consulted. While the opinions of experts are essential to any complex undertaking, the value of public participation is bearing itself out to be just as important, and indeed, effective.

For example, the above noted article documents the process whereby the parents/legal guardians gained the normalization of timely access to their child's medical charts at the British Columbia Children's Hospital in Vancouver. The process was initiated by [Partners in Care](#), the family advisory committee for the hospital, through feedback garnered from patient comment cards. In seeking to define the issue, it was determined that the current lack of access to charts was a "process" problem as opposed to an "access" problem, the investigation of which revealed to both staff members of the hospital and members of the advisory council that it was primarily privacy issues related to "third parties" that was delaying the timely turnover of chart requests; and by timely, they meant immediate! It became clear that the current policy was based on exceptional factors as opposed to the norm, and the joint task force consisting of advisory council members and hospital staff collaborated together to make immediate family access the "default" setting throughout the hospital. It is an excellent example of where the patient's safety has correctly "trumped" issues surrounding privacy, an on-going dialogue of hierarchical assignment in Canada, and certainly here in Manitoba.

Considerable educational campaigns for both staff and parents preceded the rollout of the new policy in action. In the year subsequent to the change, the fear of litigation was proven hollow, and the overall experience of patients/family members was significantly improved from the standpoint of satisfaction with both service and quality of clinical care. Parents acting previously as passive observers in the management of their child's illness became much more able to contribute input towards medical interventions, armed as they were with the same information that the professionals on the health care team were working from. Other initiatives related to information sharing and communication, the most oft-cited contributory factor in the investigational analysis of medical errors, that the council is working on includes gaining the right for parents to enter comments on the chart, as well as family participation in rounds.

After a significant consultative and planning course, the WRHA is poised to begin the process of incorporating the patient/family member voice into the considerations surrounding the topic of patient safety. A provisional council is mere weeks away from its inaugural meeting, its membership consisting of people who have already identified themselves as ready, willing, and able catalysts to the paradigm shift occurring from one of paternalism to one of inclusion and collaboration. If you would be interested in adding your views to this subject, please contact me via email at rsidorchuk@wrha.mb.ca , or phone me at 926-7164.

Take care, and be safe!

Featured Book

Book Review

To Do No Harm: Ensuring Patient Safety in Health Care Organizations, by Julianne Morath and Joanne Turnbull, Jossey-Bass, 2005, ISBN 0-7879-6770-X

by Dr. Rob Robson, Director of Patient Safety WRHA

Copies of this book are available at:

Location: Grace General Hospital Library
Call Number / Volume: WX 185 M831t 2005

Location: Victoria General Hospital Library
Call Number / Volume: WX 185 M831t 2005

You can also purchase a copy of this book through the [UM Health Sciences Bookstore](#)

This recent addition to the patient safety literature provides a clear and easily understood overview of the field. Written by two practitioners with years of experience, the book is full of useful case studies and examples drawn both from their own direct experience and also from that of other organizations.

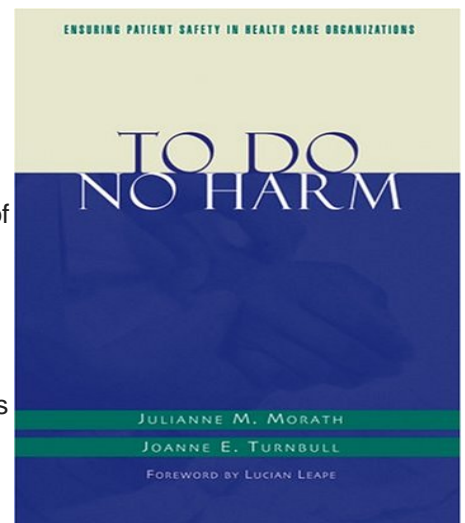
The book asks a number of important questions and the authors are not shy about dealing with important “icons”. They identify “striving for the wrong kind of excellence” as one of the barriers to advancing the patient safety agenda and provide practical examples of how to measure activities that will in fact contribute to improving patient outcomes.

An important feature of this book is the emphasis on the need for clear and consistent executive leadership on patient safety issues. As a corollary, there is an in-depth discussion of accountability at all levels within healthcare organizations. On both subjects the authors draw from their own experience in changing the prevailing culture and values within facilities and systems.

One of the most useful aspects of the books is the number of Appendices (fourteen). They provide many good examples of procedures and processes that have worked. Many are drawn from the Children’s Hospitals and Clinics in Minneapolis where Julianne Morath has provided executive leadership for several years.

Overall, this book provides the clearest recent overview of the patient safety field. While not hesitating to identify problem areas, the authors emphasize the many success stories and provide clear explanations of the steps to be taken to implement similar plans in other facilities.


In virtually all areas the ideas and suggestions are easily transferable to the Canadian situation with very little need for “translation”. This book should be required reading for all healthcare managers and executives and should be available for any staff or patients who want to broaden their understanding of the main issues in the field.



Journal Articles on Patient Safety

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

The following is a select bibliography of articles appearing in PubMed from January to April 2005.
To link to the full-text of the articles you will require a University of Manitoba library card or University

of Manitoba staff/student card. You can link to articles online by clicking on  To request articles that are not available electronically, use the Document Delivery form available after clicking on the UM Links button. If you have questions about obtaining a library card or requesting items, contact the [Neil John Maclean Health Sciences Library](#).

1. Acad Med. 2005 Feb;80(2):189-92.



Physicians' views of interventions to reduce medical errors: does evidence of effectiveness matter?

Rosen AB, Blendon RJ, DesRoches CM, Benson JM, Bates DW, Brodie M, Altman DE, Zapert K, Steffenson AE, Schneider EC.

Division of General Medicine, University of Michigan Health Systems, 300 North Ingalls, Suite 7C27, Ann Arbor, MI 48109, USA. abrosen@umich.edu

PURPOSE: Despite widespread public attention and numerous ongoing patient safety initiatives, physicians are skeptical of the most commonly prescribed interventions to reduce medical errors. This study examined the association between the published evidence of effectiveness of interventions to reduce medical errors and physicians' ratings of the effectiveness of those interventions. It further assessed whether academic affiliation was associated with physicians' ratings of effectiveness. **METHOD:** The authors conducted a literature review seeking evidence of effectiveness of 13 interventions to reduce medical errors. A four-page questionnaire was sent to a random sample of 1,332 U.S. physicians in the spring of 2002. A total of 831 (62%) responded, providing ratings of the perceived effectiveness of these interventions to reduce medical errors. **RESULTS:** We identified published evidence of effectiveness for six of the 13 interventions. Physicians rated 34% of these and 29% of the interventions without published evidence as "very effective" ($p < .01$). Physicians with an academic affiliation and those in practice for more years were slightly more likely to rate interventions with published evidence as "very effective." **CONCLUSIONS:** Physicians' ratings of the effectiveness of interventions to reduce medical errors are only weakly associated with published evidence of effectiveness. More evidence, better dissemination strategies for existing evidence such as inclusion in medical school curriculum or recertification examinations, and a focus on removing barriers to interventions may be needed to engage physicians in moving patient safety interventions into medical practice.

PMID: 15671327 [PubMed - indexed for MEDLINE]

2: Am J Manag Care. 2005 Jan;11(1):49-52.



Health plan members' views on forgiving medical errors.

Mazor KM, Simon SR, Yood RA, Martinson BC, Gunter MJ, Reed GW, Gurwitz JH.

Meyers Primary Care Institute, University of Massachusetts Medical School and Fallon Foundation, Worcester, Mass 01605, USA. kathleen.mazor@umassmed.edu

BACKGROUND: How patients respond to medical errors may influence how physicians approach disclosure of medical errors, but information on patients' responses is limited. Research is needed on how the circumstances that surround a medical error affect how patients respond. **OBJECTIVE:** To investigate whether patients' tendency to forgive a physician following a medical error varied under different circumstances. **STUDY DESIGN:** Cross-sectional survey. **METHODS:** We mailed a questionnaire to 1500 randomly selected health plan members; the response rate

was 66%. Questionnaire items assessed the likelihood of forgiveness following a medical error under 12 circumstances drawn from a review of the literature. RESULTS: Respondents were most likely to forgive a physician if the patient failed to provide complete information (93% would or might forgive) and least likely to forgive if the error was due to efforts to keep costs down (11% would or might forgive). Most respondents would not forgive a physician when the physician was tired or distracted (68%), was incomplete in data collection (76%), lacked knowledge (78%), or failed to follow up (85%). Men were more likely to forgive than women; the most educated respondents were most likely to forgive. CONCLUSIONS: Our findings suggest that patients are not likely to forgive a physician in circumstances in which they suspect incompetence, inattention, or a lack of caring on the part of the physician involved. A more comprehensive understanding of forgiveness and the effect of forgiveness on the physician-patient relationship following a medical error is needed.

PMID: 15697100 [PubMed - indexed for MEDLINE]

3: Am J Med Qual. 2005 Mar-Apr;20(2):70-7.



Attitudes About Patient Safety: A Survey of Physicians-in-Training.
Sorokin R, Riggio JM, Hwang C.

Thomas Jefferson University Hospital, Philadelphia, Pennsylvania.

Little is known about the attitudes of physicians-in-training on patient safety, although success in error reduction strategies requires their support. We surveyed house staff and fourth-year medical students from 1 academic institution about their perceptions of adverse patient events. Three hundred twenty-one trainees (41%) completed the survey. Most believe adverse events are preventable (61%) and think improved teamwork (88%), better procedural training (74%), and improved sign-out (70%) would reduce medical mishaps. Forty-seven percent of trainees agree computerized order entry and restricted work hours would prevent adverse events. Although 60% feel malpractice fears inhibit discussion, 80% of trainees agreed physicians must disclose adverse events to patients and grow more comfortable with disclosure as training progresses (P for trend $<.01$). In conclusion, trainees believe adverse events are preventable and are poised to respond to many components of the patient safety movement.

PMID: 15851384 [PubMed - in process]

4: Anaesthesia. 2005 Mar;60(3):257-73.



Medication errors in anaesthesia and critical care.
Wheeler SJ, Wheeler DW.

University Department of Anaesthesia, University of Cambridge, BOX 93,
Addenbrooke's Hospital, Cambridge, CB2 2QQ, UK.

There is an increasing recognition that medication errors are causing a substantial global public health problem, as many result in harm to patients and increased costs to health providers. However, study of medication error is hampered by difficulty with definitions, research methods and study populations. Few doctors are as involved in the process of prescribing, selecting, preparing and giving drugs as anaesthetists, whether their practice is based in the operating theatre, critical care or pain management. Anaesthesia is now safe and routine, yet anaesthetists are not immune from making medication errors and the consequences of their mistakes may be more serious than those of doctors in other specialties. Steps are being taken to determine the extent of the problem of medication error in anaesthesia. New technology, theories of human error and lessons learnt from the nuclear, petrochemical and aviation industries are being used to tackle the problem.

Publication Types:
Review
Review, Tutorial

PMID: 15710011 [PubMed - indexed for MEDLINE]

5: Ann Intern Med. 2005 Apr 19;142(8):627-30.



Ambiguity and workarounds as contributors to medical error.
Spear SJ, Schmidhofer M.

Harvard Business School, Boston, Massachusetts 02163, USA. sspear@hbs.edu

Why are some organizations error-prone-regularly subject to interruptions and inconveniences, some of which periodically coalesce catastrophically-whereas other organizations, although similar in the products and services they generate and the process technologies they use, are reliable, adaptable, and continuously self-improving, relentlessly learning from experience to get ever better? Analyzing medical error reports and studies of high-performing, non-health care organizations reveals 2 differences. High performers know how to prevent problems from producing further consequences once they occur and how to prevent their recurrence. They do this by specifying how work is expected to proceed-who will do what for whom, with what purpose, when, where, and how-before work is actually done. Then, when anything contrary to expectations occurs, it is immediately identified as a problem. Through this approach, the effects of problems are contained, the causes are quickly investigated, process knowledge is deepened, and recurrence is prevented. In contrast, error-prone organizations tolerate ambiguity, a prevailing lack of clarity over what is supposed to happen at any given time. Problems are thus hard to identify, and, even when recognized, they are worked around. People "get the job done," but don't initiate efforts to learn from the problem or improve the process. We believe that coupling high degrees of specification with rapid responses to individual problems can improve health care. Superlative manufacturing, service, and military organizations apply this approach to myriad processes and situations, and initial health care trials of this approach have been promising. We discuss how such an approach could be initiated in health care more broadly.

PMID: 15838069 [PubMed - indexed for MEDLINE]

6: Ann Intern Med. 2005 Mar 1;142(5):352-8.



Fumbled handoffs: one dropped ball after another.
Gandhi TK.

Harvard Medical School and Brigham and Women's Hospital, Boston, Massachusetts
02120, USA. tgandhi@partners.org

Missed follow-up of abnormal test results and resultant delays in diagnosis is a safety issue that is gaining increasing attention. Despite increases in the numbers and types of available diagnostic tests, current systems in health care do not reliably ensure that test results are received and acted upon by ordering physicians. This article examines the case of a patient whose diagnosis of tuberculosis was substantially delayed because of systems problems, including poor continuity (with multiple-provider involvement), lack of communication of test results and other clinical information, and several handoffs. Strategies to ensure adequate communication of critical information and follow-up of test results are discussed, such as explicit criteria for communication of abnormal results, test-tracking systems for ordering providers, and use of information technologies.

Publication Types:
Case Reports
Clinical Conference

PMID: 15738454 [PubMed - indexed for MEDLINE]

7: AORN J. 2005 Feb;81(2):336-41; quiz 343-6.



Update on the National Patient Safety Goals--changes for 2005.
Catalano K.

Provider Health Net Services, Addison, TX, USA.

Each year since 2003, the Joint Commission on Accreditation of Healthcare Organizations has established National Patient Safety Goals for accredited health care organizations. The goals are developed to promote improvement in patient safety by helping health care organizations address specific safety concerns. This article discusses the current goals and highlights new information for 2005.

PMID: 15768544 [PubMed - in process]

8: Caring. 2005 Feb;24(2):34-5, 37, 39.



Examining "operational failures" to reduce home care errors.

Bruno L, Ahrens J.

Center for Home Care Policy and Research, Visiting Nurse Service of New York,
USA. lori.bruno@vnsny.org

The majority of health care errors that impact patient safety can be linked not to caregivers' lack of skills or knowledge, but to faulty work design (Perrow 1984; Reason 1990). Yet little is known about operational failures in home health care that lead to adverse events. This article summarizes the findings of a recent case study (Tucker 2004) that identifies 23 operational failures that took place during seven home care visits over the course of one day. The majority of these failures were linked to either the patient/family or the home health agency servicing the family rather than to the individual nurse treating the patient. Findings suggest that to understand and reduce errors in home health care, further examination of the structure of the work environment is necessary to create an atmosphere that can promote better patient care.

PMID: 15773240 [PubMed - indexed for MEDLINE]

9: Healthc Q. 2005;8(2):30-2.



The patient safety journey.

Dyke J.

The patient safety journey will involve front line providers, researchers, patients, community and institution-based care teams and others, and many changes in the way organizations and procedures are structured. This is no small task, yet is critical: the Canadian public and healthcare providers are rightly asking that real strides be made. "At the end of our first five-year mandate, I hope that we can point to the results of a new Canadian Adverse Events study and say, 'Yes, the Canadian health system is safer than it was when we started and it will continue to get safer as we learn more,'" said Dr. John Wade. "That's what success should look like."

PMID: 15828564 [PubMed - in process]

10: Healthc Q. 2005;8(1):116-9.



First do no harm: Hamilton Health Sciences' experience as first hospital in the world to fully implement Medley Medication Safety System.

Faguy P, Gauthier L, Duffet M.

Hamilton Health Sciences.

PMID: 15715342 [PubMed - indexed for MEDLINE]

11: Healthcare Benchmarks Qual Improv. 2005 Jan;12(1):8-9.



Survey finds hospitals lagging behind on safety.
[No authors listed]

--Survey is first to include measures covering all 30 NQF-endorsed safety practices. --Protocols, policies, and procedures found lacking in many different areas. --Survey questions designed to help hospitals focus on potential areas of improvement.

PMID: 15724557 [PubMed - indexed for MEDLINE]

12: Healthcare Benchmarks Qual Improv. 2005 Jan;12(1):1-4.



Patient safety authority enables sharing of lessons learned.
[No authors listed]

The Pennsylvania Patient Safety Authority requires hospitals to report serious events and potentially harmful events. - Hospitals can be fined and physicians can lose licensing for failure to report events. --More than 50,000 events have been reported statewide since the system went on-line in July 2004.

PMID: 15724554 [PubMed - indexed for MEDLINE]

13: J Perinat Neonatal Nurs. 2005 Jan-Mar;19(1):46-51.



Patient safety and teamwork in perinatal care: resources for clinicians.
Miller LA.

Perinatal Risk Management and Education Services, Chicago, IL 60618, USA.
LISACNM@comcast.com

Recent data reveal communication issues and organizational culture to be key factors in adverse perinatal outcomes. Hierarchical communication is common in healthcare and can be a significant impediment to safe care. Principles of teamwork employed by other industries, such as aviation and the military, can be appropriately applied to healthcare. This article provides a brief introduction to Crew Resource Management as well as a listing of print, multimedia, and Web resources for clinicians interested in promoting cultural change and effective teamwork.

PMID: 15796424 [PubMed - in process]

14: J Perinat Neonatal Nurs. 2005 Jan-Mar;19(1):37-45.



Perinatal Patient Safety Project: a multicenter approach to improve performance reliability at Kaiser Permanente.
McFerran S, Nunes J, Pucci D, Zuniga A.

Perinatal Patient Safety Project, Oakland, CA 94612, USA.
Sharon.V.Mcferran@kp.org

High-reliability organizations, including high-reliability perinatal units, are built on a solid foundation of timely communication and collegial teamwork to maintain patient safety as a top priority. In these units, concise, real-time,

and constant communication is valued. Teamwork and collegiality characterize the professional relationships and hierarchy is minimized. The Perinatal Patient Safety Project utilized human factors techniques and systems improvements to create high-reliability perinatal units within a 1-year pilot project. This article focuses on the approaches used to improve communication in 4 Kaiser Permanente medical centers participating in this project.

PMID: 15796423 [PubMed - in process]

15: J Perinat Neonatal Nurs. 2005 Jan-Mar;19(1):15-23.



Improving perinatal and neonatal patient safety: The AHRQ patient safety indicators.

Johnson CE, Handberg E, Dobalian A, Gurol N, Pearson V.

Rehabilitation Outcomes Research Center of Excellence, North Florida/South Georgia Veteran's Health System, Gainesville, FL 32608, USA.
Christopher.Johnson4@med.va.gov

This study reviews the development and implementation of the Agency for Healthcare Research and Quality (AHRQ) patient safety indicators (PSIs). The genesis of the use of administrative data as a tool to combat safety problems is presented, and how indicators were constructed using various administrative codes. Examples of how the PSIs are being used to identify potential safety problems within the general population are presented, with a special emphasis on how these are being used within the perinatal and neonatal arena to understand current issues within that subpopulation. Results from studies within the general population and targeted at perinatal and neonatal patients are presented. Finally, suggestions are discussed for clinicians to use the AHRQ PSIs as one of their early warning tools for potential safety-related problems.

PMID: 15796421 [PubMed - in process]

16: J Postgrad Med. 2005 Jan-Feb;51(1):61-7.



Crossing to safety: transforming healthcare organizations for patient safety.
Ralston JD, Larson EB.

Center for Health Studies, Group Health Cooperative, University of Washington, Washington, USA. ralston.j@ghc.org.

The current healthcare system is not designed to ensure better patient safety. In addition, healthcare is simultaneously becoming increasingly complex and increasingly fragmented. Medical knowledge and technology are expanding at an incredible rate, making it difficult for the healthcare providers to keep pace with advancing knowledge. Patients' needs are changing too: shifting from the diagnosis and treatment of a single, acute problem to the long-term management of multiple, interrelated chronic conditions. Our systems of care are not keeping up with these changes and, consequently, patients are experiencing unnecessary risk. Improving patient safety requires a transformation in how we currently care for patients. Healthcare organizations must adopt a new paradigm of care that holds patient safety as a core value and practice. To achieve this aim, healthcare organizations should build and maintain a culture of patient safety, provide leadership for patient safety that establishes a blame-free environment, proactively survey and monitor for adverse events, continually engineer patient safety into healthcare processes, and provide information and communication technologies to support patient safety.

PMID: 15793345 [PubMed - in process]

17: JAMA. 2005 Mar 16;293(11):1359-66.



Error reporting and disclosure systems: views from hospital leaders.

Weissman JS, Annas CL, Epstein AM, Schneider EC, Clarridge B, Kirle L, Gatsonis C, Feibelman S, Ridley N.

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CONTEXT: The Institute of Medicine has recommended establishing mandatory error reporting systems for hospitals and other health settings. **OBJECTIVE:** To examine the opinions and experiences of hospital leaders with state reporting systems. **DESIGN AND SETTING:** Survey of chief executive and chief operating officers (CEOs/COOs) from randomly selected hospitals in 2 states with mandatory reporting and public disclosure, 2 states with mandatory reporting without public disclosure, and 2 states without mandatory systems in 2002-2003. **MAIN OUTCOME MEASURES:** Perceptions of the effects of mandatory systems on error reporting, likelihood of lawsuits, and overall patient safety; attitudes regarding release of incident reports to the public; and likelihood of reporting incidents to the state or to the affected patient based on hypothetical clinical vignettes that varied the type and severity of patient injury. **RESULTS:** Responses were received from 203 of 320 hospitals (response rate = 63%). Most CEOs/COOs thought that a mandatory, nonconfidential system would discourage reporting of patient safety incidents to their hospital's own internal reporting system (69%) and encourage lawsuits (79%) while having no effect or a negative effect on patient safety (73%). More than 80% felt that the names of both the hospital and the involved professionals should be kept confidential, although respondents from states with mandatory public disclosure systems were more willing than respondents from the other states to release the hospital name (22% vs 4%-6%, $P = .005$). Based on the vignettes, more than 90% of hospital leaders said their hospital would report incidents involving serious injury to the state, but far fewer would report moderate or minor injuries, even when the incident was of sufficient consequence that they would tell the affected patient or family. **CONCLUSIONS:** Most hospital leaders expressed substantial concerns about the impact of mandatory, nonconfidential reporting systems on hospital internal reporting, lawsuits, and overall patient safety. While hospital leaders generally favor disclosure of patient safety incidents to involved patients, fewer would disclose incidents involving moderate or minor injury to state reporting systems.

PMID: 15769969 [PubMed - indexed for MEDLINE]

18: JAMA. 2005 Mar 9;293(10):1197-203.



Comment in:

JAMA. 2005 Mar 9;293(10):1261-3.

Role of computerized physician order entry systems in facilitating medication errors.

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CONTEXT: Hospital computerized physician order entry (CPOE) systems are widely regarded as the technical solution to medication ordering errors, the largest identified source of preventable hospital medical error. Published studies report that CPOE reduces medication errors up to 81%. Few researchers, however, have focused on the existence or types of medication errors facilitated by CPOE. **OBJECTIVE:** To identify and quantify the role of CPOE in facilitating prescription error risks. **DESIGN, SETTING, AND PARTICIPANTS:** We performed a qualitative and quantitative study of house staff interaction with a CPOE system at a tertiary-care teaching hospital (2002-2004). We surveyed house staff ($N = 261$; 88% of CPOE users); conducted 5 focus groups and 32 intensive one-on-one interviews with house staff, information technology leaders, pharmacy leaders, attending physicians, and nurses; shadowed house staff and nurses; and observed them using CPOE. Participants included house staff, nurses, and hospital leaders. **MAIN OUTCOME MEASURE:** Examples of medication errors caused or exacerbated by the CPOE system. **RESULTS:** We found that a widely used CPOE system facilitated 22 types of medication error risks. Examples include fragmented CPOE displays that prevent a coherent view of patients' medications, pharmacy inventory displays mistaken for dosage guidelines, ignored antibiotic renewal notices placed on paper charts rather than in the CPOE system, separation of functions that facilitate double dosing and incompatible orders, and inflexible ordering formats generating wrong orders. Three quarters of the house staff reported observing each of these error risks, indicating that they occur weekly or more often. Use of multiple qualitative and survey methods identified and

quantified error risks not previously considered, offering many opportunities for error reduction. CONCLUSIONS: In this study, we found that a leading CPOE system often facilitated medication error risks, with many reported to occur frequently. As CPOE systems are implemented, clinicians and hospitals must attend to errors that these systems cause in addition to errors that they prevent.

Publication Types:
Evaluation Studies

PMID: 15755942 [PubMed - indexed for MEDLINE]

19: Jt Comm J Qual Patient Saf. 2005 Jan;31(1):13-20.



The gap between nurses and residents in a community hospital's error-reporting system.

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BACKGROUND: Little is known about current attitudes and practices among residents and nurses regarding error reporting. A survey was conducted to suggest differing needs for training and other interventions to enhance reporting. METHODS: The authors surveyed 24 residents and 60 nursing staff in all inpatient care units at a community hospital from 2001 to 2002. The authors used self-administered questionnaires to assess respondents' knowledge and use of the hospital's error-reporting system, perceptions and attitudes toward error reporting, reported behaviors in hypothetical error scenarios, and conditions that influence error reporting. RESULTS: Only half of the residents (54%) knew about the hospital's error-reporting system, whereas nearly all nurses did (97%; $p = .001$). Only 13% of the residents (versus 72% of the nurses) had ever used the reporting system ($p = .001$). Residents (29%) were less likely than nurses (64%) to report being comfortable discussing mistakes with supervisors ($p = .006$), and residents (38%) were more likely than nurses (0%) to rate the hospital atmosphere as nonsupportive of error reporting ($p = .001$). DISCUSSION: Error-reporting systems may give a biased picture of the true pattern of medical errors, and hospitals may need to initiate other interventions to improve residents' error reporting.

PMID: 15691206 [PubMed - indexed for MEDLINE]

20: LDI Issue Brief. 2005 Mar;10(5):1-4.



Computerized physician order entry systems: the right prescription?
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Policymakers increasingly urge the use of information technology to improve the quality and efficiency of health care. In particular, computerized physician order entry (CPOE) is emphasized for its ability to reduce prescribing errors inherent in paper-based systems. This Issue Brief summarizes research that sounds a cautionary note about the potential for computerized systems to facilitate medication errors, as well as reduce them.

PMID: 15810170 [PubMed - indexed for MEDLINE]

21: Med Care. 2005 Mar;43(3 Suppl):I48-57.



Racial, ethnic, and socioeconomic disparities in estimates of AHRQ patient

safety indicators.
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BACKGROUND: Patient safety events that result from the happenstance of mistakes and errors should not occur systematically across racial, ethnic, or socioeconomic subgroups. **OBJECTIVE:** To determine whether racial and ethnic differences in patient safety events disappear when income (a proxy for socioeconomic status) is taken into account. **RESEARCH DESIGN:** This study analyzes administrative data from community hospitals in 16 states with reliable race/ethnicity measures in the 2000 Healthcare Cost and Utilization Project of the Agency for Healthcare Research and Quality (AHRQ), using the publicly available AHRQ patient safety indicators (PSIs). **RESULTS:** Different indicators show different results for different racial/ethnic subgroups. Many events with higher rates for non-Hispanic blacks (compared with non-Hispanic whites) remain higher when income is taken into account, although such differences for Hispanics or Asian/Pacific Islanders (APIs) tend to disappear. Many events with lower rates for Hispanics and APIs remain lower than whites when income is taken into account, but for blacks, they disappear. **DISCUSSION:** The higher rates for minorities that reflect the way health care is delivered raise troubling questions about potential racial/ethnic bias and discrimination in the US health care system, problems with cultural sensitivity and effective communication, and access to high-quality health care providers. **CONCLUSIONS:** The AHRQ PSIs are a broad screen for potential safety events that point to needed improvement in the quality of care for specific populations.

PMID: 15746591 [PubMed - indexed for MEDLINE]

22: Med Care. 2005 Mar;43(3 Suppl):142-7.



Assessing patient safety in the United States: challenges and opportunities.
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BACKGROUND: In 1999, the US Congress mandated the Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services (DHHS), to report annually to the nation about healthcare quality. One chapter in the National Healthcare Quality Report (NHQR) is focused on patient safety. **OBJECTIVES:** The objectives of this study were to describe the challenges in reporting the national status on patient safety for the first NHQR and discuss emerging opportunities to improve the comprehensiveness and reliability of future reporting. **RESEARCH DESIGN:** This study is a selective review of definitions, frameworks, data sources, measures, and emerging developments for assessing patient safety in the United States. **RESULTS:** Available data and measures for patient safety assessment in the nation are inadequate, especially for comparing regions and subpopulations and for trend analysis. However, many opportunities are emerging from the recently increased investments in patient safety research and many ongoing safety improvement efforts in the private sector and at the federal, state, and local government levels. **CONCLUSION:** There are many challenges in assessing national performance on patient safety today. Ongoing developments on multiple fronts will provide data and measures for more accurate and more comprehensive assessments of patient safety for future NHQRs.

Publication Types:
Review

PMID: 15746590 [PubMed - indexed for MEDLINE]

23: Nurs Adm Q. 2005 Jan-Mar;29(1):97-101.



Patient and nurse safety: how information technology makes a difference.
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The Institute of Medicine's landmark report asserted medical error is seldom the fault of individuals, but the result of faulty healthcare policy/procedure systems. Numerous studies have shown that information technology can shore up weak systems. For nursing, information technology plays a key role in protecting patients by eliminating nursing mistakes and protecting nurses by reducing their negative exposure. However, managing information technology is a function of managing the people who use it. This article examines critical issues that impact patient and nurse safety, both physical and professional. It discusses the importance of eliminating the culture of blame, the requirements of process change, how to implement technology in harmony with the organization and the significance of vision.

PMID: 15779711 [PubMed - indexed for MEDLINE]

24: Nurs Adm Q. 2005 Jan-Mar;29(1):78-87.



Intravenous medication safety system averts high-risk medication errors and provides actionable data.
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A major responsibility of nursing leaders is to implement systems and policies to improve patient and staff safety, avoid medication errors, and most importantly safeguard patients against harm. In the medication use process, the nurse at the bedside is the most vulnerable, and intravenous (i.v.) drug administration often results in the most serious medication error outcomes. At a 675-bed, tertiary-care "Magnet Hospital System," nurses played a key role in a multidisciplinary process that led to successful implementation of a computerized i.v. medication safety system. Software customization, staff training and product set-up were completed in approximately 2 months; 685 devices were installed in 3 hospitals within 12 hours. Nursing acceptance is excellent, and implementation of the system is thought to enhance nursing retention and recruitment. Preliminary data indicate an estimated 849 programming changes ("near misses") annually, ie, potential infusion errors averted by the i.v. medication safety system. A chronogram created from safety data demonstrates that most infusion error warnings occurred between 3:00 PM and 9:00 PM, with an unexpected peak at 6:00 PM. Implementation of the i.v. medication safety system has prevented potentially serious infusion errors and has provided previously unavailable, actionable continuous quality improvement data for best practice improvements.

PMID: 15779709 [PubMed - indexed for MEDLINE]

25: Nurs Adm Q. 2005 Jan-Mar;29(1):72-7.



Using information to empower nurse managers to become champions for patient safety.
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There is no longer any question about the risks to patients safety that exist in the hospital. Hospitals are macrosystems that are built upon many interrelated microsystems. Most patient care and hence most errors that directly affect the care outcomes and negatively impact patient safety occur at the microsystem unit level, which is the same level that many improvements to patient safety occur. Patient Safety Net (PSN) is an on-line occurrence reporting tool being used by University HealthSystem Consortium (UHC) member hospitals to report medical events and improve care. As PSN became progressively integrated into the daily operations of these UHC members isolated anecdotes began to surface about how unit nurse managers were able to implement rapid and effective patient safety improvements at the microsystem level on the basis of data received through PSN, without involving performance and safety committees mechanisms. This article highlights the survey performed to validate these improvement anecdotes.

PMID: 15779708 [PubMed - indexed for MEDLINE]

26: Nurs Adm Q. 2005 Jan-Mar;29(1):57-62



Designing and implementing a close call reporting system.
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Medical errors and adverse events related to medication errors have received press coverage over the past 3 years. Nursing leaders have by necessity and duty become leaders in the field of patient safety. Defining and reporting errors become critical when analysis of errors relies on adequate and accurate reporting of errors. The next step towards a culture of safety is to avoid "blaming" employees, establishing trust and instituting a close call/near miss reporting system. By encouraging all staff to identify close calls you raise the level of awareness of employees for maintaining a safe patient care environment. Nursing leaders need to guide staff in identifying and reporting close calls through the development and implementation of a transparent reporting system involving recognition and rewarding staff.

PMID: 15779706 [PubMed - indexed for MEDLINE]

27: Nurs Adm Q. 2005 Jan-Mar;29(1):39-44.



Nurse's role in tracking adverse drug events: the impact of provider order entry.
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Adverse drug events (ADE), or injuries caused by drug therapy, are a frequent and serious problem in hospitalized patients. Monitoring, preventing, and treating ADEs is an important patient safety function. Nurses play a significant role in this function, because their data is a unique and important indicator of ADEs and because they are the final point of medication administration. New provider order entry systems with electronic medical records have been viewed as an effective innovation and solution to high rates of ADEs. These systems increase legibility of drug orders, provide decision support, and increase access to the medical record. However, they may not interface with nursing processes effectively. This study reports the experience of a team conducting an ADE surveillance study in a Veterans Health Administration setting where extensive computerized innovations are in place. Lessons learned regarding the integration of nursing work processes with the computerized setting are described. Three areas of concern are highlighted: decreased access to nursing narratives, lack of decision support for medication administration, and failure to code nursing data. Each of these is discussed in terms of relevance to patient safety and the design of information systems.

PMID: 15779704 [PubMed - indexed for MEDLINE]

28: Nurs Adm Q. 2005 Jan-Mar;29(1):24-30.



Real-time reporting drives the race toward zero.
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LifeCare Hospitals of Pittsburgh is a 155-bed freestanding, Acute Long Term Care Hospital, one of 333 nationwide. Patients with complex care needs who are recovering from acute events, postsurgical interventions, and multiple

comorbidities stay an average of 25 days. Like other hospitals, reducing medication errors is a focus of the quality improvement program. Provision of a safe environment is tantamount to achieving quality patient outcomes. Creative solutions to the problem of medication errors are needed. Healthcare executives need effective strategies to engage care providers in solving problems in the course of work and in a nonpunitive environment. Over the period of 1 year, medication errors reaching patients at LifeCare decreased by 50% through culture changes, rapid learning cycles, and strong support from the hospital's leaders.

PMID: 15779702 [PubMed - indexed for MEDLINE]

29: Nurs Clin North Am. 2005 Mar;40(1):25-32.



Reduction of adverse drug events and medication errors in a community hospital setting.
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Keys to success in reducing ADEs have included the support of administrative leaders through their visibility and emphasis on safety as an organizational priority, and financial support for safety projects. Administrative participation was also helpful in promoting safety efforts through the reinforcement of expectations when progress was sluggish. The use of rapid cycle change provided enough early success to serve in motivating staff to push ahead. It allowed staff the opportunity to analyze changes, make adjustments, and retest on a slightly larger scale. Other key success factors included the motivation of teams through continual sharing of progress and success stories; celebrations for achievements are held routinely. As an organization, SJMC has shared its success strategies with other organizations and promoted networking with other organizations to determine what strategies have worked elsewhere. This is helpful as it prevents time from being wasted on solutions that have been tried without success. Within the OSF Healthcare System, the following phrase has been adopted in regard to patient safety, "Safety is like peeling an onion; the more you look, the more you find, and each layer makes you cry."

PMID: 15733944 [PubMed - indexed for MEDLINE]

30: Nurs Clin North Am. 2005 Mar;40(1):1-23.



Creating an organizational culture for medication safety.
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Medication errors are costly from human, economic, and societal perspectives. All patients are vulnerable to the detrimental effects of these errors. Recommendations regarding the problem of medication errors include: Prevention of error by learning from the nonpunitive reporting of errors and near misses; Evaluation of the system for potential causes of error through failure mode and effects analysis and encouragement of a questioning attitude; Elimination of system problems that increase the risk of error; Recognition that humans are fallible and that error will occur even in a perfect system; Minimization of the consequences of errors when they do occur. An important goal for healthcare organizations should be to create a culture that accepts the imperfection of human performance and solicits the assistance of team members in the development of safeguards for error prevention. Proposed interventions to prevent medication errors can be described by the PATIENT SAFE taxonomy, which includes: Patient participation; Adherence to established policy and procedures; Technology use; Information accessibility; Education regarding medication safety; Nonpunitive approach to reporting of errors and near misses; Teamwork, communication, and collaboration; Staffing: adequate number and staffing mix; Administration support for the clinical goal of patient safety; Failure mode and effects analysis with team member involvement; Environment and equipment to support patient safety

Publication Types:
Review

Review, Tutorial

PMID: 15733943 [PubMed - indexed for MEDLINE]

31: Perform Improv Advis. 2005 Feb;9(2):21-2, 13.



Quality, patient safety recognized in incentive plans, survey finds.
[No authors listed]

In an effort to improve the quality of care, healthcare organizations are likely to include quality performance targets in their incentive plans, according to a survey.

PMID: 15816312 [PubMed - in process]

32: Psychiatr Q. 2005 Spring;76(1):85-95.



Engaging patients and family members in patient safety--the experience of the New York City Health and Hospitals Corporation.

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As one of its strategies to improve care, the New York City Health and Hospitals Corporation (HHC) has launched a number of initiatives to increase patient and family member involvement in the delivery of mental health services, including the hiring of peer counselors and the use of parent advocates. The effort to orient mental health services toward a more rehabilitative and recovery model has resulted in a significant change in the clinical culture. The article outlines patient and family member initiatives undertaken by the Corporation and offers some preliminary results that show the strong bond between increased patient and family member involvement and patient safety.

PMID: 15757238 [PubMed - in process]

33: Qual Lett Healthc Lead. 2005 Jan;17(1):2-10, 1.



The IOM medical errors report: 5 years later, the journey continues.
[No authors listed]

In 1999, the Institute of Medicine released a report, To Err Is Human: Building a Safer Health System, which shed a new light for providers and patients across the nation looking at patient safety and medical errors. Since then, new ways of addressing patient safety have emerged. But how far does the healthcare system still have to go?

PMID: 15745281 [PubMed - indexed for MEDLINE]

34: Qual Saf Health Care. 2005 Apr;14(2):135-9.



Implementing a national strategy for patient safety: lessons from the National Health Service in England.

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Improving patient safety has become a core issue for many modern healthcare systems. However, knowledge of the best ways for government initiated efforts to improve patient safety is still evolving, although there is considerable commonality in the challenges faced by countries. Actions to improve patient safety must operate at multiple levels of the healthcare system simultaneously. Using the example of the NHS in England, this article highlights the importance of a strategic analysis of the policy process and the prevailing policy context in the design of the national patient safety strategy. The paper identifies a range of policy "levers" (forces for change) that can be used to support the implementation of the national safety initiative and, in particular, discusses the strengths and limitations of the "business case" approach that has attracted recent interest. The paper offers insights into the implementation of national patient safety goals that should provide learning for other countries.

PMID: 15805460 [PubMed - in process]

35: Qual Saf Health Care. 2005 Apr;14(2):130-4.



"Going solid": a model of system dynamics and consequences for patient safety.
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Rather than being a static property of hospitals and other healthcare facilities, safety is dynamic and often on short time scales. In the past most healthcare delivery systems were loosely coupled—that is, activities and conditions in one part of the system had only limited effect on those elsewhere. Loose coupling allowed the system to buffer many conditions such as short term surges in demand. Modern management techniques and information systems have allowed facilities to reduce inefficiencies in operation. One side effect is the loss of buffers that previously accommodated demand surges. As a result, situations occur in which activities in one area of the hospital become critically dependent on seemingly insignificant events in seemingly distant areas. This tight coupling condition is called "going solid". Rasmussen's dynamic model of risk and safety can be used to formulate a model of patient safety dynamics that includes "going solid" and its consequences. Because the model addresses the dynamic aspects of safety, it is particularly suited to understanding current conditions in modern healthcare delivery and the way these conditions may lead to accidents.

PMID: 15805459 [PubMed - in process]

36: Qual Saf Health Care. 2005 Apr;14(2):123-9.



A web-based incident reporting system and multidisciplinary collaborative projects for patient safety in a Japanese hospital.
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PROBLEM: When patient safety programs were mandated for Japanese health care institutions, a safety culture, a tool for collecting incident reports, an organizational arrangement for multidisciplinary collaboration, and interventional methods for improvement had to be established. **DESIGN:** Observational study of effects of new patient safety programs. **SETTING:** Osaka University Hospital, a large government-run teaching hospital. **STRATEGY FOR CHANGE:** A voluntary and anonymous web-based incident reporting system was introduced. For the new organizational structure a clinical risk management committee, a department of clinical quality management, and area clinical risk managers were established with their respective roles clearly defined to advance the plan-do-study-act cycle and to integrate efforts. For preventive action, alert procedures, staff education, ward rounds by peers, a system oriented approach for reducing errors, and various feedback channels were introduced. **EFFECTS OF CHANGE:** Continuous incident reporting by all hospital staff has been observed since the introduction of the new system. Several error inducing situations have been improved: wrong choice of drug in computer prescribing,

maladministration of drugs due to a look-alike appearance or confusion about the manipulation of a medical device, and poor after hours service of the blood transfusion unit. Staff participation in educational seminars has been dramatically improved. Ward rounds have detected problematic procedures which needed to be dealt with. LESSONS LEARNT: Patient safety programs based on a web-based incident reporting system, responsible persons, staff education, and a variety of feedback procedures can help promote a safety culture, multidisciplinary collaboration, and strong managerial leadership resulting in system oriented improvement.

PMID: 15805458 [PubMed - in process]

37: Qual Saf Health Care. 2005 Apr;14(2):113-6.



Do split-side rails present an increased risk to patient safety?
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BACKGROUND: Concerns have been raised about the safety of split-side bed rails for patients in the UK.
OBJECTIVES: To investigate whether split-side rails were more likely to be associated with entrapment and injury of patients than other bed rail types. To establish whether there was a difference in the site of injury caused by different bed rail types and whether the outcome of the injury (death versus survival) varied by bedrail type. **METHODS:** A search of the USA Food and Drug Administration MAUDE database was carried out. The reports were screened using rigorous inclusion/exclusion criteria and then coded for rail type, incident outcome, and area of body involved. **RESULTS:** Split-side rail incidents only accounted for 5% of the reports and were more likely to involve the chest or pelvis. Although the biggest overall risk by rail type cannot be determined from these data, the severity of the outcome changed with the equipment type. Incidents involving half rails were more likely to be associated with head, neck, or face entrapments and were also more likely than other bed rail types to result in death. **DISCUSSION:** Split-side rail entrapments were not a common occurrence. However, our findings suggest that bed rails are associated with some level of risk of entrapment that potentially could result in death. Healthcare providers should therefore ensure that they follow the guidelines for risk assessment and rail use from the MHRA and other professional bodies so that the cultural norm in the UK continues to be "opt in", where no bed rails are used unless indicated by a documented clinical assessment.

PMID: 15805456 [PubMed - in process]

38: Qual Saf Health Care. 2005 Feb;14(1):56-60.



Comment in:
Qual Saf Health Care. 2005 Feb;14(1):60-1.

Safety in the operating theatre - Part 2: human error and organisational failure.
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Over the past decade, anaesthetists and human factors specialists have worked together to find ways of minimising the human contribution to anaesthetic mishaps. As in the functionally similar fields of aviation, process control and military operations, it is found that errors are not confined to those at the "sharp end". In common with other complex and well defended technologies, anaesthetic accidents usually result from the often unforeseeable combination of human and organisational failures in the presence of some weakness or gap in the system's many barriers and safeguards. Psychological factors such as inattention, distraction and forgetfulness are the last and often the least manageable aspects of the accident sequence. Whereas individual unsafe acts are hard to predict and control, the organisational and contextual factors that give rise to them are present before the occurrence of an incident or accident. As such, they are prime candidates for treatment. Errors at the sharp end are symptomatic of both human fallibility and underlying organisational failings. Fallibility is here to stay. Organisational and local problems, in contrast, are both diagnosable and manageable.

PMID: 15692005 [PubMed - indexed for MEDLINE]

39: Stud Health Technol Inform. 2004;103:400-6.



A peculiar aspect of patients' safety: the discriminating power of identifiers for record linkage.
Quantin C, Binquet C, Bourquard K, Pattisina R, Gouyon-Cornet B, Ferdynus C,
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Today, one of the main stake of the interfaced health information systems or networks is to be able to gather the different parts of the medical record of a patient without any risk to mix them with those of one other patient. This objective could appear easy to reach but only in theory because in practice many name are misspelled or erroneous and a great attention has to be paid to define what is the best identifier to link medical record. As a linkage using less informative identifiers could lead to linkage errors, it is essential to quantify the information associated to each identifier. The aim of this study was to estimate the discriminating power of different identifiers susceptible to be used in a record linkage process. This work showed the interest of three identifiers when linking data concerning a same patient using an automatic procedure based on the method proposed by Jaro; the date of birth, the first and the last names seemed to be the more appropriate identifiers. Including a poorly discriminating identifier like gender did not improve the results. Moreover, adding a second christian name, often missing, increased linkage errors. On the contrary, it seemed that using a phonetic treatment adapted to the French language could improve the results of linkage in comparison to the Soundex. However, whatever, the method used it seems necessary to improve the quality of identifier collection as it could greatly influence linkage results.

PMID: 15747947 [PubMed - indexed for MEDLINE]