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1. Actions, Behaviors, and Characteristics of RNs Involved in Compensable Injury

Painter LM, Dudjak LA.

*J Nurs Admin.* 2010(Dec); 40(12):534–539.

Available at: http://journals.lww.com/jonajournal/Abstract/2010/12000/Actions_Behaviors_and_Characteristics_of_RNs.7.aspx

This study sought insight into medical errors related to nursing care using a review of malpractice claims data. In their analysis of 16 claims in which nurses played a role in the compensable event, the authors found that the majority of cases involved failure to perform appropriate assessment and intervention. Other findings of note included that one-third of nurses were working on a unit to which they were not typically assigned when the event occurred, and that many of the nurses involved in events had educational preparation at less than the bachelor's level. The authors comment on the implications of these findings and discuss steps nurse leaders can take to improve the safety of nursing care. Four tables and one figure are included.

2. Assessing and Improving Safety Culture throughout an Academic Medical Centre: A Prospective Cohort Study


*Qual Saf Health Care.* 2010(Dec); 19(6):547–554.

Available at: http://qualitysafety.bmj.com/content/19/6/547.abstract

This study assessed the impact of a comprehensive initiative designed to improve safety-related attitudes and behavior among staff throughout a large academic medical center. The interventions consisted of expanded implementation of the Comprehensive Unit-Based Safety Program (CUSP) as well as numerous hospital-wide efforts including the implementation of an electronic event-reporting system, safety education for staff at all levels, and strategies designed to promote communication and learning about adverse events. The authors report that the intervention was associated with significant and sustained improvement in safety climate as measured by the Safety Attitudes Questionnaire. Three tables and two figures are included.

3. Automated Drug Dispensing System Reduces Medication Errors in an Intensive Care Setting


*Crit Care Med.* 2010(Dec); 38(12):2275–2281.

Available at: http://journals.lww.com/ccmjournal/Abstract/2010/12000/Automated_drug_dispensing_system_reduces.1.aspx

This study assessed the impact of an intervention designed to improve medication safety in the ICU of a large university hospital in France. The analysis showed that implementation of a computer-based dispensing system was associated with significant reduction in the rate of errors related to preparation and administration of medications. Four tables and two figures are included.

4. A Behavioral and Systems View of Professionalism

Lesser CS, Lucey CR, Eggener B, Braddock CH III, Linas SL, Levinson W.

*JAMA.* 2010(Dec 22/29); 304(24):2732–2737.

Available at: http://jama.ama-assn.org/content/304/24/2732.abstract

In this article, the authors propose a redefinition of professionalism in health care, focusing on the premise that professionalism should be conceptualized as a set of competencies and behaviors rather than an innate personality trait. Drawing upon recent literature, the authors present a framework for understanding medical professionalism in these more practical and concrete terms and discuss how adoption of this new approach could play a key role in medical education and healthcare system reform. Two tables and one figure are included.

5. Creating Cultures of Safety: Risk Management Challenges and Strategies

Raso R, Gulinello C.

*Nurs Manage.* 2010(Dec); 41(12):26–33.

Available at: http://journals.lww.com/nursingmanagement/Fulltext/2010/12000/Creating_cultures_of_safety__Risk_management.7.aspx

This article emphasizes the need to align hospital risk management activities with patient safety goals and the role of nurse managers in this process. The authors consider ten common problems that may arise in the delivery of patient care and describe strategies for addressing these issues.
6. Cultural Safety and the Socioethical Nurse
Woods M.
Nurs Ethics. 2010(Nov); 17(6):715–725.
Available at: http://nej.sagepub.com/content/17/6/715.
abstract
The concept of cultural safety emerged in New Zealand in relation to the provision of care to members of the Maori population, and it has been applied in other cultures as an approach to address health disparities between indigenous and non-indigenous groups. In this paper, the author provides an overview of the origins and theoretical foundation of cultural safety and argues that this concept has relevance for nursing professionals in many cultures who are concerned with providing safe and culturally appropriate care.

7. Diagnostic Error in a National Incident Reporting System in the UK
Sevdalis N, Jacklin R, Arora S, Vincent CA, Thomson RG.
This study sought to provide insight into diagnostic errors and the role of incident reporting systems in identifying such errors. In an analysis of incident reports submitted to the UK’s national reporting system during a 2-year period, the authors found that diagnosis-related incidents accounted for 0.5% of all reported incidents, were more likely than other types of incidents to involve significant patient harm, and appeared to occur disproportionately in the ER. While the authors acknowledge that diagnostic errors present unique challenges for reporting and analysis, they nevertheless conclude that formally structured error reporting systems can provide a useful tool for capturing and analyzing information about these errors. Three figures are included.

8. End-of-Life Caregiver Interactions with Health Care Providers: Learning from the Bad
Guo G, Phillips LR, Reed PG.
Available at: http://journals.lww.com/jncqjournal/Abstract/2010/10000/End_of_Life_Caregiver_Interactions_With_Health.9.aspx
This qualitative study explored family caregivers’ perspectives on their interactions with healthcare professionals in the course of providing care for an elderly patient at the end of life. The authors analyzed data from interviews with 27 family caregivers to identify attributes of “good” and “bad” interactions as experienced by the caregivers. Good interactions were characterized by providers being caring, friendly, and supportive, taking time to listen, and demonstrating trust in the caregivers’ abilities. Bad interactions outnumbered good ones and often involved providers being insensitive to patients’ and caregivers’ needs or failing to communicate information. Noting that some of the interactions described were “startling,” the authors suggest that these findings may point to the need for greater attention to healthcare professionals’ skills in providing end-of-life care. One table is included.

9. Guiding Inpatient Quality Improvement: A Systematic Review of Lean and Six Sigma
Glasgow JM, Scott-Cazewell JR, Kaboli PJ.
Available at: http://www.ingentaconnect.com/content/jcaho/jcqs/2010/00000036/00000012/art00002
This study sought to evaluate existing evidence concerning the effectiveness of Lean and Six Sigma methods as tools for hospital quality improvement. On the basis of their analysis of 47 articles identified through systematic literature review, the authors conclude that Lean and Six Sigma have facilitated many types of quality improvement efforts. However, the authors argue that, given methodological limitations of the studies examined and the absence of evidence demonstrating sustained improvement, further and more rigorous studies of these methods are needed. Two tables are included.

10. Hospital-Based Comparative Effectiveness Centers: Translating Research into Practice to Improve the Quality, Safety and Value of Patient Care
Umscheid CA, Williams K, Brennan PJ.
J Gen Intern Med. 2010(Dec); 25(12):1352–1355.
Available at: http://www.springerlink.com/content/hl7373m7137h3731/
This article argues that hospital-based organizations for comparative effectiveness (CE) research, used in a number of countries but less common in the United States, make an important contribution to efforts to improve healthcare quality and patient safety. The authors describe the design and operation of a variety of existing CE centers and argue for wider adoption of this model in the US. One table is included.

Lisby M, Nielsen LP, Brock B, Mainz J.
Available at: http://intqhc.oxfordjournals.org/content/22/6/507.abstract
This study sought to describe the ways in which medication errors have been defined in published literature, and to determine whether differences among these definitions could
give rise to discrepancies in the measurement of errors. In an analysis of 45 studies identified through systematic review of the relevant literature, the authors found considerable inconsistency in how medication errors were defined. Reported prevalence of error varied widely among the studies but did not appear to correlate with variations in the definition of error, and the authors note that a variety of differences in other aspects of study design and of data collection methods also likely contributed to such discrepancies. The authors conclude that measurement of medication errors could be greatly facilitated by the development of standardized definitions and greater consistency in study methods. Four tables and one figure are included.

12. Nighttime and Weekend Medication Error Rates in an Inpatient Pediatric Population

Miller AD, Piro CC, Rudisill CN, Bookstaver PB, Bair JD, Bennett CL.


Available at: http://www.theannals.com/cgi/content/abstract/44/11/1739

A number of studies have investigated whether patients admitted to the hospital at night or on weekends experience higher rates of medical errors than those admitted during daytime hours and on weekdays. To explore the issue further, this study investigated whether time of day or day of the week affected overall rates of medication error among inpatients at an academic children’s hospital. In an analysis of medication errors collected by the institution’s voluntary reporting system over a 1-year period, the authors found that rates of error were significantly higher during evening and nighttime shifts than during day shifts. The authors discuss the implications of these findings and consider possible strategies for improvement, particularly in relation to pharmacy services. Four tables and two figures are included.

13. Patient Participation in Surgical Site Marking: Can This Be an Additional Tool to Help Avoid Wrong Site Surgery?

Bergal LM, Schwarzkopf R, Walsh M, Tejwani NC.


Available at: http://journals.lww.com/journalpatientsafety/Abstract/2010/12000/Patient_Participation_in_Surgical_Site_Marking__5.aspx

This study investigated whether patients could be involved successfully in preoperative marking of their surgical sites. In an analysis of 200 orthopedic surgery patients, the authors assessed patients’ compliance with site-marking instructions and examined whether various patient characteristics influenced compliance. Results showed that of 68.2% of patients who marked a site, most did so correctly according to the instructions provided. However, several patients marked the correct site but used an incorrect symbol, and two patients marked the wrong site altogether. Patients who marked their sites were younger on average and more likely to be native English speakers than patients who did not, but other demographic variables did not significantly influence compliance. The authors conclude that involving patients in site marking may provide a useful supplement to mandatory site marking by surgeons, but that whether it will offer significant additional safety benefits remains uncertain. Two tables and one figure are included.

14. Radiation Oncology Safety Information System (ROSIS) — Profiles of Participants and the First 1074 Incident Reports

Cunningham J, Coffey M, Knöös T, Holmberg O.

*Radiother Oncol.* 2010(Dec); 97(3):601–607.

Available at: http://www.thegreenjournal.com/article/S0167-8140(10)00641-9/fulltext

The Radiation Oncology Safety Information System (ROSIS) is an international reporting system designed to collect and analyze data on safety incidents related to radiation therapy. This article describes characteristics of the radiation departments participating in the system and presents data on incidents reported to the system during the first five years of its operation. Five tables and three figures are included.

15. Responding to Patient Safety Incidents: The “Seven Pillars”

McDonald TB, Helmchen LA, Smith KM, et al.


Available at: http://qualitysafety.bmj.com/content/19/6/1.31.abstract

This article describes one academic medical center’s approach to responding to adverse incidents and errors in patient care. The approach is conceived as consisting of seven essential components or pillars: incident reporting, investigation, communication and disclosure, apology and remediation, system improvement, data tracking and performance evaluation, and education and training. Four tables and one figure are included.

16. Twenty-Four-Hour Observational Study of Hospital Hand Hygiene Compliance

Randle J, Arthur A, Vaughan N.

*J Hosp Infect.* 2010(Nov); 76(3):252–255.

Available at: http://www.journalofhospitalinfection.com/article/S0195-6701(10)00317-8/abstract

This study used direct observations over a continuous 24-hour period to assess hand hygiene performance among healthcare workers, patients, and visitors at a large teaching hospital. In their analysis of a total of 823 opportunities for hand
hygiene, the authors found that compliance varied among types of healthcare professionals and was lower among doctors (47%) than among nurses (75%) or other staff (59%), while compliance among patients and visitors was approximately 56%. Healthcare workers’ compliance also varied depending on the nature of the occasion for hand hygiene, with higher levels of compliance before performance of an aseptic task and after body fluid exposure and lower levels before patient contact and after contact with objects in the patient’s environment. The authors conclude that while observed rates of hand hygiene were higher than have been found in previous studies, the low rate of compliance among doctors continues to pose concern. Two tables are included.

17. Underreporting of Patient Safety Incidents Reduces Health Care’s Ability to Quantify and Accurately Measure Harm Reduction
   Noble DJ, Pronovost PJ.
   Available at: http://journals.lww.com/journalpatientsafety/Abstract/2010/12000/Underreporting_of_Patient_Safety_Incidents_Reduces.10.aspx

In this article, the authors discuss reasons for underreporting of patient safety incidents and the impact of underreporting on the measurement of healthcare safety performance. The authors argue that underreporting produces data biases that may lead to distorted impressions about which incidents are most prevalent or of highest priority, substantially impeding efforts to identify, understand, and address safety problems. One table and two figures are included.

18. The Use of Human Factors Methods to Identify and Mitigate Safety Issues in Radiation Therapy
   Radiother Oncol. 2010(Dec); 97(3):596–600.
   Available at: http://www.thegreenjournal.com/article/S0167-8140(10)00600-6/fulltext

This article describes how an approach incorporating techniques from human factors engineering was used to improve safety in the delivery of radiation therapy at a hospital in Ontario, Canada. Three figures are included.

19. Variability in the Measurement of Hospital-Wide Mortality Rates
   Available at: http://www.nejm.org/doi/full/10.1056/NEJMc1006396

Considerable debate has occurred over the validity of using hospital-wide mortality rates as a gauge of hospitals’ quality performance. This study critically evaluated several existing methods for measuring hospital mortality rates in an attempt to shed further light on this issue. The authors compared four commercially available measurement systems by applying each system to an identical set of data on more than 2.5 million discharges from Massachusetts hospitals that occurred during a 3-year period. The authors found that the four methods yielded widely differing results, mainly because each method used different rules to determine which patients were included in the analysis. Although they acknowledge that findings could provide important information, the authors argue that this lack of agreement points to serious concerns about the use of such methods for evaluating quality of hospital care. Three tables and two figures are included.

20. The WHO Patient Safety Curriculum Guide for Medical Schools
   Available at: http://qualitysafety.bmj.com/content/19/6/542.abstract

In this article, authors of the WHO Patient Safety Curriculum Guide for Medical Schools discuss the rationale for formal inclusion of patient safety education in medical training, describe how the WHO guide was conceived and developed, and provide an overview of its contents and objectives for its use. Four tables are included.