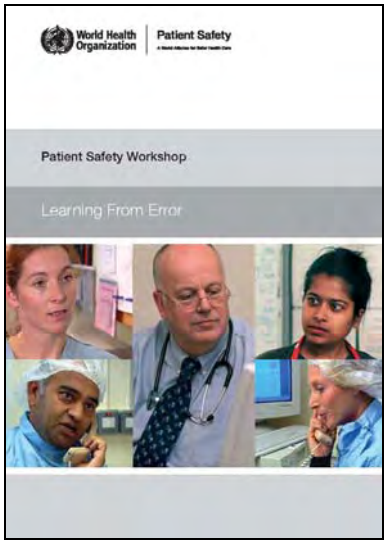
Canterbury Medical Library

Articles of Interest : Quality

V6 No2 November 2010

Quality●Net

Patient Safety Workshop: Learning from error



Did you attend the Clinical Audit Lunchtime presentation on the 18th October? If not you may like to contact the CDHB Clinical Audit department to arrange to view their DVD of the World Health Organization's 'Learning from Error' movie.

The 'Learning from Error' training booklet and a video version of the movie can be downloaded from the World Health Organization's publications centre website. However, the video version isn't as clear as the DVD version available through the CDHB Clinical Audit department.

World Health Organization. Publications Centre:
http://www.who.int/publications/en/

A colour version of the booklet is available online from:
http://whqlibdoc.who.int/publications/2010/9789241599023_eng.pdf.

See the WHO Patient Safety website for news on improvements in patient safety worldwide:
http://www.who.int/patientsafety/en/

Project RED

http://www.jcrinc.com/ahrq-project-red/

Project RED (Re-Engineered Discharge) intervention which aims to improve the patient's preparedness for self care and at reduce the likelihood of readmission. The Agency for Healthcare Research and Quality (AHRQ) provided funding for development and implementation of this patient-centered, standardized approach to discharge planning and discharge education.

Taken a look at the GENR8 site yet? It's starting to take off!

Genr8 is an interactive idea-sharing website to support sharing of ideas and collaboration between health professionals in Canterbury. A place for creative thinking and ideas to 'make it better' for our patients and the community. Get your ideas working! Share your ideas, network with others, make it happen.

Take a look at the **Leaderboard** to see which ideas are the most popular with CDHB staff

Check out the **Share Ideas That Worked** section and add your own comments.

Share ideas that made it better for you through **Add an Idea** (need to register first).

Join one of the **Communities** - Falls Prevention Community, Quality & Innovation Awards.

www.genr8.health.nz

Beyond Traditional Patient Safety Tools and Techniques

http://www.rmf.harvard.edu/files/documents/forum/v28n1/complete.pdf

The March 2010 issue of this newsletter (CRICO/RMF Forum) produced by a medical insurance company in the US is worth a look. This issue '*Beyond Traditional Patient Safety Tools and Techniques'* includes articles on:

- Are Lean and Six Sigma Good Tools for Improving Quality and Patient Safety?
- How Can Competing Patient Safety Improvement Strategies Be Harnessed?
- Which Tools Should Health Care Leaders Consider?
- Are Some Patient Safety Interventions Better Than Others, or Is It the Implementation?
- How Do Organizations Reach a Single, Widely-accepted "Way" to Address Patient Safety?

WHO Patient Safety Curriculum Guide for Medical Schools

http://www.who.int/patientsafety/education/curriculum/download/en/index.html

WHO Patient Safety has developed a curriculum to enable and encourage medical schools to include patient safety in their courses. Medical school curricula tend to focus on pure clinical skills, diagnosis and treatment of disease. However to reduce medical error and reduce harm to patients both medical schools and teaching hospitals need to train physicians to follow safe practices, analyze bad outcomes, and work collaboratively in teams to redesign care processes to make them safer. This focus needs to begin on Day 1 of medical school and continue throughout medical education and residency training.

The IHI Improvement Map

http://www.ihi.org/IHI/Programs/ImprovementMap/

Worth a look, not earth shattering but less complicated than it first seems. Take a look at the 'Most Visited Processes' section on the right-hand side of the IHI Improvement Map homepage. Falls Prevention and Acute Myocardial Infarction are currently featured. Click on a topic then on the 'Resources' tab to see case studies for the topic.

A few Internet resources of more specific interest:

Resuscitation Council (UK).

http://www.resus.org.uk/siteindx.htm#main

The Resuscitation Council (UK) publishes the Resuscitation Guidelines which contain detailed information about emergency life support and deal with some of the issues of basic and advanced life support for adults, paediatrics and the newborn. Also included are guidelines for the use of Automated External Defibrillators and other related topics.

The Resuscitation Guidelines 2010 are now available online from the Resuscitation Council (UK) website:
http://www.resus.org.uk/pages/GL2010.pdf

NSW Falls Prevention Network

http://fallsnetwork.powmri.edu.au/

Join the network to receive updates from the mailing list - useful discussion that is relevant in an Australasian context.

Prevention of Falls Network Europe (PROFANE)

http://www.profane.eu.org/phpBB3/index.php

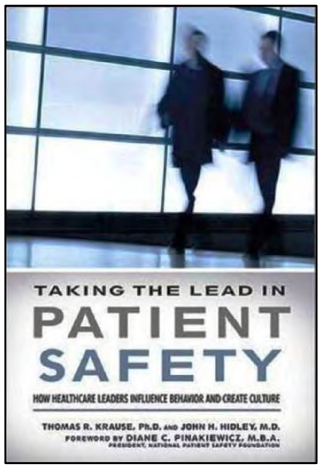
Forums include a general forum, falls and bone health, falls prevention.

Emergency preparedness: Preparing hospitals for disasters

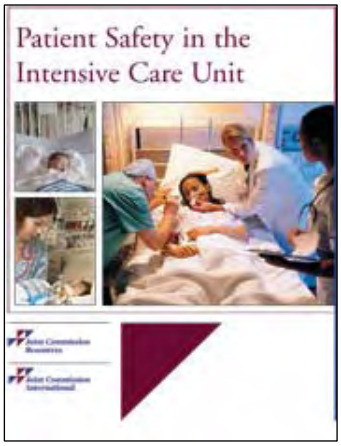
California is familiar with earthquakes and their Hospitals' Association provides this site to assist its hospitals prepare for disasters.
http://www.calhospitalprepare.org/category/content-area/planning-topics/natural-disasters/earthquake

For further information on Clinical Audit & Quality Improvement please contact:
Irena de Rooy, Quality Facilitator - ext 86194
Shona MacMillan, Quality Manager - ext 81363

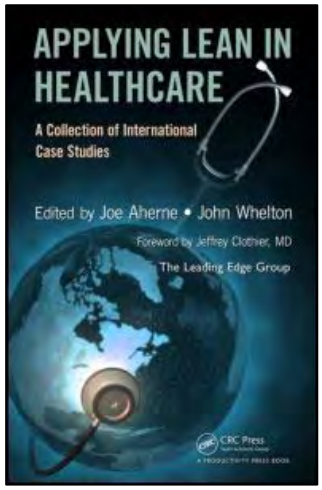
New books of Interest



1. **Advanced performance improvement in health care : principles and methods.** [Donald E. Lighter]. Sudbury, Mass. : Jones and Bartlett Publishers, c2011. *Canterbury Medical Library: W 84.4.AA1 L723 2011*
2. **Applying lean in healthcare : a collection of international case studies**. [Joe Aherne, and John Whelton (Eds)]. Boca Raton : CRC Press, c2010. *Canterbury Medical Library: W 84.1 A652 2010*
3. **Health care errors and patient safety.**[Brian Hurwitz and Aziz Sheikh]. Chichester, UK ; Hoboken, NJ : Wiley-Blackwell/BMJ Books, 2009. *Canterbury Medical Library: WX 153 H434 2009*



4. **Health promotion : planning and strategies.**[Jackie Green and Keith Tones]. London : Sage, 2010. *Canterbury Medical Library: WA 590 G796 2010*
5. **Lean hospitals: improving quality, patient safety, and employee satisfaction**. [Mark Graban]. Boca Raton : CRC Press, c2009. *Canterbury Medical Library:HD 58.9 G727 2009*
6. **Nursing outcomes : the state of the science.** [Diane M. Doran (Ed)]. Sudbury, MA : Jones & Bartlett Learning, c2011. *Canterbury Medical Library: WY 100 N974 2011*
7. **Patient safety in the intensive care unit.** Joint Commission on Accreditation of Healthcare Organizations. Oakbrook Terrace, Ill. : Joint Commission Resources, c2010. *Canterbury Medical Library: WX 218 P298 2010*



8. **Patient safety pocket guide.** Oakbrook Terrace, Ill : Joint Commission Resources, c2009. *Canterbury Medical Library:WX 153 P298 2009*
9. **Taking the lead in patient safety : how healthcare leaders influence behavior and create culture.** [Thomas R. Krause and John Hidley]. Hoboken, N.J. : John Wiley & Sons, c2009. *Canterbury Medical Library:WX 185 K91 2009.*

Library Hours

Friday 5 November 2010 - Friday 17 December 2010	
Monday – Thursday	8.30am - 6.00pm
Friday	8.30am - 5.00pm
Saturday	1.00pm - 5.00pm
Sunday	closed
Saturday 18 December 2010 - Sunday 30 January 2011	
Saturday 18 - Sunday 19 December	closed
Monday 20 - Wednesday 22 December	8.30am - 5.00pm
Thursday 23 December	8.30am - 4.00pm
Friday 24 December 2010 - Tuesday 4 January 2011	
Christmas/New Year Break	closed
Wednesday 5 January - Sunday 9 January 2011	
Wednesday - Friday	8.30am - 5.00pm
Saturday & Sunday	closed

The Clinical Audit Committee, Christchurch Hospital, invites you to

A Lunchtime
CLINICAL AUDIT & QUALITY IMPROVEMENT PRESENTATION

Monday, 29th of November, 2010
12.30 – 13.30 hrs

Oncology Lecture Theatre.

12:00 **Five year audit pancreas and liver surgery.**
Presented by Saxon Connor, Surgeon.

13:00 **Anastomotic leak following right hemicolectomy in General Surgical Department at Christchurch Hospital.**
Presented by Bilal Akbar, Cardiothoracic Registrar.

All Staff Welcome!
Please bring your own lunch

Articles of Interest :

Most articles listed are available from the CDHB and University of Otago networks. Articles marked are only available from the University of Otago network.

To access the online article click on the link below the article. Alternatively locate the journal using the library's electronic journals portal: http://www.chmeds.ac.nz/departments/library/index.htm

CDHB staff who are library members can access all of these articles on Canterbury Medical Library's public computers - bring a USB flash drive to download pdfs of the articles you select.

Request a print copy: CDHB and University of Otago staff may use the attached request form to request a photocopy of most articles listed here. Note that under the Copyright Act the library can only supply one photocopy from any one journal issue.

1. **Association of interruptions with an increased risk and severity of medication administration errors.** [Westbrook JI, Woods A, Rob MI, Dunsmuir W, Day RO]. Archives of Internal Medicine 2010 Apr 26; 170(8):683-90.
   http://archinte.ama-assn.org/cgi/content/short/170/8/683
2. **Can we make cuts that will not harm health care?** [Rich G, Leonard P, Zalmanovitch Y, Vashdi D]. BMJ British Medical Journal 2010 Mar 20; 340(7747):628-31.
   http://www.bmj.com/content/340/7747/Analysis.full.pdf
3. **A Conversation with Peter Pronovost About Patient Safety.** [Klein S, McCarthy D]. Quality matters 2010 (Apr/May):1-6.
   http://www.commonwealthfund.org/Content/Newsletters/Quality-Matters/2010/April-May-2010/Q--A.aspx
4. **Diagnostic Adverse Events: On to Chapter 2:** Comment on " Patient Record Review of the Incidence, Consequences, and Causes of Diagnostic Adverse Events". [Thomas EJ, Brennan T]. Archives of Internal Medicine 2010 Jun 28; 170(12):1022-2.
   http://archinte.ama-assn.org/cgi/content/extract/170/12/1021
5. **Disclosure of patient safety incidents: a comprehensive review.** [O'Connor E, Coates HM, Yardley IE, Wu AW]. International Journal for Quality in Health Care 2010 22(5):371-9.
   http://intqhc.oxfordjournals.org/content/22/5/371
6. **Effect of a comprehensive surgical safety system on patient outcomes.** [de Vries EN, Prins HA, Crolla RMPH, den Outer AJ, van Andel G, van Helden SH, et al.]. New England Journal of Medicine 2010 Nov 11; 363(20):1928-37.
   http://www.nejm.org/doi/full/10.1056/NEJMsa0911535
7. **Effectiveness of interventions designed to promote patient involvement to enhance safety: a systematic review**. [Hall J, Peat M, Birks Y, Golder S, Entwistle V, Gilbody S, et al.]. Quality and Safety in Health Care 2010 19:1-7.
   http://dx.doi.org/10.1136/qshc.2009.032748
8. **Giving Medication Administration the Respect It Is Due:** Comment on:" Association of Interruptions With an Increased Risk and Severity of Medication Administration Errors". [Kliger J]. Archives of Internal Medicine 2010 170(8):690-92.
   http://archinte.ama-assn.org/cgi/content/full/170/8/690
9. **Human factors in the management of the critically ill patient.** [Bion JF, Abrusci T, Hibbert P]. British Journal of Anaesthesia 2010 Jul; 105(1):26-33. (Review)
   http://ejournals.ebsco.com/Issue.asp?IssueID=1228012
10. **Interdisciplinary communication in general medical and surgical wards using two different models of nursing care delivery.** [Fernandez R, Tran DT, Johnson M, Jones S]. Journal of Nursing Management 2010 Apr; 18(3):265-74.
    http://dx.doi.org/10.1111/j.1365-2834.2010.01058.x
11. **Losing the Moment: Understanding Interruptions to Nurses' Work.** [McGillis Hall L, Pedersen C, Fairley L]. Journal of Nursing Administration 2010 Nov 4; 40(4):169-76.
    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=linkout&SEARCH=20305462.ui

12. **Measuring patient safety culture: an assessment of the clustering of responses at unit level and hospital level.** [Smits M, Wagner C, Spreeuwenberg P, van der Wal G, Groenewegen PP]. Quality & Safety in Health Care 2009 Aug; 18(4):292-6. [Research Support, Non-U.S. Gov't]
http://qshc.bmj.com/content/18/4/292

13. **Meeting the Complex Needs of the Health Care Team:** Identification of Nurse—Team Communication Practices Perceived to Enhance Patient Outcomes. [Propp KM, Apker J, Zabava Ford WS, Wallace N, Serbenski M, Hofmeister N]. Qualitative Health Research 2010 20(1):15-28.
http://qhr.sagepub.com/content/20/1/15

14. **Multiple Accountabilities in Incident Reporting and Management.** [Hor S, Iedema R, Williams K, White L, Kennedy P, Day AS]. Qualitative Health Research 2010 20(8):1091-100.
http://dx.doi.org/10.1177/1049732310369232

15. **A novel method for reproducibly measuring the effects of interventions to improve emotional climate, indices of team skills and communication, and threat to patient outcome in a high-volume thoracic surgery center.** [Nurok M, Lipsitz S, Satwicz P, Kelly A, Frankel A, Nurok M, et al.]. Archives of Surgery 2010 May; 145(5):489-95. (Comment in: Arch Surg. 2010 May;145(5):495; PMID: 20491165) [Randomized Controlled Trial]
http://archsurg.ama-assn.org/cgi/content/short/145/5/489

16. **Patient record review of the incidence, consequences, and causes of diagnostic adverse events.** [Zwaan L, de Bruijne M, Wagner C, Thijs A, Smits M, van der Wal G, et al.]. Archives of Internal Medicine 2010 Jun 28; 170(12):1015-21. (Review) (Comment in: Arch Intern Med. 2010 Jun 28;170(12):1021-2).
http://archinte.ama-assn.org/cgi/reprint/170/12/1015

17. **Patient safety is evolving: comment on "A novel method for reproducibly measuring the effects of interventions to improve emotional climate, indices of team skills and communication, and threat to patient outcome in a high-volume thoracic surgery center".** [Uhlig PN]. Archives of Surgery 2010 May; 145(5):495. (Comment on: Arch Surg. 2010 May;145(5):489-95; PMID: 20479349) [Comment]
http://archsurg.ama-assn.org/cgi/content/full/145/5/495

18. **Responding to patient safety incidents: the “seven pillars”**. [McDonald TB, Helmchen LA, Smith KM, Centomani N, Gunderson A, Mayer D, et al.]. Quality and Safety in Health Care 2010 Epub 2010 March 1.
http://qshc.bmj.com/content/early/2010/02/26/qshc.2008.031633.full.pdf

19. **Root cause analysis in clinical adverse events**. [Mengis J, Nicolini D]. Nursing Management 2010 Feb; 16(9):16,18-20.
http://search.ebscohost.com/login.aspx?direct=true&db=heh&AN=48304952&site=ehost-live

20. **Visual revelations.** [Wainer H]. Chance 2010 23(2):47-53.
http://www.springerlink.com/content/n3234n7t2m3wj331/

21. **“Water cooler” learning: Knowledge sharing at the clinical “backstage” and its contribution to patient safety.** [Waring JJ, Bishop S]. Journal of Health Organization and Management 2010 24(4):325-42.
http://www.emeraldinsight.com/journals.htm?issn=1477-7266&volume=24&issue=4

22. **What have we learned about interventions to reduce medical errors?** [Woodward HI, Mytton OT, Lemer C, Yardley IE, Ellis BM, Rutter PD, et al.]. Annual Review of Public Health 2010 Apr 21; 31:479-97 1 p following 97. (Review) [Review].
http://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.012809.103544

Websites mentioned in Quality.Net

Here are the full URLS for the websites mentioned in Quality.Net. Sometimes you will be asked to “Block” or “Allow” a link. This is a security feature but you will need to click on “Allow” in order to see the article.

It can be quite bewildering trying to negotiate through a new website or portal to get to the article you want. If you are having problems phone the library on 80504 or call at the library reference desk for assistance.

Contact the library Reference Desk (ext 80504) if you have any problems with electronic resources

Links for items on PAGE 1

World Health Organization.
http://www.who.int/en/

World Health Organization. Publications Centre:
http://www.who.int/publications/en/

‘Learning from Error’ training booklet and video
http://whqlibdoc.who.int/publications/2010/9789241599023_eng.pdf

WHO Patient Safety
http://www.who.int/patientsafety/en/

Project Red
http://www.jcrinc.com/ahrq-project-red/

Genr8
www.genr8.health.nz

Links for items on PAGE 2

Beyond Traditional Patient Safety Tools and Techniques
http://www.rmf.harvard.edu/files/documents/forum/v28n1/complete.pdf

WHO Patient Safety Curriculum Guide for Medical Schools
http://www.who.int/patientsafety/education/curriculum/download/en/index.html

The IHI Improvement Map
http://www.ihi.org/IHI/Programs/ImprovementMap/

Resuscitation Council (UK).
http://www.resus.org.uk/siteindx.htm#main

Resuscitation Guidelines 2010 (Resuscitation Council (UK))
http://www.resus.org.uk/pages/GL2010.pdf

NSW Falls Prevention Network
http://fallsnetwork.powmri.edu.au/

Prevention of Falls Network Europe (PROFANE)
http://www.profane.eu.org/phpBB3/index.php

Emergency preparedness: Preparing hospitals for disasters (California Hospitals Association)
http://www.calhospitalprepare.org/category/content-area/planning-topics/natural-disasters/earthquake

ARTICLES OF INTEREST – QUALITY

November 2010

Indicate article numbers as required and return to:

Canterbury Medical Library
Christchurch Hospital
Private Bag 4710
CHRISTCHURCH

In the space below, indicate article numbers which you require from the **November 2010** Articles of Interest - Quality:

_____

_____

Copies of these articles are all available on request, at a cost of

$3.50 inc GST per article for current library members
$4.20 inc GST per article for non library members

If you wish to clarify which charge will apply, please contact the library to check whether or not you are enrolled as a current library member. We will, otherwise, simply charge as noted above.

Please tick the appropriate box to indicate how you will pay*:

☐ **Account Code to Charge:** _____ (please specify)
Photocopied articles, charged to a cost code, will be sent to you in your dept via the internal mail.

☐ **Personal payment** – *This option requires payment in cash. You will be contacted when the material is available for collection, & payment, from the Loans Desk of the library***.**

CSM & HS Department ..... (please specify)

CDHB Hospital & Department ..... (please specify)

Signature:_____

* This request will not be processed if [*has not been processed because*] you have failed to supply the information required.

Requester's name: _____

Address: _____

_____

If you have any suggestions regarding topics you would like to see in future Articles of Interest - Quality please list them.

_____