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1. The Association between Continuity of Care and Outcomes: A Systematic and Critical Review
Van Walraven C, Oake N, Jennings A, Forster AJ.

In this study, the authors undertook a systematic review of literature concerning the impact of continuity of care on patient outcomes. Taken together, the 18 studies that qualified for inclusion provided evidence of a strong relationship between increased provider continuity (defined as a relationship between a patient and provider(s) over time) and better patient outcomes. The authors suggest that further research is needed to examine the impact of other aspects of continuity not addressed in the included studies, such as the effective transmission of patient information and coordination of treatment among multiple doctors. Four tables and two figures are included.

2. The Comprehensive Care Rounds: Facilitating Multidisciplinary Communication among Caregivers of Complex Patients in the Neonatal Intensive Care Unit
Boos VD, Okah FA, Swinton CH, Wolff DM, Haney B.
Available at: http://journals.lww.com/advancesinneonatalcare/Abstract/2010/12000/The_Comprehensive_Care_Rounds__Facilitating.7.aspx

This article describes Comprehensive Care Rounds, a system of team meetings established in the neonatal intensive care unit of a midwestern US hospital to enhance communication and teamwork among clinical caregivers. The authors describe the design and objectives of the care rounds and present four brief case studies illustrating how the rounds have contributed to improvements in safety and quality of care. Two figures are included.

3. The Effect of a Simple Checklist on Frequent Pre-Induction Deficiencies
Thomassen Ø, Brattebø G, Søfteland E, Lossius HM, Hetne J-K.

This article describes the design and implementation of a pre-procedure checklist designed to improve the safety of anesthesia administration at a Norwegian teaching hospital. The authors found that the checklist was helpful in correcting a number of potential safety problems, most of which involved missing equipment or supplies. One table and four figures are included.

4. Emotional Influences in Patient Safety
Croskerry P, Abbass A, Wu AW.
Available at: http://journals.lww.com/journalpatientsafety/Abstract/2010/12000/Emotional_Influences_in_Patient_Safety.1.aspx

This article explores the hypothesis that clinicians’ emotions and subjective responses may have significant and unrecognized effects on their treatment of patients. To support their argument, which contrasts with the generally accepted view of clinical performance as a dispassionate process, the authors draw upon a range of evidence from the psychological and medical literatures. This evidence suggests that physicians are subject to a range of emotional influences, including day-to-day or seasonally based mood shifts, decision-making biases, and other “variations in emotional state” that can affect clinical cognition and interactions with patients. Concluding that the best defense is for physicians to become more cognizant of the potential for “emotional error,” the authors offer strategies designed to increase awareness and to ensure that such errors do not compromise the quality or safety of patient care. One table and one figure are included.

5. Enhancing Communication in Surgery through Team Training Interventions: A Systematic Literature Review
Gillespie BM, Chaboyer W, Murray P.
AORN J. 2010(Dec); 92(6):642–657.
Available at: http://www.aornjournal.org/article/S0001-2092(10)00878-1/abstract

This article presents findings of a review of literature examining the impact of team training in the operating room setting. Of the 12 studies that qualified for inclusion in analysis, nearly all found that team training had a positive impact on teamwork and communication among OR personnel. Among the smaller number of studies that examined the effects of team training on patient outcomes, several reported reduced rates of surgical complications as a secondary outcome, but a number of other patient-related outcomes did not appear to be affected. The authors conclude that while these results provide encouraging evidence for the benefits of team training interventions, further research is needed to evaluate the sustainability of interventions and to better understand their impact on patient outcomes. Two tables are included.
6. Evaluation of Consistency in Dosing Directions and Measuring Devices for Pediatric Nonprescription Liquid Medications

Yin HS, Wolf MS, Dreyer BP, Sanders LM, Parker RM. JAMA. 2010(Dec 15); 304(23):2595–2602. Available at: http://jama.ama-assn.org/content/304/23/2595.full

This study, occasioned by the FDA's recent release of new guidelines for dosing instruments included with over-the-counter (OTC) liquid medications, sought to assess to what extent these guidelines were being met by pediatric OTC medications on the market at the time when the guidelines were issued. In a comprehensive analysis of 200 OTC medications, the authors identified numerous inconsistencies and issues considered problematic under the new guidelines, including discrepancies between dosing instructions and markings on the measuring device, missing or extraneous markings, and use of nonstandard or undefined abbreviations. The authors suggest that this study's findings be used as a baseline against which future studies may assess manufacturers' response to the guidelines. Two tables and four figures are included.


This publication highlights the work of eight hospitals participating in an ongoing hand hygiene improvement initiative led by the Joint Commission Center for Transforming Healthcare. The report describes various practices and strategies these hospitals have used to monitor healthcare workers' hand hygiene performance, identify obstacles to compliance, and implement solutions.

8. How to Use an Article about Quality Improvement


This article provides a guide to assist clinicians and patient safety and quality improvement (QI) professionals in reading, interpreting, and applying the results of QI studies. Focusing on methodological considerations specific to this type of research, the article offers a series of questions designed to promote critical evaluation and understanding of QI literature. Two tables are included.

9. Iatrogenic Events in Neonates: Beneficial Effects of Prevention Strategies and Continuous Monitoring


This study assessed the impact of an intervention designed to improve safety of care for neonatal intensive care unit patients at a French university hospital. The authors report that the intervention, which involved the use of a system of continuous incident reporting along with targeted prevention strategies, was associated with significant reduction in the rate of serious iatrogenic events. While significant decreases occurred in rates of several specific problems targeted in the study, including central catheter–related infections and ten-fold drug dosing errors, an unexpected increase in one type of event—unplanned extubations—was observed. Five tables are included.

10. Impact of a Comprehensive Safety Initiative on Patient-Controlled Analgesia Errors


This study evaluated the impact of an intervention designed to improve the safety of patient-controlled analgesia (PCA) administration at a university medical center in Ontario, Canada. The authors analyzed data on more than 25,000 patients from a 7-year period to assess the incidence of errors associated with PCA and to compare error rates between the pre- and post-intervention periods. They found that overall rates of error were low (occurring in .25% of patients who received PCA) and errors decreased following implementation of the intervention, which involved the adoption of new pumps along with procedural changes and staff education. Four figures are included.

11. Infection Control Hazards and Near Misses Reported by Nursing Students


This study examined nursing students' role in infection control surveillance through an analysis of incident reports submitted by student nurses. Looking at all reports from a three-year period submitted by students to their institution's voluntary incident reporting system, the authors found that 25% of
reports involved infection control issues. The authors describe characteristics of the problems reported and discuss their findings in the context of ongoing efforts to develop effective safety reporting systems. Two tables are included.

12. Integrating CUSP and TRIP to Improve Patient Safety
Available at: http://www.hosppract.com/index.php?article=348
This article highlights two patient safety and quality improvement programs developed and implemented as part of the Michigan Keystone Project: CUSP (Comprehensive Unit-Based Safety Program) and TRIP (Translating Evidence Into Practice). CUSP draws upon empirical observation to reduce risks at the hospital unit level, while TRIP seeks to apply externally proven best practices to improve safety practice. As the authors illustrate, the programs differ with respect to design and implementation requirements but can be used together complementarily. Two figures are included.

13. Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?
Available at: http://jhppl.dukejournals.org/cgi/content/abstract/35/5/797
This paper describes an exploratory study that evaluated the feasibility and impact of mediation as a potential alternative to medical malpractice litigation. An in-depth analysis is presented describing the process and outcomes of mediation in the settlement or attempted settlement of 31 malpractice suits. While the authors report that participants were generally satisfied with the mediation process, they identify many missed opportunities for hospitals to use the process to improve safety of care and communication with injured patients—unrealized benefits they attribute in part to the lack of participation in the process by physicians from the hospitals involved. Three figures are included.

14. Making Sure: Registered Nurses Watching Over Their Patients
Schmidt LA. Nurs Res. 2010(Nov–Dec); 59(6):400–406.
Available at: http://journals.lww.com/nursingresearchonline/Abstract/2010/11000/Making_Sure__Registered_Nurses_Watching_Over_Their.5.aspx
This study sought to establish a theoretical understanding of the processes by which hospital nurses “watch over” the safety of patients in their care. The authors present a conceptual framework developed using a grounded theory analytic approach and drawing upon data from interviews conducted with 15 registered nurses who cared for patients in various hospital settings. The framework describes nurses’ surveillance of patients as consisting of six categories of activity that together constitute the central process of “making sure.” One figure is included.

15. Medication Errors in Paediatric Outpatients
Available at: http://qualitysafety.bmj.com/content/19/6/1.27.abstract
This study sought to describe the incidence and nature of medication errors occurring in pediatric ambulatory care settings. The authors used prospectively collected data from six pediatric practices in Massachusetts, all of which used paper-based prescribing systems, to determine the frequency of errors and to classify errors according to patient and provider characteristics, type of error, type of medication involved, and other factors. Results showed that errors were frequent, occurring in connection with half of all prescriptions issued, and approximately one–fifth of errors had the potential to cause patient harm. In their discussion of implications and potential strategies for improvement, the authors note that many of the errors identified in this study could have been prevented through the use of electronic prescribing technology, in particular the significant proportion of errors attributed to illegibility. Five tables are included.

16. A Patient-Centered Model to Improve Metrics without Cost Increase: Viewing All Care through the Eyes of Patients and Families
Available at: http://journals.lww.com/jonajournal/Abstract/2010/12000/A_Patient_Centered_Model_to_Improve_Metrics.8.aspx
This article describes an approach to the provision of patient- and family-centered care developed at an academic medical center. Based on the premise that an empathic appreciation of the patient’s experience is crucial to improvement, the method uses techniques such as patient and family shadowing and care flow mapping to enable providers to evaluate the physical environment of the facility, processes of care, and other aspects of the patient experience from the perspective of patients and family members. The authors describe the implementation of the method in several care settings and discuss possibilities for expanding its use to other areas. Two tables and one figure are included.
17. Preoperative Communication to Improve Safety: A Literature Review
Penprase B, Elstun L, Ferguson C, Schaper M, Tiller C.
*Nurs Manage.* 2010(Nov); 41(11):18–24.
Available at: http://journals.lww.com/nursingmanagement/Fulltext/2010/11000/Preoperative_communication_to_improve_safety__A.4.aspx

In this article, the authors review studies from the past decade investigating the impact of clinical communication on patient safety in the operating room environment, focusing on the use of preoperative briefings as an improvement technique. While concluding that the existing evidence supports the benefit of preoperative briefings for provider communication and patient safety, the authors suggest that further research is needed to examine the potential broader benefits of briefings beyond the outcomes demonstrated in existing studies. One figure is included.

18. Reclaiming the Morbidity and Mortality Conference: Between Codman and Kundera
Prasad V.
Available at: http://mh.bmj.com/content/36/2/108.abstract

This essay examines the ways in which the shift toward systems-based thinking in medicine has called into question the role of the morbidity and mortality (M&M) conference and considers how the M&M conference’s original objectives might be reconciled with changing approaches to the management of medical error. The author argues that the goal of the M&M conference should be not only to improve the delivery of care but to enable the medical profession to “transcend hubris” by coming to terms with its own fallibility.

19. Root Cause Analysis of Transfusion Error: Identifying Causes to Implement Changes
Elhence P, Veena S, Sharma RK, Chaudhary RK.
*Transfusion.* 2010(Dec); 50(12 Pt 2):2772–2777.

This case study describes an instance of transfusion error that occurred at an academic hospital in North India. The error was initially identified through a report to the institution’s error reporting system and was found to have stemmed from a sequence of mistakes, beginning with an incorrectly labeled blood sample, that ultimately led to the transfusion of blood to the wrong patient (the patients involved suffered no harm from the error). As the authors point out, this case illustrates both the potential for errors to occur during the transfusion process and the value of an effective error reporting system in identifying and addressing such errors. Three figures are included.

20. State-Sponsored Public Reporting of Hospital Quality: Results Are Hard to Find and Lack Uniformity
Ross JS, Sheth S, Krumholz HM.
*Health Aff (Millwood).* 2010(Dec); 29(12):2317–2322.
Available at: http://content.healthaffairs.org/content/29/12/2317.abstract

This analysis sought to identify and compare the characteristics of state-operated systems for public reporting of hospital quality and performance data. The authors found that, at the time when their review was conducted in summer 2009, only 25 US states had hospital quality reporting systems. There was considerable variation among the existing programs with respect to methods of data collection, types of information reported, and the format in which information was presented. The authors discuss the implications of these findings and offer recommendations for the design of future public reporting efforts. Two tables are included.