

This series from Canterbury Medical Library is issued quarterly if sufficient articles are available.

Quality•Net

Clinical Excellence Commission (CEC)

<http://www.cec.health.nsw.gov.au/currentprojects.html>

Check out their Projects and Programs page which covers a varied range of projects:

The Patient Flow and Safety Collaborative aimed to reduce the rates of significant adverse events through fostering a safety culture (includes a toolkit).

Other projects include chronic care, falls prevention, venous thromboembolism prevention.

Maryland Hospital Guide

<http://mhcc.maryland.gov/consumerinfo/hospitalguide>

Check out the Quality Leaders Guide which includes quality measures to assess the quality of care for Heart Attack (AMI), Heart Failure (CHF), Pneumonia, Surgical Infection Prevention (SIP) - Hip, Knee, Colon Surgeries



Cleveland Clinic Quality outcomes

<http://www.clevelandclinic.org/quality/outcomes/>

The Clinic created this series of outcomes books summarizing surgical and medical trends and approaches; data on patient volume and outcomes; and new technologies and innovations.

Intended for Cleveland's own surgical and medical departments and also for a wider health care provider audience.

National Center for Patient Safety

<http://www.va.gov/ncps/pubs.html>

This American governmental organisation has a number of publications worth notice. Includes their *Topics in Patient Safety (TIPS)* series:
Nov/Dec - root cause analysis.
Jan/Feb - JCAHO National Patient Safety Goals,

By the way: What makes a near miss?

Medical errors continue to make headlines and a number of articles mention near-miss incidents. What makes a near miss?

A near-miss is: where a patient safety incident was prevented because some course of action was taken. *Example:* If drugs are written up and are about to be given to the wrong patient but were spotted and not actually given, this is a near-miss.

A near-miss is not: where an incident has occurred without harm to the patient. *Example:* If the drugs were given to the wrong patient but the patient suffered no harm, this is not a near-miss, but a minor incident in which the patient suffered no ill effect.

This useful distinction is from St Mary's Hospital quality newsletter 'Quality matters' available at: <http://www.st-marys.nhs.uk/qualitymatters.html>

“A near-miss is where a patient safety incident was prevented because some course of action was taken.”

From St Mary's Hospital quality newsletter 'Quality matters' (Summer 2005)

Checked any good healthcare Blogs lately?

Richard Smith on health care quality Richard Smith formerly editor of the British Medical Journal (BMJ). Known for his provocative comments about the quality of healthcare see his blog on the Guardian newspaper website: http://commentisfree.guardian.co.uk/richard_smith/

Nursing Research: Show me the evidence! The Saint Joseph Hospital(Orange, California) blog for discussion forum for those interested in evidenced based nursing <http://evidencebasednursing.blogspot.com/>



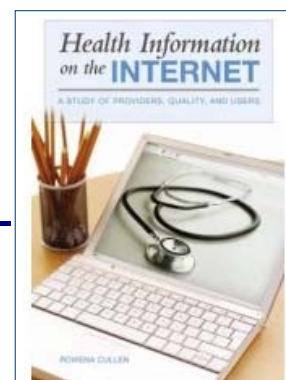
Articles of Interest *Articles are available from the library unless marked with an **O**, which indicates availability from the Canterbury District Health Board Intranet or the Christchurch School of Medicine & HS network.*

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

1. **Building the business case for clinical quality.** [Ward WJ Jr, Spragens L, Smithson K.] *Healthc Financ Manage* 2006 Dec;60(12):92-8. (O)
2. **Crossing the quality chasm: the role of information technology departments.** [Weir CR, Hicken BL, Rappaport HS, Nebeker JR.] *Am J Med Qual* 2006 Nov-Dec;21(6):382-93. (O)
3. **Does telling people what they have been doing change what they do? A systematic review of the effects of audit and feedback.** [Jamtvedt G, Young JM, Kristoffersen DT, O'Brien MA, Oxman AD.] *Qual Saf Health Care* 2006 Dec;15(6):433-6. (O)
4. **Experiences of health professionals who conducted root cause analyses after undergoing a safety improvement programme.** [Braithwaite J, Westbrook MT, Mallock NA, Travaglia JF, Iedema RA.] *Qual Saf Health Care* 2006 Dec;15(6):393-9. (O)
5. **Guidance for guidelines.** [Steinbrook R.] *N Engl J Med* 2007 25 Jan;356(4):331-3. (Display / Bay 31)
6. **An integrated framework for safety, quality and risk management: an information and incident management system based on a universal patient safety classification.** [Runciman WB, Williamson JA, Deakin A, Benveniste KA, Bannon K et al.] *Qual Saf Health Care* 2006 1 Dec;15(Suppl 1):i82-i90. (O)
7. **Nature of human error: implications for surgical practice.** [Cuschieri A.] *Ann Surg* 2006 Nov;244(5):642-8. (O)
8. **No quick fix for the NHS.** [Coombes R.] *BMJ* 2007 20 Jan;334(7585):124-5. (Display / Bay 7)
9. **Nurses' perceptions of causes of medication errors and barriers to reporting.** [Ulanimo VM, O'Leary-Kelley C, Connolly PM.] *J Nurs Care Qual* 2007 Jan-Mar;22(1):28-33. (Bay 159)
10. **Patient flow in the emergency department: is timeliness to events related to length of hospital stay?** [Clark K, Normile LB.] *J Nurs Care Qual* 2007 Jan-Mar;22(1):85-91. (Bay 159)
11. **A quality guarantee in acute coronary syndromes: the American College of Cardiology's Guidelines Applied in Practice program taken real-time.** [Vasaiwala S, Nolan E, Ramanath VS, Fang J, Kearly G, Van Riper S et al.] *Am Heart J* 2007 Jan;153(1):16-21. (Display / Bay 363)
12. **Quality improvement in New Zealand healthcare. Part 7: clinical governance—an attempt to bring quality into reality.** [Perkins R, Pelkowitz A, Seddon M; EPIQ.] *N Z Med J* 2006 13 Oct;119(1243). (O)
13. **Safe design of healthcare facilities.** [Reiling J.] *Qual Saf Health Care* 2006 Dec;15(Suppl 1):i34-i40. (O)
14. **A search for the "Holy Grail" of health care: a correlation between quality and profitability.** [Gilleen J, Shaha S, Sampanes E, Mullins C.] *Healthc Financ Manage* 2006 Dec;60(12):114-21. (O)
15. **Using a sentinel adverse incident audit on a Medicine for the Elderly ward.** [Witham MD, Jenkins PM, McMurdo ME.] *Qual Saf Health Care* 2006 Dec;15(6):446-7. (O)

New books of Interest *Nothing specific to quality this month but these may be of interest.*

1. **Health information on the Internet : a study of providers, quality, and users.** [Rowena Cullen]. Westport, Conn: Praeger, 2006. W 26.5 C967 2006
2. **The physician's survival guide for the hospital : let the hospital work for you** [Samuel H. Steinberg]. New York; Lincoln: iUniverse, c2006. WX 203 S819 200
3. **The trouble with medical journals.** [Richard Smith]. London: Royal Society of Medicine Press, c2006. WZ 345 S657 2006



Library Hours Monday 28 January – Sunday 15 April

Monday –Thursday	8.30am – 8.00pm
Friday	8.30am – 5.00pm
Saturday	1.00pm – 5.00pm
Sunday	Closed

Exceptions

Thursday 5 April	8.30am - 6.00pm
Friday 6 April (Easter Friday)	Closed
Saturday 7 April (Easter Saturday)	1.00pm - 5.00pm
Sunday 8 April (Easter Sunday)	Closed
Monday 9 April (Ester Monday)	Closed
Tuesday 10 April	8.30am - 6.00pm

ARTICLES OF INTEREST – QUALITY

February 2007

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 **February 2007** Articles of Interest - Quality:

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

\$3.50 + GST (i.e. \$3.95) per article for current library members

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