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1. **A Survey on Patient Safety Culture in Primary Healthcare Services in Turkey.**
   Bodur S, Filiz E.
   Int J Qual Health Care. 2009(Oct); 21(5):348–355.
   This article reports findings of a study that assessed patient safety culture at primary healthcare organizations in Konya, Turkey. The authors administered an adapted version of a US Agency for Healthcare Research and Quality's safety culture survey tool to a total of 180 providers, including general practitioners, nurses, and other healthcare staff at twelve primary care facilities. While responses reflected a positive safety culture in some areas, such as teamwork, in other areas they suggested room for improvement. In particular, respondents' most negative ratings were those related to safety event reporting and organizational response to error, with most respondents indicating that reporting of or communication about errors occurred only infrequently. Additional details of these findings and implications are discussed. Multiple tables are included.

2. **Attitudes of Patients and Care Providers toward a Surgical Site Marking Policy.**
   Goldberg AE, Harnish JL, Stegienko S, Urbach DR.
   Surg Innov. 2009(Sep); 16(3):249–257.
   This study explored attitudes and experiences related to surgical site marking among patients and providers at a university health system in Toronto, Ontario, that had recently introduced a site marking requirement for all surgical procedures. Analysis of data from interviews with patients and clinicians and from direct observation of site marking procedures identified several prominent themes, including the effectiveness and objectives of site marking as a patient safety measure, questions about who should be responsible for marking the site, and concerns about patient privacy and dignity. Providers considered site marking important when there was potential ambiguity about the surgical site, but questioned its utility in cases where the correct site seemed unequivocal. Some participants wondered whether the preoperative meeting between the patient and provider, ostensibly a secondary consequence of the site marking requirement, was in fact the policy's primary goal. Two tables are included.

3. **Can Education and Training for Domestic Staff Increase Awareness of Infection Control Practices and Improve Cleanliness within Hospitals?**
   Aziz A.
   J Infection Prev. 2009(Sep); 10(5):171–177.
   This article describes the development, implementation, and impact of an educational workbook designed to improve understanding of and adherence to infection control practices among domestic staff at a UK teaching hospital. Results of a pre- and post-intervention assessment showed implementation of the workbook was associated with significant improvements in domestic staff's awareness of infection control practices and in the hospital's performance on a standardized assessment of environmental cleanliness. Implications and recommendations for further steps to improve hospital infection control practice with respect to domestic staff are discussed. One table and multiple figures are included.

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4. **Cost Savings Associated with Increased RN Staffing in Acute Care Hospitals: Simulation Exercise.**
Shamliyan TA, Kane RL, Mueller C, Duval S, Wilt TJ.
Nurs Econ. 2009(Sep/Oct); 27(5):302–314,331.
This study sought to estimate the economic impact of increased nurse staffing in acute care hospitals from the perspectives of the hospital industry and of the public. The authors used calculations based on a meta-analysis of published evidence to model the potential effects of higher nurse staffing with respect to hospital-associated mortality, incidence of avoidable adverse events, and associated costs. According to this model, increased nurse-to-patient ratios would yield considerable societal benefits, but the business argument for hospitals was less clear. One figure and multiple tables are included.

5. **Costs of Quality Improvement: A Survey of Four Acute Care Hospitals.**
Chen LM, Rein MS, Bates DW.
Jt Comm J Qual Patient Saf. 2009(Nov); 35(11):544–550.
This study sought to estimate the costs associated with quality improvement and patient safety activities at four acute care teaching hospitals belonging to a healthcare system in the northeastern US. The authors conducted interviews with hospital CMOs and other staff to gather data on the nature and annual costs of quality- and safety-related activities at each facility. They found that total estimated costs of these activities varied from $2 million to $21 million among the hospitals examined; relative costs varied less dramatically, from $200 to $400 per discharge, or 1% to 2% of total operating revenue. Hospitals differed considerably in their apportionment of funding among the various activities, and activities considered high impact were not necessarily the most expensive. Four tables are included.

6. **Enhancing Medication Use Safety: Benefits of Learning from Your Peers.**
Kazandjian VA, Ogunbo S, Wicker KG, Vaida AJ, Pipesh F.
Qual Saf Health Care. 2009(Oct); 18(5):331–335.
This study assessed the impact of involvement in a statewide medication safety initiative on medication use practices at participating hospitals. The authors examined changes in medication safety performance over a 2-year period (2005–2007) at 35 Maryland hospitals participating in the MEDSAFE project, a collaborative quality improvement initiative launched in 2000. They found that hospitals' performance on a standardized medication safety assessment improved significantly at the statewide level during the period examined, although improvement at the level of individual facilities was more variable. Further details of these findings, implications, and possibilities for future research are discussed. Three tables and three figures are included.

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7. **Family Alert: Implementing Direct Family Activation of a Pediatric Rapid Response Team.**
Ray EM, Smith R, Massie S, et al.
Jt Comm J Qual Patient Saf. 2009(Nov); 35(11):575–580.
This article describes how a children's hospital adapted its existing rapid response system to enable activation of the system by patients' family members. The authors discuss the implementation and impact of the family activation feature and comment on challenges encountered and lessons learned, with particular emphasis on the importance of effective staff and family education in the intervention's success. Two figures are included.

8. **FDA's Safe Use Initiative: Collaborating to Reduce Preventable Harm from Medications.**
Silver Spring, MD: US Food and Drug Administration; November 4, 2009.
Available at: http://www.fda.gov/downloads/Drugs/DrugSafety/UCM188961.pdf
This report introduces the FDA's recently launched Safe Use Initiative, a program aimed at developing collaborative efforts to reduce avoidable harm associated with prescription and over-the-counter medication use in the US. The report presents data on medication-related risks, provides a historical overview of FDA medication risk management activities and efforts by other organizations, and sets forth objectives, areas of focus, and next steps for the initiative.

9. **Hand Washing, a Key Anti-Flu Strategy, Often Neglected by Health Care Workers.**
Mitka M.
JAMA. 2009(Nov 4); 302(17):1850–1851.
Healthcare workers' hand hygiene compliance has remained suboptimal despite vigorous efforts at improvement. This article points out that the spread of the H1N1 flu virus underscores the importance of hand hygiene as an infection control measure in the healthcare environment, and highlights new national and global initiatives that focus on hand hygiene improvement.

10. **Hospital Governance and the Quality of Care.**
Jha AK, Epstein AM.
Health Aff. 2010(Jan/Feb); 29(1). Published online November 6, 2009.
This study sought insight into hospital governing boards' involvement in quality of care, using data from a survey of board chairs of 1,000 US hospitals. The authors found that boards overall had limited engagement in quality-related activities. For instance, fewer than a third of the boards had received formal training related to quality issues, and only about half rated quality among the top priorities for board oversight or evaluation of CEO performance. In addition, board engagement in quality varied significantly between hospitals that performed better and those that performed more poorly on selected quality measures. Further study findings and implications are discussed. One table and two figures are included.

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11. **Improving Medication Error Reporting in Hospice Care.**
Boyer R, McPherson ML, Deshpande G, Smith SW.
Am J Hosp Palliat Med. 2009(Oct/Nov); 26(5):361–367.
This study sought to describe the frequency and nature of medication errors in hospice patients, and to assess the impact of an educational intervention on awareness and reporting of medication errors among hospice staff. The authors examined medication error reports from two hospice organizations in Maryland and compared data from before and after implementation of the intervention. Results indicated that participants' ability to identify errors improved following the intervention; reporting of errors increased in only one of the two facilities examined. Additional findings, implications, and possibilities for further research are discussed. Multiple tables and figures are included.

12. **Lost in Transmission — FDA Drug Information That Never Reaches Clinicians.**
Schwartz LM, Woloshin S.
N Engl J Med. 2009(Oct 29); 361(18):1717–1720.
This perspective piece argues that a better system is needed to ensure that important FDA drug information is communicated to the physicians who prescribe these medicines. The FDA collects extensive information about a drug's relative harms and benefits as part of the drug approval process, but this information sometimes does not make it into the drug package inserts and other information sources on which prescribers rely. The authors discuss several notable examples of such omissions and suggest steps that could be taken to improve communication of drug information to prescribers.

13. **Making Health Care Better.**
Leonhardt D.
New York Times. Sunday Magazine, November 8, 2009.
This article examines the tension between intuition- and evidence-based approaches to medical treatment from a historical and sociological perspective. The author describes how Intermountain Healthcare, a Utah-based hospital system, has developed evidence-based treatment protocols that have measurably improved patient outcomes for a variety of conditions. While the success of projects such as Intermountain's demonstrates that individual hospital systems can use scientific methods to improve care, the medical profession overall has been slow to adopt such approaches. The author discusses reasons for this resistance, the progress that has been made in spite of this ambivalence, and the prospects for further change.

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14. **Medication Reconciliation in Ambulatory Care: Attempts at Improvement.**
Nassaralla CL, Naessens JM, Hunt VL, et al.
Qual Saf Health Care. 2009(Oct); 18(5):402–407.
This study evaluated the impact of an initiative designed to improve the quality of medication reconciliation in four outpatient clinics at the Mayo Clinic, Rochester, Minn. The two-stage intervention used a variety of methods to increase staff and patient awareness of and involvement in the medication reconciliation process, including training staff in medication reconciliation technique and encouraging patients to bring lists of their current medications with them to appointments. Results showed that the accuracy of medication lists increased significantly following implementation of the interventions, suggesting that such an approach can be effective in improving medication reconciliation in the ambulatory care setting. Multiple tables and figures are included.

15. **Physician Quality Officer: A New Model for Engaging Physicians in Quality Improvement.**
Walsh KE, Ettinger WH, Klugman RA.
Am J Med Qual. 2009(Jul/Aug); 24(4):295–301.
This article reports on how UMass Memorial Medical Center, an academic medical center in Worcester, Mass, redesigned its program for physician quality officers in order to increase physician involvement in organizational quality improvement. The authors describe the structure and implementation of the new program and discuss challenges encountered and lessons learned during the process. Three tables are included.

16. **Quality: The Mayo Clinic Approach.**
Swensen SJ, Dilling JA, Milliner DS, et al.
Am J Med Qual. 2009(Sep/Oct); 24(5):428–440.
This article provides an overview of the guiding principles and activities that comprise the Mayo Clinic's approach to ensuring patient safety and quality of care. The authors describe the 4-part theoretical framework underlying this approach and highlight a variety of quality improvement methods employed in each of the areas it addresses — culture, infrastructure, engineering, and execution. Multiple figures are included.

17. **Rate of Undesirable Events at Beginning of Academic Year: Retrospective Cohort Study.**
Haller G, Myles PS, Taffé P, Perneger TV, Wu CL.
BMJ. 2009(Oct 13); 339:b3974. doi:10.1136/bmj.b3974
This study investigated whether care provided by medical trainees is riskier at the beginning of the academic year, when trainees are new to the hospital workplace, than at other times of the year. The authors examined data on anesthesia procedures performed during a 5-year period by trainees at a university hospital in Melbourne, Australia. Trainees varied in level of clinical experience but were all in their first year of service at the study hospital. Results showed that safety-compromising incidents occurred significantly more frequently at the beginning of the academic year and were equally common among trainees at all levels of experience. Possible explanations for these findings, implications, and potential strategies for improvement are discussed. Four tables and one figure are included.

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18. **Shared Medical Regulation in a Time of Increasing Calls for Accountability and Transparency: Comparison of Recertification in the United States, Canada, and the United Kingdom.**
Shaw K, Cassel CK, Black C, Levinson W.
JAMA. 2009(Nov 11); 302(18):2008–2014.
This article describes current systems for physician recertification in the US, Canada, and the UK, and discusses how increasing demands for accountability may provoke a shift from the current self-regulatory models to ones in which regulatory responsibility is shared between the medical profession and stakeholders. Two tables are included.

19. **Storytelling: Its Place in Infection Control Education.**
Cole M.
J Infection Prev. 2009(Sep); 10(5):154–158.
This article argues that storytelling can be a powerful educational technique as a component of efforts to improve healthcare workers' hand hygiene compliance. The author outlines the pedagogical and psychological rationale for the use of storytelling as an educational tool and offers a vignette illustrating how such an approach might be applied in practice.

20. **The Effect of Environmental Design on Reducing Nursing Errors and Increasing Efficiency in Acute Care Settings: A Review and Analysis of the Literature.**
Chaudhury H, Mahmood A, Valente M.
Environment and Behavior. 2009(Nov); 41(6):755–786.
This study sought to synthesize existing evidence concerning the impact of nurses' work environment on propensity for error, efficiency, and quality of care. The authors present findings from a comprehensive literature review and from focus groups that explored this question. A variety of aspects of the physical environment, including noise, lighting, ergonomics of furniture and equipment, and spatial layout and navigability, were identified as key factors influencing safety and efficiency of care. On the basis of these findings, four design principles for reducing the risk of error in the nursing care environment are proposed. Two tables and two figures are included.

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