## Patient Safety

Birbeck, G. L., Zingmond, D. S., Cui, X., & Vickrey, B. G. (2006). Multispecialty stroke services in california hospitals are associated with reduced mortality. *Neurology, 66*(10), 1527-1527-1532.
This study sought to evaluate whether a multispecialty service, a distinct hospital ward, protocols, or a specialist are associated with reduced mortality among patients with stroke. The study concluded that multispecialty stroke services are underutilized despite their association with reduced stroke mortality.

Dykes, P. C., Acevedo, K., Boldrighini, J., Boucher, C., Frumento, K., Gray, P., et al. (2005). Clinical practice guideline adherence before and after implementation of the HEARTFELT (HEART failure effectiveness & leadership team) intervention. *The Journal of Cardiovascular Nursing, 20*(5), 306-314.
HEART Failure Effectiveness & Leadership Team (HEARTFELT) is a multifaceted intervention designed to improve adherence with the American College of Cardiology/American Heart Association practice guidelines for heart failure (HF). The purpose of this study was to assess differences in clinician adherence with clinical practice guidelines before and after implementation of HEARTFELT. A quasi-experimental, untreated control group design with separate pretest/posttest samples was employed at a community hospital in Connecticut. The untreated historical control group included patients aged 65 years or older with HF and a nonequivalent comparison group of patients with stroke. The posttest samples included patients with the diagnosis of HF and stroke admitted after implementation of the HEARTFELT intervention. The HEARTFELT intervention included automated pathway in electronic medical record (order sets, interdisciplinary plan of care, self-management plan), access to evidence for clinicians and patients, HF self-management education tools, and ongoing discipline-specific feedback regarding adherence. Data were analyzed using parametric and nonparametric methods. The HEARTFELT intervention significantly improved clinician adherence with addressing all self-management categories in the electronic medical record (P = .000) and adherence with self-management education given to the patient in writing at discharge (P = .000). There were no significant differences in adherence with medical interventions (P = .39). While guideline adherence is associated with less practice variation and improved processes, methods of integration into practice in community hospital settings have been largely unexplored. The multifaceted HEARTFELT intervention is promising for its potential to integrate evidence at the point of care, to reduce unwarranted variation in practice, and ultimately to improve the outcomes of individuals with HF.

Gandhi, T. K. (2005). Fumbled handoffs: One dropped ball after another. (see comment). *Annals of Internal Medicine, 143*(7), 542-542-543.
This article discusses the idea that missed follow-up of abnormal tests results and resultant days in diagnosis is a safety issue that is gaining increased attention. Current systems in health care do not reliably ensure that test results are received and acted upon by ordering physicians. This article examines a specific case of a patient who's diagnosis was delayed because of systems problems.

Horsburgh, M., Merry, A., Seddon, M., Baker, H., Poole, P., Shaw, J., et al. (2006). Educating for health care quality improvement in an interprofessional learning environment: A new zealand initiative. *Journal of Interprofessional Care, 20*(5), 555-555-557.
The University of Auckland's Faculty of Medical and Health Sciences have created an interdisciplinary learning initiative for their undergraduate medical, nursing and pharmacy students. The program brings the students together for two learning modules, one focused on Maori Health and the other on Patient Safety.

Howe, A. (2006). Can the patient be on our team? an operational approach to patient involvement in interprofessional approaches to safe care. *Journal of Interprofessional Care, 20*(5), 527-527-534.
This paper describes a spectrum of practical approaches that can be implemented by teams and organizations, ranging from whole population prevention strategies to the learning that can be gained from avoidable deaths. It explores concrete examples of the ways in which individual patients

might be included in a team approach to self protection, and addresses underpinning principles of effective interprofessional working which are needed to make such approaches effective.

Kyrkjebo, J., Brattebo, G., & Smith-Strom, H. (2006). Improving patient safety by using interprofessional simulation training in health professional education. *Journal of Interprofessional Care, 20*(5), 507-507-516.
This paper reports the findings from pilot testing a simulated training program in interprofessional student teams. The findings suggest that the students were satisfied with the program, but some of the videos and simulation exercises could be more realistic and more in accordance with each other. Involving students in interprofessional team training seem to be more likely to enhance their learning process.

Ladden, M. D., Bednash, G., Stevens, D. P., & Moore, G. T. (2006). Educating interprofessional learners for quality, safety, and systems improvement. *Journal of Interprofessional Care, 20*(5), 497-497-505.
Until recently, knowledge and skills necessary for systems improvement in the health professions was not included in formal educational curricula. In addition, interprofessional collaboration was not taught as a means to improve systems. Achieving Competence Today (ACT) was designed as a new model for interprofessional education for quality, safety, and health systems improvement. This paper describes the ACT program and curriculum model and makes recommendations for the future.

Sheps, S. (2006). Reflections on safety and interprofessional care: Some conceptual approaches. *Journal of Interprofessional Care, 20*(5), 545-545-548.

Vincent, C. (2003). Understanding and responding to adverse events. *The New England Journal of Medicine, 348*(11), 1051-1056. doi:10.1056/NEJMhpr020760
An adverse outcome for a patient is difficult, sometimes traumatic, for all concerned. Such incidents pose considerable challenges to an organization, both in terms of the need to respond intelligently to their occurrence and in terms of the need to deal with their aftermath. The challenge is to find a way forward that provides the necessary support for the people involved while ensuring that the lessons of the incident are learned both by individual staff members and by the overall organization. In this article, I address two broad themes: first, how to investigate clinical incidents and learn useful lessons from them, and second, how to support the patients, families, and staff members who are involved.

Woolf, S. H. (2004). Patient safety is not enough: Targeting quality improvements to optimize the health of the population. (see comment) (review). *Annals of Internal Medicine, 140*(1), 33-33-36.
While patient safety is an important issue to address in health care, other issues such as chronic disease management and health promotion are also important, as lives are at stake when considering these topics as well. Policy makers need to consider the system as a whole and consider the potential effect on overall population health when prioritizing health care improvements.