CyberSpace

Useful information on the world wide web

Compiled by A. L. Scheffler

Web based information about patient safety and quality improvement—both popular and academic—is proliferating rapidly as the quality/safety movement gathers momentum in the United States, Australia, the UK, New Zealand, Canada, Scandinavia, Switzerland, and elsewhere around the world. One may ask—how useful is this online information? Who accesses it, for what ends, with what outcomes? How well does it translate across national, cultural, linguistic, professional, and disciplinary boundaries? And are patients safer because of it? We lack even tentative answers to such questions at present.

Online resource updates

Quality and Safety in Health Care will sort through the onslaught of online articles, reports, and opinions on patient safety and healthcare quality, and periodically summarize them on our website. In addition, the print edition of QSHC will provide summary guides to electronic resources on particular topics and themes. These may include cultural factors that promote or hinder the creation of safer health care; the potential of patient advocacy efforts to improve patient-provider communication and avoid unnecessary litigation; and lessons from non-medical research disciplines, such as organisational behavior, human factors engineering, and risk perception and communication. We will spotlight these issues using an interdisciplinary and international approach that draws on the perspectives of relevant stakeholders in different health systems: patients, their families and caregivers, nurses, pharmacists, social workers, physicians, risk managers, laboratory technicians, health services researchers, quality managers, advocates, policy makers, system and facility managers, and journalists.

Sites for sore eyes

To begin, we provide a list of selected websites featuring patient safety and healthcare quality information and documents. This list is meant to be suggestive only—a starting point for a rich journey of discovery and learning. None of these sites stands alone; each offers links to other sites and sources.


American Hospital Association (http://www.aha.org/PatientSafety/Safe_home.asp) ➤ The AHA, representing some 6000 US hospitals, has placed clinical quality and patient safety at the top of its public advocacy agenda.


Anesthesia Patient Safety Foundation (http://www.apsf.org/) ➤ The APSF was founded in 1984 “to ensure that no patient shall be harmed by anesthesia”. Its quarterly newsletter is available online.


Bristol Royal Infirmary Inquiry (http://www.bristol-inquiry.org.uk/final_report/index.htm) ➤ This July 2001 report—an exhaustive investigation of bad outcomes in paediatric cardiac surgery—is a treasure trove of material on the professional and organizational roots of adverse medical events. Drill down into the archived testimony to find many excellent submissions from safety specialists.

British Medical Journal (http://www.bmj.com/) ➤ BMJ published its comprehensive theme issue on medical error in March 2000 (http://bmj.com/cgi/content/full/320/7237/727). It is not yet online, but a summary is available online.

Canadian Provincial Court of Manitoba (http://www.pediatriccardiacinquest.mb.ca/) ➤ The November 2000 inquest report by Judge Murray Sinclair found “a failure of quality assurance and monitoring of the Health Sciences Centre Pediatric Cardiac Surgery Program” after 12 children died there in 1994. This land breaking report is a blueprint for reforming postgraduate oversight of physicians.

Critical Incidents Reporting System (http://www.anesthesia.ch/cirs/) ➤ Dr Sven Staender at the University of Basel facilitates the CIRS, “an anonymous and international forum on critical incidents in anaesthesiology”.

Department of Health (http://www.doh.gov.uk) ➤ In June 2000 the DoH released “An organization with a memory: report of an expert group on learning from adverse events in the NHS” (http://www.doh.gov.uk/reportmemreport/index.htm). This document “examines the key factors at work in organisational failure and learning” and recommends “creation of a new national system for reporting and analysing adverse health care events, to make sure that key lessons are identified and learned...”. A follow up on report “Building a safer NHS for patients” (http://www.doh.gov.uk/buildsaferhns/index.htm) outlines in greater detail a “new national system for learning from error and adverse events.” The National Patient Safety Agency (http://www.npsa.org.uk/html/npsa.htm) was launched in October 2001 to operate the new reporting system.

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Online Resource Updates

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Institute for Healthcare Improvement (http://www.ihi.org/) ▶ IHI is a leading international healthcare quality improvement organisation. It serves as the National Programme Office for the “Pursuing perfection” initiative funded by the Robert Wood Johnson Foundation (http://www.ihi.org/pursuingperfection/inet/index.asp).

Institute for Safe Medication Practices (http://www.ismp.org/) ▶ Founded in the 1970s, ISMP focuses on helping hospitals, practitioners, and patients prevent medication related injuries and deaths. It publishes the biweekly Medication Safety Alert. ISMP has affiliates in Canada and Spain.

Institute of Medicine (http://www.iom.edu/) ▶ The massive media coverage given the IOM’s November 1999 report “To err is human: building a safer health system” (http://www.nap.edu/catalog/9728.html) helped to move patient safety well up the US (and global) policy agenda for much of 2000. The “errors” report, as it came to be known, also generated intense and sometimes acrimonious debate among safety researchers about whether estimating the annual mortality attributed to medical errors was either valid or useful. In March 2001 the IOM released a major report on quality in health care “Crossing the quality chasm: a new health system for the 21st century” (http://www.nap.edu/catalog/10027.html). The IOM’s 1998 JAMA article “The urgent need to improve health care quality” (http://jama.ama-assn.org/issues/v280n11/abs/ps80006.html) is still worth reading.


Leapfrog Group (http://www.leapfroggroup.org/) ▶ Launched in 2000 by large corporate purchasers of health benefits, the Leapfrog Group aims to advance the “business case for safety” by encouraging safer and higher quality hospital care.

National Center for Patient Safety (http://www.patientsafety.gov/) ▶ NCPS, part of the US Veterans Health Administration, is working to improve safety and quality across the system of veterans’ health facilities by applying human factors principles and research on safety in high reliability organisations.


National Patient Safety Foundation (http://www.npsf.org/) ▶ NPSF is an independent nonprofit organisation founded in 1997 by the American Medical Association, 3M Healthcare, CNA HealthPro, and Schering-Plough. NPSF and its partners have convened a series of influential “Annenberg” conferences; the next conference is in Indianapolis in April 2002 (http://www.mederrors.org/). The NPSF also operates an active research program (http://www.npsf.org/html/research.html); publishes Focus, a quarterly newsletter (http://www.npsf.org/html/publications.html); maintains an extensive online bibliography (http://www.npsf.org/html/bibliography.html); and hosts a popular email discussion list and current literature awareness alert with more than 1200 subscribers as of February 2002 (http://patientsafety-l@listserv.npsf.org/archives/index.html).

National Quality Forum (http://www.qualityforum.org/) ▶ NQF is a non-profit, public-private membership organisation founded in 1999 to develop and implement a national strategy for health care quality measurement and reporting.

New Zealand Ministry of Health (http://www.moh.govt.nz/moh.nsf/) ▶ Recent reports include “Adverse events in New Zealand public hospitals: principal findings from a national survey” (December 2001) and “Toward clinical excellence: learning from experience” (September 2001).


Videos
• “First, do no harm” (2000) is a dramatised case study of a healthcare system breakdown during the treatment of an obstetrics patient. (Available for purchase from Partnership for Patient Safety at http://www.p4ps.org/purchase_harm.html.)
• “Beyond blame” (1997) is a short documentary film on how medication errors affect all involved—practitioners and patients alike. (Available for purchase from Bridge Medical at http://www.mederrors.com/.)

Call for citations
This is but a beginning. Kindly help us close the gaps by submitting citations for online materials—research reports, journal articles, proposed or enacted legislation, interactive websites, archived listserv messages—which you have found to be particularly useful for improving quality, creating safety, or preventing harm to patients in some relevant context or setting. We will review these materials for possible inclusion in future updates. We especially welcome citations (preferably in English translation, where available) for materials originating outside the “developed” world. Please send your citations to Adam L Scheffler at a-scheffler-1@alumni.uchicago.edu.

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