Quality improvement report

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- Rockeymoore MB, Holzmueller CG, Milstein A, et al. Updating the Leapfrog Group Intensive Care Unit Physician Staffing Standard. J Clin Outcomes Managt 2003;10:31–7.
- Berenholtz SM, Pronovost PJ. Barriers to translating evidence into practice. Curr Opin Crit Care 2003;9:321–5.
- Sexton, JB, Thomas, EJ, Helmreich RL. Error, stress, and teamwork in medicine and aviation: cross sectional surveys. BMJ 2000;320:745–9.
- Sexton JB, Helmreich RL. Analyzing cockpit communications: The links between language, performance, error, and workload. *Hum Perfor Extrem Environ* 2000;5:63–8.
- Thomas EJ, Sexton JB, Helmreich RL. Discrepant attitudes about teamwork among critical care nurses and physicians. *Crit Care Med* 2003;31:956–9.
- Thomas EJ, Sexton JB, Helmreich RL. Translating teamwork behaviours from aviation to healthcare: development of behavioural markers for neonatal resuscitation. *Qual Saf Health Care* 2004;13:57–64.
- Thomas EJ, Sherwood GD, Mulhollem JL, et al. Working together in the neonatal intensive care unit: provider perspectives. J Perinatol 2004;24:552–9.
- Pronovost P, Weast B, Rubin H, et al. Implementing and validating a comprehensive unit-based safety program. J Pat Saf 2005;1:33–40.
- Pronovost P, Needham D, Berenholtz S, et al. An intervention to decrease catheterrelated bloodstream infections in the ICU. N Engl J Med 2006;355:2725–32.
- Drakulovic MB, Torres A, Bauer TT, et al. Supine body position as a risk factor for nosocomial pneumonia in mechanically ventilated patients: a randomised trial. Lancet 1999;354:1851–8.
- Dodek P, Keenan S, Cook D, et al. Evidence-based clinical practice guideline for the prevention of ventilator-associated pneumonia. Ann Intern Med 2004;141:305–13.
- Torres A, Serra-atlles J, Ros E, *et al.* Pulmonary aspiration of gastric contents in patients receiving mechanical ventilation: the effect of body position. *Ann Intern Med* 1992;116:540–3.

- Berenholtz SM, Dorman T, Ngo K, et al. Qualitative review of intensive care unit quality indicators. J Crit Care 2002;17:1–15.
- The Joint Commission. Measure information form (ICU-1). Ventilator-associated pneumonia (VAP) prevention—patient positioning. http://www.jcaho.org/pns/ core+measures/2abicu1vap.pdf (accessed 10 Nov 2005).
- Rello J, Ollendorf DA, Oster G, et al. Epidemiology and outcomes of ventilatorassociated pneumonia in a large US database. Chest 2002;122:2115–21.
- 20. **Kollef MH.** The prevention of ventilator-associated pneumonia. *NEJM* 1999;**340**:627–34.
- Dodek P, Keenan S, Cook D, et al. Evidence-based clinical practice guideline for the prevention of ventilator-associated pneumonia. Ann Intern Med 2004;141:305–13.
- 22. Berenholtz SM, Milanovich S, Faricloth A, *et al.* Improving care for the ventilated patient. *Jt Comm J Qual Saf* 2004;**30**:195–204.
- Fuchs RJ, Berenholtz SM, Dorman T. How do intensivists improve outcomes? Contemp Crit Care 2004;1:1–10.
- The Centers for Disease Control and Prevention (CDC) Healthcare Infection Control Practices Advisory Committee. Guidelines for preventing health careassociated pneumonia, 2003: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. MNWR Recomm Rep 2004;53:1–36.
- National Academy for State Health Policy (NASHP). Current state programs addressing medical errors: an analysis of mandatory reporting and other initiatives. 2001.
- Bates DW, Makary MA, Teich JM, et al. Asking residents about events: how accurate are they? Jet Comm J Qual Improve 1998;24:197–202.
- Luther KM, Maguire L, Mazabob J, et al. Engaging nurses in patient safety. Crit Care Nurs Clin North Am 2002;14:341–6.
- Reason J. Understanding adverse events: human factors. In: Vincent C, ed. *Clinical risk management*. London: BMJ Publishing Group, 1995:9–30.
- 29. Reason J. Human error. Cambridge: Cambridge University Press, 1990.

Corrections

McKay J, Bowie P, Murray L, Lough M. Levels of agreement on the grading, analysis and reporting of significant events by general practitioners: a cross-sectional study. *Qual Saf Health Care* 2007;**17**:339–345. An error has occurred in the references for this paper; reference 6 should read as follows: Kostopoulou O, Delaney B. Confidential reporting of patient safety events in primary care: results from a multilevel classification of cognitive and system factors. *Qual Saf Health Care* 2007;**16**:95–100.

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Mohammed MA, Worthington P, Woodall WH. Plotting basic control charts: tutorial notes for healthcare practitioners *Qual Saf Health Care* 2008;**17**:137–45. An error has occurred in the appendix for this paper: In the row 'Continuous data (x) of which there are n items' and the column 'Three-sigma control limits', 2.26 should be 2.66.

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