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1. **Babel Babble: Physicians' Use of Unclarified Medical Jargon with Patients.**
Castro C.M., Wilson C., Wang F., Schillinger D.
Am J Health Behav. 2007(Sep/Oct); 31(Suppl 1):S85–S95.
This study examined physicians' use of clinical jargon during interactions with patients. Researchers analyzed physicians' use of jargon terms and patients' comprehension in 74 physician visits by type 2 diabetes patients identified as having limited health literacy. Results showed that physicians regularly employed jargon without explaining its meaning, and that patients' comprehension of jargon tended to be low. Reasons for physicians' reliance on jargon and the potential impact of unclarified jargon use on patients, as well as methods for improving patient comprehension, are touched upon. Several tables and one figure are included.

2. **Communication during Ward Rounds in Internal Medicine: An Analysis of Patient–Nurse–Physician Interactions Using RIAS.**
Weber H., Stöckli M., Nübling M., Langewitz W.A.
Pat Educ Couns. 2007(Aug); 67(3):343–348.
This study sought to characterize communication among patients, physicians and nurses during internal medicine ward rounds. Recorded interactions were analyzed using a modification of the Roter Interaction Analysis System (RIAS), a system for coding patient-provider dialogues. Results showed that physician-patient exchanges tended to predominate, while nurses' participation in the interactions was limited. Two data tables are included, as well as a sample transcript of a patient-physician interaction.

3. **Communication Techniques for Patients with Low Health Literacy: A Survey of Physicians, Nurses, and Pharmacists.**
Schwartzberg J.G., Cowett A., VanGeest J., Wolf M.S.
Am J Health Behav. 2007(Sep/Oct); 31(Suppl 1):S96–S104.
This study investigated healthcare providers' use of methods for improving communication with patients with low health literacy. Researchers surveyed a convenience sample of healthcare professionals regarding frequency of use and perceived efficacy of various communication techniques. Results showed that using simple language, speaking more slowly, and giving patients printed materials—all relatively straightforward techniques—were used most frequently; more involved methods, such as the teach-back technique, were used less often. Several tables and one figure are included.

4. Impact of Peripherally Inserted Central Catheters on Catheter-Related Bloodstream Infections in the Intensive Care Unit.

Patel B.M., Dauenhauer C.J., Rady M.Y., et al.
J Patient Saf. 2007(Sep); 3(3):142–148.
This study sought to ascertain the effect of using peripherally inserted central catheters (PICCs) on the incidence of catheter-related bloodstream infections (CRBSIs) in the intensive care unit. Researchers compared CRBSI rates from before and after the adoption of PICC use as a component of a central line infection prevention program. Results suggested that use of PICCs may be correlated with reduction in CRBSI rates and with shorter centrally inserted central catheter (CICC) dwell times. The authors note that further research is needed to determine the best use of PICCs as part of a CRBSI-prevention strategy. Several tables and figures are included.

5. Mature Rapid Response System and Potentially Avoidable Cardiopulmonary Arrests in Hospital.

Galhotra S., DeVita M.A., Simmons R.L., Dew M.A., members of the Medical Emergency Response Improvement Team (MERIT) Committee.
Qual Saf Health Care. 2007(Aug); 16(4):260–265.
Available at: http://qshc.bmj.com/cgi/reprint/16/4/260
This study sought to identify and classify occurrences of cardiopulmonary arrest at a tertiary care university hospital, and to examine the role of the hospital's rapid response system (RRS) in preventing these events. Researchers conducted a retrospective observational analysis of all cardiopulmonary arrests occurring in 2005. Results showed that despite improvements since implementation of RRS at this facility, cardiopulmonary arrests considered "potentially avoidable" still occurred. Also discussed are possible measures suggested by the study results as likely to prevent such events. Multiple tables are included.

6. Mortality among Hospitalized Medicare Beneficiaries in the First 2 Years Following ACGME Resident Duty Hour Reform.

Volpp K.G., Rosen A.K., Rosenbaum P.R., et al.
JAMA. 2007(Sep 5); 298(9):975–983.
This study investigated the impact of resident duty hour restrictions enacted by the Accreditation Council for Graduate Medical Education (ACGME) in July, 2003 on mortality among hospitalized Medicare patients. Researchers used interrupted time series analysis to compare mortality trends from before and after the reform took effect among hospitals with varying degrees of teaching focus. Results showed no significant association between duty hour reform and changes in mortality rates for Medicare patients during the period studied. The authors suggest that further research is needed to examine potential effects of the present reforms outside of patient mortality. Multiple tables and figures are included. Note: a related study examining the association between the ACGME reforms and mortality in Veterans Affairs (VA) hospitals appears in the same issue of JAMA and in this issue of Current Awareness.

7. Mortality among Patients in VA Hospitals in the First 2 Years Following ACGME Resident Duty Hour Reform.

Volpp K.G., Rosen A.K., Rosenbaum P.R., et al.
JAMA. 2007(Sep 5); 298(9):984–992.
This study investigated the impact of resident duty hour restrictions enacted by the Accreditation Council for Graduate Medical Education (ACGME) in July, 2003 on mortality in U.S. Veterans Affairs (VA) hospitals. Researchers used interrupted time series analysis to compare mortality trends from before and after the reform took effect among hospitals with varying degrees of teaching focus. Results showed an association between duty hour reform and significant relative improvement in mortality for medical patients in more teaching-focused hospital during the second year post-reform. No such correlation was found for surgical patients. Multiple tables and figures are included. Note: a related study examining the impact of the ACGME reforms on hospital mortality among Medicare patients appears in the same issue of JAMA and in this issue of Current Awareness.

8. Patient Safety in Canada: An Update.

No Author.
Canadian Institute for Health Information. 2007(Aug 14).
Available at:
http://www.cihi.ca/cihiweb/en/downloads/Patient_Safety_AIB_EN_070814.pdf
This analysis in brief provides an update on the current state of patient safety in Canada. The report presents summary data on adverse event occurrence for a number of reportable events, as well as results from several recent surveys examining perceptions and practices regarding patient safety. Multiple tables and figures are included.

9. Reducing Fall Risk for Frail Older Home-Care Clients Using a Multifactorial and Interdisciplinary Team Approach: Design of a Randomized Controlled Trial.

Markle-Reid M., Henderson S., Hecimovich C., et al.
J Patient Saf. 2007(Sep); 3(3):149–157.
This article describes in-progress research to investigate the efficacy of an interdisciplinary fall-prevention strategy for elders receiving home care who are vulnerable to falls. In the study, home-care clients in Ontario, Canada received either standard home-care (control group) or standard home-care plus the services of a multidisciplinary care team (intervention group) that provided individualized management of fall risk. The authors hypothesize a greater reduction in self-reported falls for the intervention group versus the control group at 6 months. Possible implications and challenges to implementation are discussed. Several tables are included.

10. SAFE Tool Improves Flow—and Patient Safety.
Mayfield S.
Focus on Patient Safety. 2007; 10(2):3–5.
Available at: http://npsf.org/paf/npsfp/fo/pdf/Focus2007Vol10No2.pdf
This article describes the Systematic Assessment of Flow and Error (SAFE) tool, a method for analyzing work processes and identifying errors developed by the author at Athens Regional Medical Center in Athens, GA. The author discusses the application of SAFE in the healthcare context and its potential to improve patient safety. A hypothetical event analysis using the SAFE framework is presented. Two figures are included.

11. Sidelining Safety—The FDA's Inadequate Response to the IOM.
Smith S.W.
N Eng J Med. 2007(Sep 6); 357(10):960–963.
Available at: http://content.nejm.org/cgi/reprint/357/10/960.pdf
In this commentary, the author discusses the FDA's response to the Institute of Medicine's (IOM) 2006 report, The Future of Drug Safety. This report recommended a number of changes to FDA operations as part of a plan for improvement of the U.S. drug-safety system. Although the FDA has made some changes in response to this report, these changes, in the author's view, do not satisfactorily address the IOM's criticisms. What is needed, Smith argues, are fundamental changes to aspects of the FDA's structure and practice that, at present, tend to "marginalize" patient safety.

12. Simulation and the Teaching and Learning of Practice in Critical Care Units.
Day L.
Am J Crit Care. 2007(Sep); 16(5):504–507.
This article examines the role of simulation in the training of new nurses in critical care. The author compares high-fidelity simulation against traditional teaching techniques, in which new nurses work with actual patients under the supervision of more experienced colleagues. These traditional training methods, she argues, impart valuable experiential knowledge that may not be provided in the "decontextualized" setting of the simulation lab. Thus, the author feels, simulation should supplement, rather than replace, traditional methods for training new nurses.

13. The Impact of a Closed-Loop Electronic Prescribing and Administration System on Prescribing Errors, Administration Errors and Staff Time: A Before-and-After Study.
Franklin B.D., O'Grady K., Donyai P., Jacklin A., Barber N.
Qual Saf Health Care. 2007(Aug); 16(4):279–284.
Available at: http://qshc.bmj.com/cgi/reprint/16/4/279
This study evaluated the impact of an electronic prescribing and medication administration intervention at a UK teaching hospital. The intervention used electronic prescribing technology in conjunction with automated dispensing, bar code patient identification, and electronic medication administration records (EMARs). Comparison of pre-and post-intervention data showed that prescribing and administration errors decreased following implementation; however, staff time devoted to medication-related tasks increased. The authors conclude that systems such as used in this intervention can be effective in reducing prescribing and medication administration errors. Multiple tables are included.

14. The Impact of Abbreviations on Patient Safety.
Brunetti L., Santell J.P., Hicks R.W.
Joint Comm J Qual Pat Saf. 2007(Sep); 33(9):576–583.
Available at: http://psnet.ahrq.gov/public/Brunetti_JCJQPS_2007.pdf
This study sought to determine the incidence, nature, and impact on patient safety of medication errors resulting from abbreviation use. United States Pharmacopeia (USP) MEDMARX records from a two-year period (2004–2006) in which an error was attributed to abbreviation were analyzed using descriptive statistics. Results, summarized in the paper, showed that almost 5% of errors reported during the study period were attributable to misinterpretation of abbreviations. Recommendations for curtailing abbreviation use, several case examples of abbreviation-related miscommunication and error, and a table listing the Joint Commission's "Do Not Use" abbreviations are included in the article. Multiple tables and one figure are included.

15. The Rosiglitazone Story—Lessons From an FDA Advisory Committee Meeting.
Rosen C.J.
N Engl J Med. 2007(Aug 30); 357(9):844–846.
Available at: http://content.nejm.org/cgi/reprint/357/9/844.pdf
This editorial comments on the recent FDA joint advisory committee meeting to address the potential cardiovascular risks associated with use of the drug rosiglitazone to treat type 2 diabetes. The author, who chaired the committee, gives background on the clinical pharmacology of rosiglitazone and outlines the recent study results that provoked concern over the drug's safety. Rosen discusses lessons that can be learned from the rosiglitazone saga; he suggests that, although the committee decided against recommending withdrawal of rosiglitazone from the market, this case nevertheless highlights shortcomings in the U.S. drug safety regulatory system and the consequent need for change.

16. **The Safety Journal: Lessons Learned with an Error Reporting Tool to Stimulate Systems Thinking.**
Singh R., Naughton B., Singh A., Anderson D.R., Singh G.
J Patient Saf. 2007(Sep); 3(3):135–141.
This article describes the design and implementation of a safety "journal" as part of a medical residency patient safety curriculum. Third-year residents in a family medicine program were asked to record observed errors, near misses, and anticipated errors (potential safety hazards) in an anonymous journal. Based on this experiment, the authors feel that the safety journal can be an effective tool to assist medical trainees in developing a systems-based mindset around patient safety. Several tables and one figure are included.

17. **The Variability and Quality of Medication Container Labels.**
Shrank W.H., Agnew-Blais J., Choudhry N.K., et al.
Arch Intern Med. 2007(Sep 10); 167(16):1760–1765.
This study aimed to describe the content, format, and consistency of content and design of prescription drug container labels supplied by pharmacies across the U.S. Researchers evaluated container labels for samples of four widely used medications obtained from pharmacies in four U.S. cities. Results showed that the content and format of label information varied widely among pharmacies; in addition, labels tended to emphasize pharmacy-related information as opposed to patient-oriented drug-use information. Multiple tables and one figure are included.

18. **Uncertain Effects of Rosiglitazone on the Risk for Myocardial Infarction and Cardiovascular Death.**
Diamond G.A., Bax L., Kaul S.
Ann Intern Med. 2007(Aug); 147(8):578–581.
Available at: http://www.annals.org/cgi/content/full/0000605-200710160-00182v1
This article comments on limitations of the recent meta-analysis indicating an association between rosiglitazone therapy and increased cardiovascular risk. The authors discuss potential weaknesses of the study methodology and present a re-analysis of the data using alternative meta-analytic methods. On the basis of this re-analysis, the authors conclude that the cardiovascular risk of rosiglitazone remains an open question: neither increased nor decreased risk has been conclusively shown. The authors' statistical approach is described in an appendix.

19. **Underdiagnosis of Hypertension in Children and Adolescents.**
Hansen M.L., Gunn P.W., Kaelber D.C.
JAMA. 2007(Aug 22/29); 298(8):874–879.
This retrospective cohort study sought to determine the frequency of undiagnosed pediatric hypertension and the influence of various patient factors on whether or not hypertension is diagnosed. An analysis of medical-records data for over 14,000 pediatric patients at an urban academic medical system showed that hypertension was frequently undiagnosed in the study population. Several patient factors were found to influence the probability of hypertension diagnosis. Two tables are included.

20. Why Worry About Near Misses?

Marella W.M.

Pat Saf & Qual Healthcare. 2007(Sep/Oct); 4(5):22–26.

Available at: http://www.psqh.com/sepoct07/nearmisses.html

The article discusses the importance of near miss reporting as a component of hospital patient safety and risk management practice. The author argues that the collection of data on near misses—not just on adverse events, as is more typical—can be an important tool for improving safety; he illustrates the ways in which this information can be used to identify potential errors and system vulnerabilities before an adverse event occurs. The author also addresses some of the challenges associated with near miss reporting and offers responses to several common objections.

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