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1. **Ask Me 3: Improving Communication in a Hispanic Pediatric Outpatient Practice.**
   Mika V.S., Wood P.R., Weiss B.D., Treviño L.
   Am J Health Behav. 2007(Sep/Oct); 31(Suppl 1):S115-S121.
   This study investigated the effects of an intervention in which Ask Me 3 materials were implemented at a pediatric clinic with a largely Hispanic patient population. The Ask Me 3 campaign, developed by the Partnership for Clear Health Communication, promotes the use of three basic questions that patients should ask during any doctor visit. Pre-and post-implementation interviews with parents of patients showed that none were aware of Ask Me 3 prior to the intervention; following the intervention, approximately 40% of parents interviewed knew about Ask Me 3, and about 20% reported having asked the questions of their children's doctors. One table is included.

2. **Building a Culture of Safety: Creating a Reliable and Sustainable Patient Safety Infrastructure through Teamwork Training.**
   Langford V., Rollins V.H.
   Pat Saf & Qual Healthcare. 2007(Sep/Oct); 4(5):44-48.
   Available at: http://www.psqh.com/sepoct07/culture.html.
   This article discusses the role of teamwork training in fostering a culture of safety and describes the implementation of a team-training program at Catholic Healthcare West (CHW) hospitals. This ongoing program is part of a larger initiative to improve the climate of safety at all CHW facilities. The authors outline the structure of the program, describe common obstacles that have arisen, and note preliminary results of the training.

3. **Building Accountability through Patient Safety Organizations.**
   Ross J.
   J PeriAnesthesia Nurs. 2007(Oct); 22(5):346-348.
   This article discusses patient safety organizations (PSOs) and the role of these organizations as an important patient safety information resource for nurses. The author gives background on the Patient Safety and Quality Improvement Act of 2005, which envisioned PSOs as a component of a large-scale adverse event reporting system and data collection network. Several state PSOs are highlighted, along with other organizations dedicated to patient safety. A list of state PSOs is included.

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4. **Combining Ratings from Multiple Physician Reviewers Helped to Overcome the Uncertainty Associated with Adverse Event Classification.**
Forster A.J., O'Rourke K., Shojania K.G., van Walraven C.
J Clin Epidemiology. 2007(Sep); 60(9):892-901.
This study sought to measure the accuracy of standard adverse event (AE) identification methods and to determine the effect of combining multiple reviewers' scores on the rate of correct classification. Researchers used latent class analysis and computer simulation to estimate the accuracy of AE classification with respect to AE prevalence, reviewer sensitivity and specificity, and number of and agreement among reviewers. Results showed that the probability of correct AE classification increased when multiple reviewers agreed upon a classification. Based on their results, the authors suggest that current AE detection methods using a single reviewer may overstate the occurrence of AEs, and that accuracy can be improved by using a greater number of reviewers. Several tables, two figures and two appendices are included.

5. **Emergency Pharmacists: A New Road to Medication Safety.**
Clancy C.M.
Pat Saf & Qual Healthcare. 2007(Sep/Oct); 4(5):8-11.
Available at: http://www.psqh.com/sepoct07/ahrq.html.
This commentary highlights the role of the emergency pharmacist—a relatively new position that is being instated in an increasing number of hospitals. Clancy outlines the evolution of the emergency pharmacist (or ED pharmacist) position, typical responsibilities, and the potential benefits to patient safety and quality of care. Also discussed are initiatives sponsored by the American Society of Health-System Pharmacists (ASHP) and the Agency for Healthcare Research and Quality to increase awareness of the role of ED pharmacists and promote the development and support of ED pharmacist programs.

6. **Facilitating Behavior Change with Low-Literacy Patient Education Materials.**
Seligman H.K., Wallace A.S., DeWalt D.A., et al.
Am J Health Behav. 2007(Sep/Oct); 31(Suppl 1):S69-S78.
This paper describes the development and application of an approach to designing patient education materials for low-literacy patients. The authors present a 6-step process and discuss in detail how they applied this process to the development of a diabetes self-management guide. As noted in the article, an important component of the process is to link key ideas to a behavioral theory model; the authors drew upon principles of social cognitive theory as a framework to create materials that would motivate and empower patients to adopt healthier behavior. One table and two figures are included.

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7. **From Punitive Action to Confidential Reporting: A Longitudinal Study of Organizational Learning from Incidents.**
Dekker S., Laursen T.
Pat Saf & Qual Healthcare. 2007(Sep/Oct); 4(5):50-56.
Available at: http://www.psqh.com/sepoct07/punitive.html.
This study explored the influence of an institutional reporting system on organizational learning—in particular, the ways in which use of a confidential reporting system may facilitate learning. Researchers observed an unnamed "safety-critical organization" over a two-year period as the organization implemented a new reporting system. Under the former system, workers reported incidents directly to their line managers, and responses to error focused on correcting the behavior of individuals; the new system allowed confidential reporting to a safety staff, and incident reports were used as opportunities to pursue system-wide learning. Results suggested that multiple factors—not just the fear of consequences, as previously established—may influence willingness to report and the relationship between reporting and organizational learning. Two tables are included.

8. **Intensive Care Unit Safety Incidents for Medical versus Surgical Patients: A Prospective Multicenter Study.**
Sinopoli D.J., Needham D.M., Thompson D.A., et al.
J Crit Care. 2007(Sep); 22(3):177-183.
This prospective study sought to determine whether medical errors, safety lapses and associated system factors for medical patients differed from those involving surgical patients. Researchers analyzed ICU Safety Reporting System (ICUSRS) incident report data from a 2-year period involving 20 medical and surgical ICUs. Results showed few significant differences between medical and surgical patients with respect to types of incidents, patient harm, or associated system factors; training and team-related factors were the most influential system factors among both groups. The authors thus suggest that similar improvement initiatives will benefit both medical and surgical patients, and that such efforts should focus on training and teamwork. One table and several figures are included.

9. **Invasive Methicillin-Resistant *Staphylococcus aureus* Infections in the United States.**
Klevens R.M., Morrison M.A., Nadle J., et al. (for the Active Bacterial Core surveillance [ABCs] MRSA Investigators)
JAMA. 2007(Oct 17); 298(15):1763-1771.
This study aimed to determine the incidence of invasive methicillin-resistant Staphylococcus aureus (MRSA) infections in 9 U.S. communities and to estimate the incidence of MRSA in the United States overall in 2005. Researchers analyzed MRSA report data from July 2004 through December 2005 from the Active Bacterial Core surveillance system (ABCs), an ongoing, population-based, active surveillance program conducted by the U.S. Centers for Disease Control and Prevention (CDC). Results showed that 8,987 cases of invasive MRSA were reported during the period examined, the majority of which were health care-associated, and that incidence was disproportionately high among certain demographics. Additional results and implications are discussed. Multiple tables are included.

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10. **Is Hospital Patient Care Becoming Safer? A Conversation with Lucian Leape.**
Buerhaus P.I.
Health Affairs. 2007(Oct 9); 26(6):w687-w696.
In this extended interview, Lucian Leape comments on the current state of patient safety, improvements that have been made, and challenges that remain. Leape opines on promising new developments and current topics of debate, such as the role of pay-for-performance programs in improving quality and safety. Leape argues that safety has demonstrably improved over the past quarter century, and, in light of several recent efforts in which hospitals have achieved safety standards previously considered unattainable, he suggests that "the last barrier is the psychological one."

11. **Isolation Status and Voice Prompts Improve Hand Hygiene.**
Swoboda S.M., Earsing K., Strauss K., Lane S., Lipsett P.A.
Am J Infect Control. 2007(Sep); 35(7):470-476.
This prospective study investigated the effect of patient isolation and electronic voice prompts on healthcare workers' hand hygiene behavior. Electronic surveillance was used to monitor frequency of hand-washing among healthcare employees in an intermediate care unit containing both isolation and non-isolation rooms; in phase II of the three-phase study, electronic voice prompts reminding employees to wash their hands were introduced as an additional variable. Results showed that hand-washing occurred more frequently in isolation rooms than in non-isolation rooms in all three phases of the study; the use of electronic voice prompts was associated with an additional improvement in hand hygiene. Multiple tables are included.

12. **Long-Term Risk of Cardiovascular Events with Rosiglitazone: A Meta-Analysis.**
Singh S., Loke Y.K., Furberg C.D.
JAMA. 2007(Sep 12); 298(10):1189-1195.
This study sought to systematically review findings on the long-term cardiovascular risks of rosiglitazone use in the treatment of type 2 diabetes. Researchers conducted a literature review and performed a meta-analysis of four selected studies involving 14,291 patients. Results indicated that rosiglitazone was associated with a significantly increased risk of myocardial infarction and heart failure as compared with a control; no significant increase in risk of cardiovascular mortality was found. Implications of these results are discussed; on the basis of these results, the authors recommend against the use of rosiglitazone in diabetic patients at risk for cardiovascular complications. Several tables and figures are included. (See also the article by Lincoff, Wolski, Nicholls and Nissen appearing in the same issue of JAMA and included in this issue of Current Awareness [no. 15].)

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13. **Low Health Literacy Puts Patients at Risk: The Joint Commission Proposes Solutions to National Problem.**
Murphy-Knoll L.
J Nurs Care Qual. 2007(Jul-Sep); 22(3):205-209.
This article gives an overview of the issue of poor health literacy and outlines the Joint Commission's research on this problem and proposed solutions. The author discusses nurses' role in addressing low health literacy, including suggested steps that nurses can take to help improve their organization's handling of health literacy, communication and cultural competency concerns.

14. **Medication Errors among Acutely Ill and Injured Children Treated in Rural Emergency Departments.**
Marcin J.P., Dharmar M., Cho M., et al.
Ann Emerg Med. 2007(Oct); 50(4):361-367.
This study investigated the incidence and nature of medication errors in high-acuity pediatric patients at rural emergency departments (EDs). Researchers conducted a retrospective record review to identify and classify medication errors among children treated at four northern California rural EDs over a three-year period. Results showed a high incidence of medication errors among the high-acuity patients constituting the study sample; none of the errors was found to have caused harm. Possible explanations for these results and their bearing on related previous findings are discussed. One figure, several tables and an appendix are included.

15. **Pioglitazone and Risk of Cardiovascular Events in Patients with Type 2 Diabetes Mellitus: A Meta-Analysis of Randomized Trials.**
Lincoff A.M., Wolski K., Nicholls S.J., Nissen S.E.
JAMA. 2007(Sep 12); 298(10):1180-1188.
This study aimed to systematically assess the effect of pioglitazone on cardiovascular adverse events in type 2 diabetes patients. Researchers conducted an independent analysis of data from manufacturer clinical trials of pioglitazone involving 16,390 patients. Results of the meta-analysis showed pioglitazone treatment was associated with significantly lower risks of death, myocardial infarction, and stroke as compared with control across the studies examined. Pioglitazone was associated with an increased risk of serious heart failure; however, this association did not result in increased mortality. The article concludes with an extended comment on the thiazolidenidione class of drugs, apropos of the recent concern regarding the cardiovascular risks of rosiglitazone. Multiple figures and tables are included. (See also the article by Singh, Loke and Furberg appearing in the same issue of JAMA and included in this issue of Current Awareness [no. 12].)

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16. **Simulation in Health Care: Setting Realistic Expectations.**
Henriksen K., Patterson M.D.
J Patient Saf. 2007(Sep); 3(3):127-134.
This article explores the use of simulation-based training in healthcare and its potential impact on patient safety. Although well established in other high-risk industries and increasingly adopted for use in the healthcare context, simulation as a component of medical training is still a relatively new and untested method: many questions remain as to its efficacy and optimal application. The authors discuss the potential benefits of simulation with respect to patient safety, provider education, and operating costs; acknowledging these advantages, they also draw attention to the challenges and pitfalls that may arise and emphasize the need for "realistic expectations" concerning simulation's capabilities.

17. **Sleepless in the Hospital: Evidence Mounts that Tired Caregivers May Compromise Quality.**
Clancy C.M.
J Patient Saf. 2007(Sep); 3(3):125-126.
This editorial highlights recent research regarding the impact of extended work shifts and resulting sleep deprivation on rates of error among medical trainees. Clancy touches upon recent studies demonstrating an association between extended shifts and increased propensity for error, including several studies funded by the Agency for Healthcare Research and Quality (AHRQ). Also noted is a new project by AHRQ and the Institute of Medicine that will examine this issue more closely.

18. **The Causal Pathways Linking Health Literacy to Health Outcomes.**
Paasche-Orlow M.K., Wolf M.S.
Am J Health Behav. 2007(Sep/Oct); 31(Suppl 1):S19-S26.
This study investigated the causal factors underlying the observed association between low health literacy and poor health outcomes. A review of the current health literacy literature, summarized in the article, was used to create a conceptual model of this causal relationship. The proposed framework hypothesizes three main routes through which health literacy influences health outcomes: healthcare access and utilization, patient-provider interaction, and patient self-care. Implications of this model and its strengths and limitations are discussed. One figure is included.

19. **The Quality of Ambulatory Care Delivered to Children in the United States.**
Mangione-Smith R., DeCristofaro A.H., Setodji C.M., et al.
N Engl J Med. 2007(Oct 11); 357(15):1515-1523.
Available at: http://content.nejm.org/cgi/reprint/357/15/1515.pdf.
This study attempted to measure the quality of care provided to pediatric outpatients in the U.S. Researchers developed a set of quality indicators and analyzed medical records from a 2-year period for 1,536 children in 12 U.S. metropolitan areas, using the frequency with which indicated care processes were delivered as an index of quality. Results indicated a number of shortfalls in the care provided to children; in general, the quality of care delivered to children was found to be comparable to that provided to adults. Multiple tables are included.

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20. **Untangling the Web—The Impact of Internet Use on Health Care and the Physician-Patient Relationship.**
Wald H.S., Dube C.E., Anthony D.C.
Pat Educ Couns. 2007(Nov); 68(3):218-224.
This study examined patients' use of Web-based health information and the effect of this phenomenon on physician-patient interaction. Results of a literature review, summarized in the article, suggest that the Web has a significant and often complicated influence on patients' approach to healthcare and on the physician-patient relationship. Characteristics of patients' use of the Web, advantages and disadvantages of healthcare-related Web use, and ways in which physicians can respond to increasingly Web-savvy patients are discussed. The authors argue that while patients' use of the Web may complicate the physician-patient relationship, it also entails an opportunity for improved collaboration between patients and providers. A guide for incorporating patients' Web use in a medical practice in included with the article.

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