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1. Confusing, Look-Alike, and Sound-Alike Medications.

Beyea S.

AORN Journal. 2007(Nov); 86(5):861–863.

This brief article provides an overview of the issue of look-alike, sound-alike and easily confused medications. Beyea summarizes published guidelines concerning this issue and gives examples of drugs that may be easily confused due to similar names or similar packaging. In addition to the use of standard lists, Beyea recommends the development of facility- and unit-specific lists as a means to better protect against this type of error.

2. Delayed Time to Defibrillation after In-Hospital Cardiac Arrest.

Chan P.S., Krumholz H.M., Nichol G., Nallamothu B.K., and the American Heart

Association National Registry of Cardiopulmonary Resuscitation Investigators.

N Engl J Med. 2008(Jan 3); 358(1):9–17.

This study examined the frequency of delayed defibrillation and its impact on survival to discharge in patients who experienced cardiac arrest and defibrillation during hospitalization. Statistical analysis of data for 6789 patients from the National Registry of Cardiopulmonary Resuscitation showed that delayed defibrillation occurred in approximately 30% of cases and was associated with significantly reduced likelihood of survival to discharge. Delayed defibrillation was also found to be associated with certain patient and hospital characteristics, noted in the article. Multiple figures and data tables are included.

3. Family Centered Patient Advocacy: A Training Manual.

Corina I., Shapiro E.

Wantagh, NY: PULSE of New York; 2007.

This handbook provides information and advice on how to be a patient advocate. As defined by the authors, a patient advocate is a family member, friend or other trusted individual designated by a patient to act as the patient's representative during medical care. The advocate functions as an extension of the patient during medical appointments or hospitalization and throughout the patient's interaction with the healthcare system to assist with communication and to protect the patient's safety. This guide describes the role of the patient advocate in a variety of settings, and offers a wealth of practical suggestions on what patients and advocates can do to become informed and well prepared participants in their care.

4. Final Five: ASCs Told to Target Patient Safety.

Rollins G.

H&HN Hospitals and Health Networks. 2007(Dec); 81(12):53–54,56.

This article discusses ongoing work to establish standardized patient safety and quality-related measures for ambulatory surgery centers (ASCs). The author outlines the five National Quality Forum-endorsed quality measures for ASCs released in November 2007 and comments on the development and potential impact of these and related initiatives. (While heretofore there has been no public reporting requirement for ASCs, it is anticipated that the Centers for Medicare & Medicaid Services (CMS) will require reporting of performance data by ASCs as a condition for reimbursement as of 2009.)

- 5. Hospital Adoption of Information Technologies and Improved Patient Safety: A Study of 98 Hospitals in Florida.**
Menachemi N., Saunders C., Chukmaitov A., Matthews M.C., Brooks R.G.
J Healthc Manage. 2007(Nov/Dec); 52(6):398–410.
This study examined the impact of healthcare information technology (IT) adoption on patient safety performance at hospitals throughout the state of Florida. Researchers analyzed survey data on hospital IT adoption in combination with patient outcomes data based on the Agency for Healthcare Research and Quality Patient Safety Indicators (PSIs) for 98 hospitals. Results showed that IT adoption as measured in the study had a significant positive influence on PSI performance for eight particular PSIs. In addition, more advanced and better-integrated IT systems were associated with better overall PSI performance. One table and an appendix are included.
- 6. Improving America’s Hospitals: The Joint Commission’s Annual Report on Quality and Safety 2007.**
Oakbrook Terrace, IL: The Joint Commission; November, 2007.
Available at: <http://www.jointcommissionreport.org/>
This second annual report from the Joint Commission (JC) presents data on JC-accredited hospitals’ performance with respect to 22 quality and safety indicators during 2006. The report includes summary and detail annotated results for performance on measures related to heart attack care, heart failure care, pneumonia care, and surgical care, as well as National Patient Safety Goal compliance data. Also included are discussion of key results and performance trends; the authors note that, while this year’s results demonstrate continued progress overall, there are still many opportunities for improvement.
- 7. Insight into Preventing Wrong-Site Surgery.**
Pennsylvania Patient Safety Authority.
Patient Safety Advisory. 2007(Dec); 4(4):109,112–123.
Available at:
<http://www.psa.state.pa.us/psa/cwp/view.asp?a=1293&q=445966&psaNav=#44>
This article presents preliminary results from ongoing work by the Pennsylvania Patient Safety Reporting System (PA-PSRS) to understand and prevent wrong-site surgery. The authors give a summary of observations from site visits, as well as examples of wrong-site surgeries and near misses excerpted from reports submitted to the PA-PSRS. Detailed notes from six hospital site visits are included in appendices.

- 8. Lost Opportunities: How Physicians Communicate About Medical Errors.**
Garbutt J., Waterman A.D., Kapp J.M., et al.
Health Affairs. 2008(Jan/Feb); 27(1):246–255.
This study investigated physicians’ attitudes and practices concerning communication about medical errors. Researchers analyzed survey data on error-reporting mentality and behavior for over a thousand participating U.S. and Canadian physicians representing diverse geographic and practice settings. Most respondents expressed willingness to report errors, considered reporting beneficial to patient safety, and supported sharing of information about errors within the hospital. At the same time, results suggested that while respondents frequently discussed errors informally with colleagues, they often did not report these errors via their organization’s formal reporting system. Possible reasons for this tendency and strategies for removing barriers to error reporting are discussed. Multiple tables are included.
- 9. Medication Use Leading to Emergency Department Visits for Adverse Drug Events in Older Adults.**
Budnitz D.S., Shehab N., Kegler S.R., Richards C.L.
Ann Intern Med. 2007(Dec 4); 147(11):755–765.
This study aimed to measure the frequency of emergency department (ED) visits for adverse drug events (ADEs) associated with Beers criteria medications as compared with other medications among older adults. The Beers criteria are a list of medicines considered unsuitable for use in older adults due to their unfavorable risk-benefit profile when used in this population. Analysis of national adverse drug event surveillance data for a one-year period showed that Beers Criteria medications were associated with a relatively small percentage of ED visits for ADEs in adults age 65 and over; at the same time, three other medications—warfarin, insulin, and digoxin—were associated with approximately one-third of the total visits. The authors suggest that efforts focusing on appropriate prescription and use of these medications could reduce the occurrence of adverse events in older patients. Multiple tables and figures are included.
- 10. Nonpayment for Harms Resulting from Medical Care: Catheter-Associated Urinary Tract Infections.**
Wald H.L., Kramer A.M.
JAMA. 2007(Dec 19); 298(23):2782–2784.
This commentary discusses the recent change to CMS reimbursement policy whereby CMS will no longer compensate hospitals for costs associated with treatment of certain preventable hospital-acquired conditions. To illustrate the significance of this change, the authors examine its ramifications with respect to hospital-acquired urinary tract infections, one of the eight conditions excluded from coverage under the new rule.

- 11. Outcomes of Care by Hospitalists, General Internists, and Family Physicians.**
Lindenauer P.K., Rothberg M.B., Pekow P.S., Kenwood C., Benjamin E.M., Auerbach A.D.
N Engl J Med. 2007(Dec 20); 357(25):2589–2600.
This research sought to determine whether care provided by hospitalists differed from care by other types of providers with respect to patient outcomes and costs. While the hospitalist movement is burgeoning in the U.S., relatively little is known about its impact in these areas. In this retrospective cohort study, researchers compared outcomes of care by hospitalists, general internists, and family physicians for 76,926 patients over a 3-year period. Results showed that hospitalist care was associated with shorter hospital stays as compared with care by either of the other groups; hospitalist care was associated with slightly lower costs as compared with care by general internists, while there was no significant difference in cost between care by hospitalists and care by family physicians.
- 12. Postoperative Robotic Telerounding: A Multicenter Randomized Assessment of Patient Outcomes and Satisfaction.**
Ellison L.M., Nguyen M., Fabrizio M.D., Soh A., Permpongkosol S., Kavoussi L.R.
Arch Surg. 2007(Dec); 142(12):1177–1181.
This study investigated the impact of postoperative telerounding on patient outcomes and satisfaction with care among patients undergoing elective urologic surgery at three academic medical centers. Telerounding refers to rounds conducted via remote videoconference, as opposed to traditional rounds in which the physician visits each patient in person. A total of 270 participating patients were randomized to receive either telerounding or traditional bedside rounds post-surgery. Contrary to expectations, results showed no differences in patient outcomes or patient satisfaction between the two groups. Several tables and one figure are included.
- 13. Prescription for Error: Process Defects in a Community Retail Pharmacy.**
Witte D., Dundes L.
J Patient Saf. 2007(Dec); 3(4):190–194.
This prospective observational study sought to determine the incidence, nature, and causes of medication dispensing errors at a community retail pharmacy. Researchers found that 33 errors occurred among 12,463 prescriptions processed, for an error rate of .26%; 12 errors were detected by patients. The authors discuss the organizational and situational factors contributing to error in the outpatient pharmacy setting and suggest steps that could be taken to address these issues. Three tables are included.

- 14. Reducing Harm to Patients: Using Patient Safety Dashboards at the Board Level.**
Pugh M., Reinertsen J.
Healthc Exec. 2007(Nov/Dec); 22(6):62,64–65.
This article discusses the design and use of patient safety dashboards or scorecards to promote board-level engagement in patient safety oversight and improvement efforts. The authors, a senior faculty member and a senior fellow of the Institute for Healthcare Improvement (IHI), offer advice concerning various aspects of the process, including establishing meaningful measures and improvement criteria, setting appropriate goals, and using the right report format for clear and accurate communication of dashboard data to the board.
- 15. Reporting Medical Errors to Improve Patient Safety: A Survey of Physicians in Teaching Hospitals.**
Kaldjian L.C., Jones E.W., Wu B.J., Forman-Hoffman V.L., Levi B.H., Rosenthal G.E.
Arch Intern Med. 2008(Jan 14); 168(1):40–46.
This study examined error-reporting attitudes and behaviors among faculty physicians and medical residents. Researchers surveyed physicians at three U.S. teaching hospitals concerning their reporting of actual errors, inclination to report hypothetical errors, and attitudes and beliefs about error reporting. Results showed that while most respondents recognized the value of error reporting and indicated they would report a hypothetical error, far fewer said that they had actually reported errors in practice. Possible reasons for this discrepancy, and its implications, are discussed. Multiple tables are included.
[Note: a paper presenting partial data from this study appeared in *J Intern Med* online in 2007 and was noted in *Current Awareness*, June (1) 2007.]
- 16. Retained Foreign Bodies after Emergent Trauma Surgery: Incidence after 2526 Cavitory Explorations.**
Teixeira P.G.R., Inaba K., Salim A., et al.
Am Surg. 2007(Oct); 73(10):1031–1034.
This study sought to determine the incidence of cases of retained foreign bodies (RFBs) following surgery in patients at a Level I trauma center. Retrospective review of morbidity and mortality data for an eight-year period identified three instances of RFB out of 10,053 trauma operations performed. The authors briefly describe the circumstances of these three cases; also discussed are the potential clinical consequences of RFB and strategies for preventing RFB occurrence. One table and one figure are included.

- 17. Retained Intra-abdominal Surgical Instruments: Time to Use Nascent Technology?**
Berkowitz S., Marshall H., Charles A.
Am Surg. 2007(Nov); 73(11):1083–1085.
This invited commentary discusses the issue of accidentally retained surgical implements and the potential use of emerging technology to address this problem. The authors review the current knowledge concerning retained foreign bodies, including risk factors for occurrence, symptomatology and criteria for removal, current strategies for prevention, and new technologies showing promise. The authors argue that an approach combining technological and systems-based interventions will likely be needed to effectively address this issue.
- 18. Role of Professional Organizations in Regulating Physician Expert Witness Testimony.**
Kesselheim A.S., Studdert D.M.
JAMA. 2007(Dec 26); 298(24):2907–2909.
This commentary deals with the question of how best to evaluate and regulate physician expert witness testimony in medical malpractice litigation. The authors critique current methods of oversight provided by state bodies and professional organizations, and offer suggestions as to how the present system could be improved.
- 19. Surgical Site Infection: The Host Factor.**
Fry D.E., Fry R.V.
AORN Journal. 2007(Nov); 86(5):801–810.
This article discusses factors that affect susceptibility or resistance to surgical site infection (SSI), in particular, the contribution of patient (host) factors. The authors review recent studies concerning the role of various host factors and the efficacy of preventive strategies that focus on strengthening the host's immune response. Also highlighted is the role and responsibility of perioperative nurses in SSI prevention management. Two figures and two tables are included.
- 20. The Good Patient.**
Buckwalter J.G.
N Engl J Med. 2007(Dec 20); 357(25):2534–2535.
In this personal essay, the author, a research scientist who is quadriplegic and has used a wheelchair for over 30 years, shares insights gleaned from his participation in a documentary film about the day-to-day lives of people in wheelchairs. Reflecting on one recorded scene—a doctor's visit during which he struggles to communicate with a doctor who seems unresponsive to his needs—Buckwalter offers a thought-provoking perspective on the complicated nature of the patient-provider relationship.

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