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- 1. A Team Training Program Using Human Factors to Enhance Patient Safety.**
Marshall D.A., Manus D.A.
AORN Journal. 2007 (Dec); 86(6):994–1011.
This article reports on the development and implementation of a team training program created by the AORN Foundation and instituted at five U.S. healthcare facilities. The program, known as the Human Factors in Healthcare Demonstration Project, uses training based on Crew Resource Management (CRM) principles to enhance teamwork, communication, and other safety-promoting cultural attributes. Included in the article are details of program content and implementation; overall results as measured by pre- and post-intervention responses to the Agency for Healthcare Research and Quality (AHRQ) patient safety culture survey; and site-specific comments for each of the five participating facilities. Multiple tables and figures are included.
- 2. Awareness during Anesthesia.**
Orser B.A., Mazer C.D., Baker A.J.
CMAJ. 2008(Jan 15); 178(2):185–188.
This commentary discusses intraoperative awareness, or patient awareness during general anesthesia, also known as anesthesia awareness. The authors describe the nature and incidence of this phenomenon and review current knowledge concerning risk factors, possible causes, and preventive strategies. Current data-collection and research efforts in this area are noted as well. One table and one figure are included.
- 3. Battling Hospital-Acquired Infections [radio broadcast].**
Fresh Air from WHYI. Jan. 9, 2008.
Available at: <http://www.npr.org/templates/story/story.php?storyId=17957719>
In this interview with Fresh Air's Terry Gross, Dr. Richard Shannon discusses the issue of hospital-acquired methicillin-resistant Staphylococcus aureus (MRSA) infections. Shannon, who is Chairman of the Department of Medicine at the University of Pennsylvania Health System, explains how the infections occur and are spread, and their (sometimes fatal) consequences for affected patients. Shannon emphasizes the need for organizational accountability and outlines a three-pronged approach to infection prevention implemented by his health system; he contends that, with the use of appropriate measures, these infections can be prevented.
- 4. Formatting Pathology Reports: Applying Four Design Principles to Improve Communication and Patient Safety.**
Valenstein P.N.
Arch Pathol Lab Med. 2008(Jan); 132:84–94.
This review article explores the use of formatting techniques to enhance communication of information in pathology reports. The author articulates four basic design principles derived from a review of the literature in other fields—publishing, aviation, and cognitive psychology—and discusses their potential application to the design of pathology and other diagnostic reports. Also included are suggestions for preventing common formatting problems that may occur during the digital transmission of reports. Multiple figures are included.

- 5. High-Tech Medication Management [podcast].**
Pinakiewicz D. (moderator), O'Donnell S., Scheckelhoff K., Chochinov J.
Future Healthcare. 2008(Q1):66–74.
Podcast available at <http://www.futurehealthcareus.com/> [free registration required].
This podcast, moderated by National Patient Safety Foundation President Diane Pinakiewicz and featuring panelists from Hospira, McKesson, and Rubbermaid Medical Solutions, explores the use of increasingly sophisticated healthcare technology to facilitate medication management and improve medication safety. The panelists discuss the capabilities and applications of medication management technology, trends in adoption and potential future developments, and the impact of increased emphasis on medication safety and the introduction of related new technology on hospital workflow.
- 6. Hospitalizations and Deaths Caused by Methicillin-Resistant *Staphylococcus aureus*, United States, 1999–2005.**
Klein E., Smith D.L., Laxminarayan R.
Emerg Infect Dis. 2007(Dec); 13(12):1840–1846.
*This study sought to determine the incidence and rate of increase of hospitalization and associated mortality due to *Staphylococcus aureus* (*S. aureus*) and methicillin-resistant *Staphylococcus aureus* (MRSA) in the U.S. between 1995 and 2005. Analysis of national hospital discharge and drug-resistance data showed that during the period examined, the estimated number of *S. aureus*-related hospitalizations increased by 62%, while the estimated number of MRSA-related hospitalizations more than doubled. Further results and implications are discussed; this evidence, the authors argue, reinforces the need for urgent national action to address this threat. Multiple tables and figures are included.*
- 7. Implementing a Pediatric Rapid Response Team In a Community Hospital.**
Kaneski T., Blevins D.
Focus on Patient Safety. 2007; 10(4):1–3.
This article describes the development and implementation of a pediatric rapid response team (PRRT) at Edward hospital in Naperville, Ill. The authors outline the rationale for establishing the PRRT, goals for the initiative, and preliminary outcomes. A table illustrating key decisions involved in implementing a PRRT is included.
- 8. Improving Patient Safety by Taking Systems Seriously.**
Shortell S.M., Singer S.J.
JAMA. 2008(Jan 30); 299(4):445–447.
This commentary considers patient safety as a function of systems of care and emphasizes the need for a systems orientation as a framework for patient safety improvement efforts. The authors note that while laudable attention has been given to the notion of the culture of safety, equally important is the idea of a “culture of systems.” Several examples are provided to illustrate this concept, and potential barriers and facilitators to systems-based care are touched upon.

- 9. Medication Reconciliation in Ambulatory Oncology.**
Weingart S.N., Cleary A., Seger A., et al.
Jt Comm J Qual Pat Saf. 2007(Dec); 33(12):750–757.
This article describes the design and implementation of an ambulatory care medication reconciliation initiative at Dana-Farber Cancer Institute (DFCI). The program involved a cyclical process whereby each patient received a list of his or her current medications during office visits, the patient reviewed and updated the list with his or her provider, and the patient’s electronic medical record was updated accordingly. Development, implementation, and results of the program are discussed in detail. The authors suggest that the DFCI program both demonstrates the feasibility of medication reconciliation in the ambulatory setting and provides a valuable model for similar efforts by other organizations. Three figures and three tables are included.
- 10. Minimizing Adverse Drug Events in Older Patients.**
Pham C.B., Dickman R.L.
Am Fam Physician. 2007(Dec 15); 76(12):1837–1844.
This article offers an overview of strategies for preventing adverse drug events among older adults. The author reviews the current knowledge concerning the nature and prevalence of adverse drug events in older adults, age-associated factors that may increase risk, and steps that providers can take to improve medication safety for older patients. Several tables are included.
- 11. Nursing Management of Medication Errors.**
Luk L.A., Ng W.I.M., Ko K.K.S., Ung V.H.
Nurs Ethics. 2008; 15(1):29–39.
This qualitative study aimed to identify and better understand the various ethical considerations relating to nurses’ handling of medication errors. Researchers conducted in-depth interviews with seven junior registered nurses who had been involved in medication errors at a hospital in Macau, China. Several themes identified through content analysis are discussed. Also touched upon are the ways in which culture-specific norms and values may influence Chinese providers’ interactions with patients and with their colleagues in this context.
- 12. Patients Need to Become Educators for Patient Safety.**
Corina I.
Focus on Patient Safety. 2007; 10(4):6–7.
In this editorial, Corina emphasizes the importance of community-based education about patient safety. Patient safety education that occurs outside the healthcare environment, Corina argues, prepares healthcare consumers to participate more effectively in their care when they do become patients. The essay concludes with advice for patient safety educators on giving an effective and audience-appropriate presentation. [See also item 16.]

- 13. Pay-for-Performance Principles That Promote Patient-Centered Care: An Ethics Manifesto.**
Snyder L., Neubauer R.L., for the American College of Physicians Ethics, Professionalism and Human Rights Committee.
Ann Intern Med. 2007(Dec 4); 147:792–794.
This brief position statement, derived from a longer paper published by the American College of Physicians (ACP) Board of Regents, presents the ACP’s views concerning the appropriate use of pay-for-performance systems. The authors discuss the ethical ramifications of pay-for-performance and consider some of its potential unintended consequences. To avert the unintended negative effects that are likely to occur with current systems, the authors argue, pay-for-performance must take on a “patient-centered” orientation in which performance measures and associated incentives are closely aligned with patients’ needs and interests.
- 14. Smart Infusion Pump Technology: Don’t Bypass the Safety Guidelines.**
Pennsylvania Patient Safety Authority.
Patient Safety Advisory. 2007(Dec); 4(4):139–143.
Available at:
<http://www.psa.state.pa.us/psa/cwp/view.asp?a=1293&q=445966&psaNav=#44>
This article deals with medication administration errors that may occur with the use of “smart” IV infusion pumps. Various types of errors are described and illustrated by excerpts from reports to the Pennsylvania Patient Safety Reporting System (PA-PSRS). The authors note that many of these errors result when providers override the systems’ built-in safeguards; they speculate as to why this may occur and offer strategies to minimize this tendency.
- 15. Systematic Evaluation of Errors Occurring during the Preparation of Intravenous Medication.**
Parshuram C.S., To T., Seto W., Trope A., Koren G., Laupacis A.
CMAJ. 2008(Jan 1); 178(1):42–48.
This direct-observation study sought to characterize errors occurring during the preparation of intravenous drug infusions, and to identify factors associated with these errors. Researchers evaluated the accuracy with which 118 study participants prepared IV infusions in an experimental setting and subjected these results to statistical analysis. Results showed that a variety of factors were associated with increased likelihood of error, including fatigue, greater length of professional experience, and use of a more concentrated stock solution. Three tables and one figure are included.

16. Teaching Patient Safety: An Educator's Guide.

Corina I.

Wantagh, NY: PULSE of New York; 2007.

This concise manual offers guidelines on how to prepare and conduct consumer patient safety educational presentations. Drawing upon a decade's experience as a patient safety advocate and educator, Corina offers techniques and step-by-step instructions to help educators develop an effective presentation. What should be covered in a presentation, how to tailor the talk to a particular audience, and common issues that arise are among the topics addressed. Several appendices provide additional tools and resources. [See also item 12.]

17. The 2008 Perioperative Nurses' Goals for Safety.

Beyea S.C.

AORN Journal. 2007(Dec); 86(6):1051–1053.

In a slight departure from the traditional discussion of the Joint Commission National Safety Goals, this "Patient Safety First" column highlights goals of particular relevance for perioperative nurses. Beyea here outlines the six goals, which include demonstrating leadership in patient safety, learning more about safety science and organizational safety initiatives, and making patient safety a priority in everyday practice. Future installments will discuss each goal in further detail.

18. The Effect of Drug Concentration Expression on Epinephrine Dosing Errors: A Randomized Trial.

Wheeler D.W., Carter J.J., Murray L.J., et al.

Ann Intern Med. 2008(Jan 1); 148(1):11–14.

This randomized, blinded, controlled study investigated the impact of drug concentration expression on dosing calculation errors and speed of medication administration. Participants in a simulated clinical scenario were required to administer a dose of epinephrine from ampules labeled with either a mass concentration or a ratio. Results showed that use of the ratio labels was associated with decreased dosing accuracy and increased time to administer medication in the experimental setting. On the basis of these results, the authors suggest that the consistent use of mass concentrations rather than ratios to express drug concentration might be of benefit to patient safety. One table, one figure, and several appendix items are included.

- 19. U.S. Adults Not Very Confident that Physicians Have the Complete Picture, According to a New WSJ.com/Harris Interactive Survey.**
WSJ Online/Harris Interactive Health-Care Poll.
2007(Dec 5); 6(18).
Available at:
http://www.harrisinteractive.com/news/newsletters/wshealthnews/HS_WSJ_HealthCarePoll_2007_v06_i18.pdf
This report presents results of a November, 2007 WSJ Online/Harris Interactive poll examining use of and attitudes toward Electronic Medical Records (EMRs) among U.S. adults. Highlighted findings include that among the 2,153 respondents, approximately one-quarter reported using some form of an EMR; and that those who had an EMR overall expressed greater confidence in their healthcare providers' grasp of their medical profile.
- 20. Working Through the Frustrations of Clinical Integration.**
Taylor M.
H&HN Hospitals and Health Networks. 2008(Jan); 82(1):34–40.
Clinical integration promises enhanced quality of care, improved patient safety, and numerous other advantages for patients, providers, and healthcare organizations alike, but organizations pursuing clinical integration may face formidable challenges along the way. The cost and complexity of the process, as well as current legal and regulatory climates, may deter progress toward clinical integration. In this article, the authors discuss the potential benefits of clinical integration, some of the stumbling blocks that may be encountered during the process, and prospects for future efforts. Examples of healthcare organizations that have achieved or are working toward clinical integration are cited throughout.

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