

**February (1) 2008**  
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1. **Being a Patient Safety Leader.**
2. **Consent Forms That Patients Can Understand.**
3. **Cost Implications of and Potential Adverse Events Prevented by Interventions of a Critical Care Pharmacist.**
4. **Effective Interventions and Implementation Strategies to Reduce Adverse Drug Events in the Veterans Affairs (VA) System.**
5. **Effectiveness and Efficiency of Root Cause Analysis in Medicine.**
6. **Evaluating the Evidence: Web Sites.**
7. **From Waste to Value in Health Care.**
8. **Health Literacy Practices in Primary Care Settings: Examples from the Field.**
9. **Improving Quality and Safety at an Academic Health Center.**
10. **Medicare's Decision to Withhold Payment for Hospital Errors: The Devil Is in the Details.**
11. **Multifactorial Assessment and Targeted Intervention for Preventing Falls and Injuries among Older People in Community and Emergency Care Settings: Systematic Review and Meta-Analysis.**
12. **Nurse Knowledge Exchange: A Safer, More Reliable Hand-off Between Nurses.**
13. **Perceptions of Patient Safety Culture Among Physicians and RNs in the Perioperative Area.**
14. **Preventing Accidents and Injuries in the MRI Suite.**
15. **Programmable Infusion Pumps in ICUs: An Analysis of Corresponding Adverse Drug Events.**
16. **Safety First: One Year On.**
17. **Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care.**
18. **The Clinician-Patient Partnership Paradigm: Outcomes Associated With Physician Communication Behavior.**
19. **The Physician's Role in Patient Safety: What's in It for Me?**
20. **Why Do Interns Make Prescribing Errors? A Qualitative Study.**

**1. Being a Patient Safety Leader.**

Beyea S.C.

AORN Journal. 2008(Jan); 87(1):221–223.

*This “Patient Safety First,” column, the second in a series focusing on patient safety goals for perioperative nurses, argues that all healthcare personnel should act as leaders with respect to patient safety—not just those in formal positions of leadership. Beyea provides several scenarios to illustrate how nurses and other healthcare workers can take the initiative to ensure safe care. Acknowledging that being a leader can be difficult, Beyea encourages nurses to embrace this challenge and to act with confidence, even in situations where it may be uncomfortable to do so.*

**2. Consent Forms That Patients Can Understand.**

Landro L.

The Wall Street Journal. February 6, 2008:D1.

*This article discusses recent efforts to improve the comprehensibility of informed consent procedures to patients. The author discusses the use of technological advances, such as electronic forms and web-based educational materials, to assist patients in understanding the medical and legal information conveyed in consent forms. An electronic informed-consent system recently implemented by the Veterans Affairs (VA) hospitals is highlighted as an example.*

**3. Cost Implications of and Potential Adverse Events Prevented by Interventions of a Critical Care Pharmacist.**

Kopp B.J., Mrsan M., Erstad B.L., Duby J.J.

Am J Health-Syst Pharm. 2007(Dec 1); 64:2483–2487.

*This study evaluated the impact of the activities of a critical care pharmacist on incidence and severity of adverse drug events (ADEs) and associated costs. Researchers at a tertiary care teaching hospital retrospectively analyzed documentation of interventions by one critical care pharmacist over a period of 4.5 months. Results showed that of 129 interventions documented, a majority were deemed likely to have prevented ADEs, with estimated potential cost savings of \$205,919–\$280,421. As interventions made during patient care rounds or chart-review accounted for the majority of interventions recorded and the greatest potential cost avoidance, the authors suggest that it may be of benefit to focus the activities of clinical pharmacists in these areas. Several tables are included.*

- 4. Effective Interventions and Implementation Strategies to Reduce Adverse Drug Events in the Veterans Affairs (VA) System.**  
Mills P.D., Neily J., Kinney L.M., Bagian J., Weeks W.B.  
Qual Saf Health Care. 2008(Feb); 17(1):37–46.  
*This descriptive study used root cause analysis (RCA) data to determine the incidence and nature of adverse drug events (ADEs) and to identify and evaluate the efficacy of corrective actions in response to ADEs at Veterans Affairs (VA) hospitals. Researchers analyzed RCA reports submitted to the VA National Center for Patient Safety and conducted interviews with patient safety managers regarding the nature and efficacy of actions taken in response to the documented ADEs. Results, detailed in the article, showed that interventions to address ADEs were for the most part (76%) reported to have been fully implemented; factors associated with reported success or failure of such interventions are discussed. Multiple figures and tables are included.*
- 5. Effectiveness and Efficiency of Root Cause Analysis in Medicine.**  
Wu A.W., Lipshutz A.K.M., Pronovost P.J.  
JAMA. 2008 (Feb 13); 299(6):685–687.  
*While root cause analysis (RCA) is increasingly in use as a method for analysis and prevention of medical errors, little is known about its effectiveness in this application. The authors outline the history of RCA and its adoption and use in healthcare, discuss potential pitfalls of the RCA method, and offer suggestions for improving its potency and usefulness in the medical context.*
- 6. Evaluating the Evidence: Web Sites.**  
Hoss B., Hanson D.  
AORN Journal. 2008(Jan); 87(1):124–141.  
*This article discusses the use of the Internet and Web-based resources as a component of evidence-based practice (EBP) technique in nursing. Although online resources can be an effective tool to support EBP, organizational and individual barriers may hinder utilization, and online sources must be carefully screened for appropriateness and validity. After giving an overview concerning the nature and utilization of EBP, the authors present detailed guidelines to assist nurses in locating, evaluating and making use of online resources. Three figures and three tables, including a list of recommended evidence-based websites, are included.*
- 7. From Waste to Value in Health Care.**  
Boat T.F., Chao S.M., O'Neill P.H.  
JAMA. 2008(Feb 6); 299(5):568–571.  
*This commentary speaks to the issue of waste in health care—i.e., extra work and unnecessary costs resulting from the faulty system performance. The authors argue that while the need to reduce waste and improve quality is widely recognized, current approaches to this issue are less effective than they could be. Accordingly, they outline a strategy for eliminating waste, which includes: clear definition of the problem and opportunities for change; increased focus on quality-improvement research; and consistent leadership to buttress quality-improvement efforts.*

- 8. Health Literacy Practices in Primary Care Settings: Examples from the Field.**  
Barrett S.E., Puryear J.S., Westpheling K.  
The Commonwealth Fund. January 2008.  
Available at:  
[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=645961](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=645961)  
*This study by the Association of Clinicians for the Underserved (ACU) explored strategies used by primary care providers to address low health literacy among their patients. The study used a national online survey, followed by site visits at five selected primary care facilities, to identify commonly used and well regarded health literacy practices among healthcare facilities throughout the U.S. Five “promising practices” extracted from the initial survey results are discussed and provide an evaluative framework. Summary and discussion of results, as well as recommendations on how to address and increase awareness of health literacy issues, are included in the report. Resources and further details on the study are provided in several appendices.*
- 9. Improving Quality and Safety at an Academic Health Center.**  
Benjamin E.M.  
Prescriptions for Excellence in Health Care. 2007(Winter); Issue 2:7–9.  
Available at: <http://www.jefferson.edu/dhp/documents/LillyIssue2.pdf>  
*This article spotlights patient safety and quality improvement activities at Baystate Health, a 3-hospital health system in Western Massachusetts. Dr. Benjamin, Vice President, Chief Quality Officer at Baystate, describes the organization’s strategic plan for safety and quality improvement, four main improvement strategies, and benchmarking and evaluation processes. Two figures are included.*
- 10. Medicare’s Decision to Withhold Payment for Hospital Errors: The Devil Is in the Details.**  
Wachter R.M., Foster N.E., Dudley R.A.  
Jt Comm J Qual Pat Saf. 2008(Feb); 34(2):116–123.  
*This article examines the implications of the recently announced change to Medicare policy, slated to take effect in 2009, under which Medicare will no longer pay for care associated with certain preventable adverse events. The authors consider the implications of this change in the context of the business case for patient safety; enumerate the necessary conditions for such a policy to be “reasonable” and feasible to execute; and touch upon possible unintended consequences. The authors express cautious optimism about the impact of the policy: while it stands to benefit patient safety overall, it also entails substantial risk; thus, care and judiciousness must be exercised in its implementation.*

- 11. Multifactorial Assessment and Targeted Intervention for Preventing Falls and Injuries among Older People in Community and Emergency Care Settings: Systematic Review and Meta-Analysis.**  
Gates S., Fisher J.D., Cooke M.W., Carter Y.H., Lamb S.E.  
BMJ. 2008; 336:130–133.  
*This study sought to assess the efficacy of multifactorial risk-assessment and intervention programs in preventing falls and fall-related injuries in older adults. Results of a meta-analysis of 19 trials showed no definite association between the use of an intervention program and reduction in number of falls or associated injuries, which may suggest that such fall-prevention interventions are less effective than previously thought. However, the authors note that current data are inconclusive, and that further research in this area is warranted.*
- 12. Nurse Knowledge Exchange: A Safer, More Reliable Hand-off Between Nurses.**  
Cristobal K., McCarthy C.  
Focus on Patient Safety. 2007; 10(4):3–5.  
*This article discusses Nurse Knowledge Exchange, a hand-off communication technique developed by nurses at Kaiser Permanente. Nurse Knowledge Exchange (NKE) uses structured documentation and communication of information as well as direct communication with the patient to improve transfer of information during hand-offs. The authors describe the four components of NKE, discuss NKE's foundation in reliability principles, and outline critical factors for its successful implementation.*
- 13. Perceptions of Patient Safety Culture Among Physicians and RNs in the Perioperative Area.**  
Scherer D., Fitzpatrick J.J.  
AORN Journal. 2008(Jan); 87(1):163–175.  
*This descriptive study examined perceptions concerning patient safety culture among nurses and physicians at a community hospital. As part of a larger performance improvement initiative, a total of 83 RNs and physicians completed the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture. Results, detailed in the article, showed that while respondents' perceptions of the hospital's safety culture were favorable overall, certain areas drew negative responses. As well, nurses' and physicians' responses differed significantly along certain dimensions. Four tables are included.*
- 14. Preventing Accidents and Injuries in the MRI Suite.**  
The Joint Commission.  
Sentinel Event Alert. Issue 38, February 14, 2008.  
Available at:  
[http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea\\_38.htm](http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_38.htm)  
*This latest edition of the Joint Commission's Sentinel Event Alert addresses potential injuries, accidents, and adverse events associated with the magnetic resonance imaging (MRI) process. The alert describes the types of events that may occur, outlines strategies for prevention, and lists the Joint Commission's recommendations for improving MRI safety.*

**15. Programmable Infusion Pumps in ICUs: An Analysis of Corresponding Adverse Drug Events.**

Nuckols T.K., Bower A.G., Paddock S.M., et al.  
J Gen Intern Med. 2008(Jan); 23(Suppl 1):41–45.

*This study sought to determine the degree to which the safety features of programmable infusion pumps (or smart pumps) correspond to preventable intravenous adverse drug events (IV-ADEs) in the ICU, and whether smart pumps would therefore outperform conventional pumps in preventing IV-ADEs. Researchers retrospectively reviewed medical-record data on preventable IV-ADEs from before and after implementation of smart pumps at two hospitals. Results showed that among the preventable IV-ADEs detected, a minimal number would have been addressed by the smart pumps' safety capabilities. The authors thus conclude that the smart pumps examined in the study, as configured, would likely not significantly reduce preventable IV-ADEs as compared with conventional pumps. Two tables are included.*

**16. Safety First: One Year On.**

The National Patient Safety Agency. December 13, 2007.

Available at: <http://www.npsa.nhs.uk/EasySiteWeb/GatewayLink.aspx?aId=7026>

*Published in December 2006, Safety First set forth 14 recommendations for improving patient safety in England's National Health Service (NHS). This update reports on progress toward the goals outlined in Safety First. Accomplishments during the past year and plans for future work are highlighted for each of the 14 recommendations. A foreword by Sir Liam Donaldson is included.*

**17. Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care.**

Fung C.H., Lim Y.-W., Mattke S., Damberg C., Shekelle P.G.  
Ann Intern Med. 2008(Jan 15); 148(2):111–123.

*This study looked at the question of whether public reporting of healthcare performance data can be shown to lead to improved quality of care—an assumption that would seem to underlie the current enthusiasm for public reporting systems. Researchers conducted a systematic review of studies published since 1999 that examined the relationships between public reporting and various indicators, including provider utilization, quality improvement activity, patient outcomes, and unintended consequences. While findings suggested an association between public reporting and increased quality improvement activity, results were mixed as to the effects on selection of hospitals/providers and on effectiveness of care. The authors note that there remains a paucity of published data concerning the influence of public reporting on healthcare quality. Multiple figures and tables are included.*

**18. The Clinician-Patient Partnership Paradigm: Outcomes Associated With Physician Communication Behavior.**

Clark N.M., Cabana M.D., Nan B., et al.

Clin Pediatr. 2008(Jan); 47(1):49–57.

*This study investigated the impact of physician communication behaviors on patients' health outcomes and perceptions concerning their care. As part of a larger study, researchers interviewed and reviewed records for 452 family members of pediatric asthma patients who visited 48 physicians participating in the parent study. Results showed that particular physician communication behaviors were linked to positive perceptions of care; in addition, many of these same behaviors tended to predict better patient outcomes. The authors discuss the implications of these results in relation to emerging notions of physician-patient partnership; on the basis of these results, they propose a model for effective physician-patient interaction. Two tables and two figures are included.*

**19. The Physician's Role in Patient Safety: What's in It for Me?**

Sutker W.L.

Proc (Baylor Univ Med Cent). 2008(Jan); 21(1):9–14.

*In these proceedings from a grand rounds presentation, the author gives a succinct overview of key concepts, issues, and current thinking in patient safety, with emphasis on the essential role of physicians in ensuring safe care. Sutker, a physician and Patient Safety Officer at Baylor University Medical Center, also highlights patient safety initiatives undertaken at his facility, and discusses how Baylor has addressed several of the Joint Commission's National Patient Safety Goals. Multiple figures and tables are included.*

**20. Why Do Interns Make Prescribing Errors? A Qualitative Study.**

Coombes I.D., Stowasser D.A., Coombes J.A., Mitchell C.

Med J Australia. 2008(Jan 21); 188(2):89–94.

*This prospective study sought to identify and describe factors associated with prescribing errors committed by medical interns at a tertiary teaching hospital in Brisbane, Australia. Analysis of interview data for 14 interns involved with a total of 47 errors showed that errors were associated with multiple factors, including environmental, task-related, individual, team, and patient factors. On the basis of these results, possible interventions to address error-conducive conditions are discussed. Several tables and one figure are included.*

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Anita Spielman, Editor

[aspelman@npsf.org](mailto:aspelman@npsf.org)