

March (2) 2008  
Volume 12, Issue 3:2

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**1. Anesthesia Awareness and the Bispectral Index.**

Avidan M.S., Zhang L., Burnside B.A., et al.  
N Engl J Med. 2008(Mar 13); 358(11):1097–1108.

*This prospective study evaluated the efficacy of bispectral index monitoring as a measure to reduce the incidence of anesthesia awareness in patients undergoing general anesthesia and identified as being at high risk to experience this phenomenon. The bispectral index (BIS) monitor uses information from an electroencephalogram to derive a numerical value indicating a patient's level of awareness on a scale from 0 (least awake) to 100 (most awake), which then modulates the administration of anesthetic. The present study compared rates of anesthesia awareness for 2,000 patients randomized to receive anesthesia according to either the BIS or the end-tidal anesthetic gas (ETAG) protocol. Results, contrary to previous study findings, showed that use of BIS monitoring was not associated with a reduction in incidence of anesthesia awareness as compared with ETAG monitoring. Two tables and three figures are included.*

**2. Are You “Just a Nurse”?**

Beyea S.C.  
AORN Journal. 2008(Feb); 87(2):441–444.

*While nurses play a crucial role in protecting patients from potential harm, nurses may perceive themselves as lacking the necessary influence to perform this role effectively—and organizational culture may reinforce this notion. Beyea argues for the need for nurses to act as advocates for their patients and discusses what individuals and organizations can do to empower nurses as agents of patient safety. This column continues a “Patient Safety First” series on patient safety goals for perioperative nurses.*

**3. Can We Use Incident Reports to Detect Hospital Adverse Events?**

Blais R., Bruno D., Bartlett G., Tamblyn R.  
J Patient Saf. 2008(Mar); 4(1):9–12.

*This study sought to characterize the types of adverse events (AEs) captured by incident reports (IRs) and to assess the efficacy of incident report analysis as a method for identifying adverse events as compared with retrospective chart review. Researchers examined 2213 randomly selected charts to determine the correspondence between evidence of AEs and presence of an incident report. Incident reports were found in 15.5% of charts in which AEs were identified and in 4.4% of charts without AEs, suggesting that the presence or absence of IRs was a relatively poor indicator for the presence of AEs. Possible reasons for this result are discussed, as well as suggestions as to how the utility of IRs in this regard might be improved. Several tables are included.*

**4. Canadian Disclosure Guidelines.**

Disclosure Working Group.

Edmonton, AB: Canadian Patient Safety Institute; 2008.

Available at: <http://www.patientsafetyinstitute.ca/Disclosure.html>

*This publication of the Canadian Patient Safety Institute sets forth a comprehensive set of guidelines concerning healthcare providers' disclosure of adverse events to patients. The first section discusses the various arguments in favor of disclosure; safety culture and the importance of support for patients; and support and training for providers. The second section offers advice on the disclosure process—under what circumstances disclosure is called for, when and where it should take place, what should be disclosed, and how and by whom it should be carried out. The final section addresses disclosure in certain special situations and contexts. Further information and resources are provided in multiple appendices.*

**5. Coordinating Care—A Perilous Journey through the Health Care System.**

Bodenheimer T.

N Engl J Med. 2008(Mar 6); 358(10):1064–1071.

*Coordination of care—the synchronization of patient information and treatment processes among patients' multiple providers—is considered imperative to the delivery of safe and efficient care. This article samples recent research findings concerning coordination or lack of coordination within the U.S. healthcare system, describes obstacles and challenges to coordination, and discusses techniques and models for improving the coordination of care in various contexts. One table is included.*

**6. CRNA Performance Using a Handheld, Computerized, Decision-Making Aid During Critical Events in a Simulated Environment: A Methodologic Inquiry.**

Coopmans V.C., Biddle C.

AANA Journal. 2008(Feb); 76(1):29–35.

*This study investigated the validity of an approach to examining the impact of use of a computer-assisted decision making (CADM) device on Certified Registered Nurse Anesthetists' (CRNA) performance in simulated critical clinical situations. Researchers used a randomized crossover design to assess four CRNAs' speed and accuracy of diagnosis and treatment with and without use of CADM in two clinical scenarios. Subjects were found to perform faster with CADM in one scenario, and without CADM in the other. Possible reasons for this result, overall strengths and weaknesses of the study method as revealed by this experiment, and possible directions for future research are discussed. Several tables are included.*

**7. Cultural Safety: An Introduction.**

De D., Richardson J.

Paediatr Nurs. 2008(Mar); 20(2):39–43.

*This article discusses the concept of cultural safety and its application as a means to providing culturally-appropriate care for diverse patient populations. Developed in New Zealand to address the healthcare needs of indigenous populations, cultural safety comprises a variety of techniques to increase providers' awareness of and sensitivity to cultural differences, enabling them to better recognize and respond to cultural variables that may influence quality and efficacy of care. The authors give an overview of the principles of cultural safety and discuss its application in pediatric nursing practice. Also included are five exercises that prompt readers to reflect further on their attitudes and experiences with respect to culture. [For another article about cultural safety, see item 20.]*

**8. Involving Patients in Safety Improvement.**

Spath P.L.

Hospitals & Health Networks. H&HN Online. February 19, 2008.

Available at: [http://www.hhnmag.com/hhnmag\\_app/jsp/hhnonline.jsp](http://www.hhnmag.com/hhnmag_app/jsp/hhnonline.jsp)

*This article discusses the inclusion of patients in hospital safety improvement initiatives and highlights the experience of one hospital that has instated patients on its patient safety committee. Topics touched upon include criteria for selecting patient/consumer representatives, preparing patients for participation, potential legal/confidentiality considerations, and alternate avenues for patient involvement where formal participation may not be feasible.*

**9. Medication Errors Involving Patient-Controlled Analgesia.**

Hicks R.W., Sikirica V., Nelson W., Schein J.R., Cousins D.D.

Am J Health-Syst Pharm. 2008(Mar 1); 65:429–440.

*This study sought to characterize and determine the incidence and severity of medication errors associated with patient-controlled analgesia (PCA). Retrospective analysis of Medmarx data from a 5-year period identified 9,571 instances of medication errors (1% of the total examined) associated with PCA, many of which resulted in patient harm. Numerous factors were found to contribute to PCA-related errors, with human factors involved in the majority of cases. Results are documented in detail; possible underlying causes of the types of errors identified and preventive measures to address these issues are touched upon. Multiple data tables are included.*

- 10. Medication Safety Messages for Patients via the Web Portal: The MedCheck Intervention.**  
Weingart S.N., Hamrick H.E., Tutkus S., et al.  
Int J Med Inform. 2008(Mar); 77(3):161–168.  
*This descriptive study examined the use of an email-based medication safety intervention to improve communication about prescriptions and identification of adverse drug events. Researchers examined patient records and patient-provider communications conducted through MedCheck, an electronic messaging system, for a stratified random sample of patients who used the MedCheck program over a one-year period. Results suggested that the MedCheck system provided an effective medium for patient-provider communication about medications and identification of adverse drug events. One figure and several tables are included.*
- 11. Organizational Climate and Health Care Outcomes.**  
MacDavitt K., Chou S.-S., Stone P.W.  
Jt Comm J Qual Pat Saf. 2007(Nov); 33(11 Suppl):45–56.  
*This study sought to synthesize existing knowledge on the relationship between organizational climate and healthcare staff and patient outcomes. Using an AHRQ-developed model of organizational climate (described and diagrammed in the article) as a framework, researchers analyzed findings from 20 cross-sectional studies identified through review of the literature. Results, presented in detail in the article, suggested a strong link between aspects of organizational climate and healthcare employee safety and wellbeing; evidence was mixed concerning the association between organizational climate and patient outcomes. One figure and multiple tables are included.*
- 12. Safety and Quality in Independent Prescribing: An Evidence Review.**  
Latter S.  
Nurse Prescribing. 2008(Feb); 6(2):59–66.  
*This article reviews current knowledge concerning independent medication prescribing by nurses, a practice introduced in the UK by legislation enacted in 2002. The authors summarize published guidelines for safe and effective prescribing; they then review findings of various studies examining the extent to which required skills and competencies are demonstrated in nurses' prescribing practice. The authors conclude that while nurse prescribers currently employ a variety of skills and competencies in their prescribing practice, certain areas still show room for improvement. Several tables are included.*
- 13. Simulation-Based Training for Patient Safety: 10 Principles That Matter.**  
Salas E., Wilson K.A., Lazzara E.H., et al.  
J Patient Saf. 2008(Mar); 4(1):3–8.  
*This article provides a definition of simulation-based training (SBT) and an overview of its uses in healthcare. The authors then present ten guiding principles, as well as a number of tips and suggestions, concerning the objectives and capabilities of SBT; development and implementation processes; training; performance evaluation; transfer into practice; and measurement of effectiveness.*

- 14. The Aftermath of a ‘Never Event’: A Child’s Unexplained Death and a System Seemingly Designed to Thwart Justice.**  
Micalizzi D.A.  
Mod Healthcare. 2008(Mar 3); 38(9):24–25.  
*When her son died as a result of unexplained complications following ankle surgery, the author desperately sought answers about what had gone wrong. In this essay, she recounts her family’s long and frustrating struggle as they wrestled to obtain information from an obstinate system. The author is a patient advocate and founder of Justin’s Hope, a nonprofit organization dedicated to improving pediatric healthcare safety and adverse event response.*
- 15. The Role of the Physical Environment in Crossing the Quality Chasm.**  
Henriksen K., Isaacson S., Sadler B.L., Zimring C.M.  
Jt Comm J Qual Pat Saf. 2007(Nov); 33(11 Suppl):68–80.  
*In the context of widespread new building and renovation of existing healthcare facilities, this article summarizes current thinking about evidence-based design—the use of research-derived evidence to inform the design of facilities that enhance safety, quality, and the ability to provide patient-centered care. Structuring their discussion around the Institute of Medicine’s (IOM) six quality aims, the authors describe various design features that can support healthcare practice consistent with each of these goals. Finally, the authors outline the financial argument in favor of improvement projects focusing on improving physical design. One figure is included.*
- 16. The Science of Improvement.**  
Berwick D.M.  
JAMA. 2008(Mar 12); 299(10):1182–1184.  
*This essay comments on the often uneasy relationship between evidence and practice in the quest for healthcare improvement. Berwick argues that while established medical science research methodologies are held as sacrosanct, healthcare improvement research may in fact be better suited by different research designs, definitions, and methods for evaluation of evidence. To this end, Berwick outlines four possible changes to the treatment of “evidence” in academic medicine that could, in his opinion, facilitate the translation of research findings into healthcare improvement practice.*

- 17. Universal Screening for Methicillin-Resistant *Staphylococcus aureus* at Hospital Admission and Nosocomial Infection in Surgical Patients.**  
Harbarth S., Fankhauser C., Schrenzel J., et al.  
JAMA. 2008(Mar 12); 299(10):1149–1157.  
*This prospective study examined the impact of Methicillin-Resistant Staphylococcus aureus (MRSA) screening at hospital admission on nosocomial MRSA infection rates among surgical patients. Patients at a Swiss teaching hospital were assigned via a crossover design to one of two groups: in the control group, preventive action consisted of standard measures of infection control only; in the intervention group, screening before or at admission was performed in addition to standard infection control. Results indicated that the use of the screening technique did not reduce rates of nosocomial MRSA among the study sample. Results and implications are discussed. Multiple tables and figures are included.*
- 18. Universal Surveillance for Methicillin-Resistant *Staphylococcus aureus* in 3 Affiliated Hospitals.**  
Robicsek A., Beaumont J.L., Paule S.M., et al.  
Ann Intern Med. 2008(Mar 18); 148(6):409–418.  
*This study assessed the impact of increased surveillance for Methicillin-Resistant Staphylococcus aureus (MRSA) on incidence of MRSA infection at a 3-facility hospital system. The intervention studied involved the use of polymerase chain reaction-based nasal screening and isolation and (in phase 3) decolonization treatment when MRSA was detected. The study compared MRSA infection rates among three 1-year periods: in year 1 (baseline), no active surveillance was used; in year 2, all patients admitted to the ICU were screened; and in year 3, all hospital admissions were screened (universal surveillance). Results showed that the use of universal MRSA screening was associated with a sizable reduction in the rate of MRSA infection during hospitalization and during the 30-day period post-discharge. Multiple tables and figures are included.*
- 19. Variation in Medication Information for Elderly Patients During Initial Interventions by Emergency Department Physicians.**  
Cohen V., Jellinek S.P., Likourezos A., Nemeth I., Paul T., Murphy D.  
Am J Health-Syst Pharm. 2008(Jan 1); 65:60–64.  
*This pilot study sought to determine the accuracy of medication information collected during initial treatment of elderly patients in the emergency department (ED) and to ascertain to what degree this information agreed with the medication information on record with patients' regular caregivers. Researchers compared medication lists established during the ED visit with lists provided by patients' outside caregivers (physicians and pharmacists) for 98 elderly patients treated at the ED of an urban academic hospital during a one-year period. Results showed that the two medication lists on average disagreed with respect to over 30% of the items listed. Possible implications for ED medication safety practice are discussed. Two tables are included.*

**20. Why Is Cultural Safety Essential in Health Care?**

Richardson S., Williams T.

Med Law. 2007(Dec); 26(4):699–707.

*First used in New Zealand to address the healthcare needs of the native Maori population, the theory of cultural safety is now finding application in other contexts. Cultural safety encourages insight into an individual's own cultural orientation and its effect on others, and emphasizes the provision of individualized treatment that recognizes a patient's unique cultural identity. This article describes the origins and development of the notion of cultural safety, articulates the key concepts underlying the theory, and discusses its importance in providing an environment of care in which patients feel comfortable, respected, and emotionally and psychosocially "safe." [For more on this topic, see item 7.]*

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