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- 1. 2007 Annual Report of Hospital Adverse Events.**  
Portland, OR: Oregon Patient Safety Commission; March 2008.  
Available at: <http://www.oregon.gov/DHS/ph/pscommission/docs/Reports/2007Hospital-Report--final.pdf>  
*This report presents findings on adverse healthcare events in Oregon from reports submitted through the state's voluntary public reporting system between 2006 and December 2007. Included are summary data on frequency of adverse events overall and by type, severity of adverse events, and contributing factors, as well as data on hospital participation and reporting rates. Safety tips for patients, advice for hospitals on responding to adverse events, and an update on the Commission's activities are provided.*
- 2. Adverse Health Events in Minnesota: Fourth Annual Public Report.**  
St. Paul, MN: Minnesota Department of Health; January 2008.  
Available at: <http://www.health.state.mn.us/patientsafety/ae/aereport0108.pdf>  
*This report presents information on hospital adverse events compiled by Minnesota's mandatory reporting system for the period October 7, 2006–October 6, 2007. Under current regulations, hospitals licensed by the Minnesota Department of Health must report to the authority occurrences of any of 27 designated adverse events in six categories. Included in this report are data on statewide incidence of events in the six main categories; statewide data detailing types of events within each of the six categories; and hospital-specific data on the 27 reportable events for each participating facility. Several appendices provide further information and resources.*
- 3. Characteristics of Patient Care Management Problems Identified in Emergency Department Morbidity and Mortality Investigations During 15 Years.**  
Cosby K.S., Roberts R., Palivos L., et al.  
Ann Emerg Med. 2008(Mar); 51(3):251–261.  
*This study sought to describe the incidence and nature of patient care management issues occurring in emergency department morbidity and mortality review cases at an urban teaching hospital. Using a previously developed framework, researchers analyzed 636 case reports from a 15-year period with respect to type of problem, stage of care in which the problem or error occurred, contributing factors, and patient outcomes. Results, detailed in the article, showed that most cases involved multiple problems and multiple contributing factors. Several tables and figures are included.*
- 4. Developing an Adverse Event Reporting System Using Administrative Data.**  
Bahl V., Thompson M.A., Commisky E.L., Anderson S., Campbell Jr. D.A.  
J Patient Saf. 2008(Mar); 4(1):31–37.  
*This article describes in detail the development and pilot testing of a system using administrative data to identify patient safety events at the University of Michigan Health System (UMHS). The system uses the AHRQ patient safety indicators along with a secondary diagnosis timing variable to identify conditions associated with adverse events that occurred during hospitalization. Results of a 4-week trial pilot showed that the system detected at least 43 confirmed events not captured by the hospital's voluntary event reporting system. Plans for full implementation and potential further applications of the system are touched upon. Several tables and figures are included.*

- 5. Development of Medical Checklists for Improved Quality of Patient Care.**  
Hales B., Terblanche M., Fowler R., Sibbald W.  
Int J Qual Health Care. 2008(Feb); 20(1):22–30.  
*This study sought to summarize existing knowledge about methods for the design and use of medical or clinical checklists as a tool to improve safety and quality of care. Researchers reviewed the relevant medical literature as well as the literatures of aviation and aerospace, where the use of safety checklists is well established. Results, detailed in the article, suggested that while a number of individualized approaches to the creation of checklists exist, the instatement of a standardized method for checklist development could facilitate broader adoption of checklists in the medical context. Several tables and figures, including a sample checklist for a medical procedure, are included.*
- 6. Effect of Pharmacists on Medication Errors in an Emergency Department.**  
Brown J.N., Barnes C.L., Beasley B., Cisneros R., Pound M., Herring C.  
Am J Health-Syst Pharm. 2008(Feb 15); 65:330–333.  
*This study evaluated the impact of involvement by a clinical pharmacist on incidence of medication errors in the emergency department (ED) at a rural tertiary-care hospital. In the intervention studied, a clinical pharmacist was present in the ED to review all medication orders and suggest adjustments when warranted. Retrospective review of patient charts showed that the ED pharmacist intervention was associated with a significant reduction in the rate of medication errors in the ED, and that the pharmacists' recommendations were heeded in nearly all cases. Two tables are included.*
- 7. Emergency Nursing and Medical Error—A Survey of Two States.**  
Hohenhaus S.M.  
J Emerg Nurs. 2008(Feb); 34(1):20–25.  
*This descriptive study sought to examine and compare error reporting practice among emergency nurses in two states. Researchers surveyed emergency nurses in Pennsylvania and North Carolina regarding their experiences, attitudes, and practices with respect to reporting medical errors at their facilities. Most respondents reported having sufficient institutional and collegial support in the error reporting process; however, the author notes with concern that evidence of underreporting of errors, as well as potential failure to identify errors in the first place, was prevalent among the study sample. Possible reasons for this result and measures to address deficiencies in current error reporting systems are discussed.*

**8. Errors and the Burden of Errors: Attitudes, Perceptions, and the Culture of Safety in Pediatric Cardiac Surgical Teams.**

Bognár A., Barach P., Johnson J.K., et al.

Ann Thorac Surg. 2008(Apr); 85(4):1374–1381.

*This study explored attitudes and perceptions concerning medical errors among members of pediatric cardiac surgery (PCS) teams, with an aim to better understand the impact of awareness of and apprehension about errors on individual team members' performance and wellbeing. PCS team members at three urban academic medical centers were surveyed to gauge attitudes and perceptions regarding safety climate, error management, and the impact of errors on clinicians involved. Results suggested that concern about errors and potential errors constituted a significant psychological burden for PCS team members; results also pointed to a number of potentially problematic team dynamics. Multiple tables are included.*

**9. How Often are Potential Patient Safety Events Present on Admission?**

Houchens R.L., Elixhauser A., Romano P.S.

Jt Comm J Qual Pat Saf. 2008(Mar); 34(3):154–163.

*Information about whether a documented medical problem was present at admission can be an important variable in the assessment of hospital safety. This study examined how the application of present-on-admission (POA) status codes to the AHRQ patient safety indicators (PSIs) would affect the performance of the PSIs in measuring hospital adverse events. Researchers analyzed 2003 Healthcare Cost and Utilization Project data from two states with respect to 13 applicable PSIs to evaluate the face validity of POA coding, as well as the effect of adjustment for POA status on the output of measurements using the PSIs. Results showed that POA-based adjustment led to significant reduction in the measured incidence of events for 3 of the PSIs examined, suggesting that these indicators may not be reliable when used without POA information; the remaining 10 PSIs were judged to provide a valid measurement with or without POA information. Multiple tables and figures are included.*

**10. Interruptions in a Level One Trauma Center.**

Brixey J.J., Tang Z., Robinson D.J., et al.

Int J Med Inform. 2008(Apr); 77(4):235–241.

*This ethnographic study sought to document and characterize interruptions to the work of emergency department (ED) clinicians—an acknowledged risk factor for the occurrence of medical errors. Researchers analyzed observational data on activities and workflow interruptions for a convenience sample of five emergency department physicians and eight registered nurses in a tertiary teaching hospital trauma center. A taxonomy of interruptions developed on the basis of these findings is presented. Results further showed that RNs were interrupted slightly more frequently than physicians, that interruptions occurred through a variety of mediums, and that aspects of the physical environment could cause an interruption. Three figures are included.*

- 11. Leveraging Computerized Sign-Out to Increase Error-Reporting and Addressing Patient Safety in Graduate Medical Education.**  
Foster P.N., Sidhu R., Gadhia D.A., DeMuisis M.  
J Gen Intern Med. 2008(Apr); 23(4):481–484.  
*This article describes the development and implementation of a mechanism to improve error reporting compliance among medical residents at a community hospital. In this initiative, a “safety log” was incorporated into the existing computerized patient sign-out process used by residents. Evaluation one year post-intervention showed that introduction of the safety log led to substantially increased rates of error reporting among hospital house staff. Additional results, successes and challenges, and prospects for further research in this area are discussed. One table and one figure are included.*
- 12. Navigating Towards Improved Surgical Safety Using Aviation-Based Strategies.**  
Kao L.S., Thomas E.J.  
J Surg Res. 2008(Apr); 145(2):327–335.  
*This article reviews current knowledge on the application in healthcare of safety techniques drawn from the aviation industry. The authors describe a number of aviation-derived approaches increasingly being adopted in the surgical context—including crew resource management (CRM) training, simulation-based training and assessment, and various methods of error reporting and analysis. Also touched upon are possible constraints on the transferability of aviation-based methods to healthcare, as well as potential directions for future research in this area.*
- 13. ‘Never Events’ and Health Care Ethics.**  
Friedman E.  
Hospitals & Health Networks. H&HN Online. April 1, 2008.  
Available at: [http://www.hhnmag.com/hhnmag\\_app/jsp/hhnonline.jsp](http://www.hhnmag.com/hhnmag_app/jsp/hhnonline.jsp)  
*Apropos of recent decisions by various health care payers to cease reimbursement for care associated with certain preventable adverse events, this editorial argues that ethical violations in healthcare should be considered equally unacceptable. To this end, the author lists 12 infractions to be designated as ethics “never events”—a number of which, she notes, ultimately effect safety and quality of care.*
- 14. Patient Safety and Job-Related Stress: A Focus Group Study.**  
Berland A., Natvig G.K., Gundersen D.  
Intensive Crit Care Nurs. 2008(Apr); 24(2):90–97.  
*This qualitative study examined the relationship between work-related stress and patient safety as perceived by critical care nurses. Researchers conducted focus group interviews with a total of 23 nurses representing two hospitals in Norway to explore their experiences and perceptions with regard to their work environment, work-related stress, and the impact of these factors on the safety of patient care. Results suggested that a number of factors—including a high-pressure work environment, perceived lack of control and influence, and friction with one’s coworkers—were felt to contribute to job-related stress and potentially to jeopardize patient safety.*

- 15. Pneumatic Tubes: A Possible Patient Safety Vacuum?**  
Pennsylvania Patient Safety Authority.  
Patient Safety Advisory. 2008(Mar); 5(1):28–30.  
Available at:  
<http://www.psa.state.pa.us/psa/cwp/view.asp?a=1293&q=445966&psaNav=#44>  
*This article discusses patient safety issues associated with the use of pneumatic tube systems (PTS) for intra-facility transport of specimens, medications, and other materials. Using examples from reports submitted to Pennsylvania’s reporting system, the article illustrates the types of problems that can occur and how these errors may compromise safety, and offers strategies for safer and more effective PTS use.*
- 16. Preventing the Retention of Foreign Objects during Interventional Radiology Procedures.**  
Pennsylvania Patient Safety Authority.  
Patient Safety Advisory. 2008(Mar); 5(1):24–27.  
Available at:  
<http://www.psa.state.pa.us/psa/cwp/view.asp?a=1293&q=445966&psaNav=#44>  
*This article discusses the issue of retention of foreign objects associated with interventional radiology. Interventional radiology (IR), a rapidly growing field, refers to surgical procedures performed via a minute incision and using radiologic monitoring to facilitate the surgical manipulation. The authors review evidence of the problem (including reports submitted to Pennsylvania reporting system), discuss risk factors for retention of surgical objects during IR procedures, and outline preventive measures and risk reduction strategies.*
- 17. Responding to Serious Medical Error in General Practice—Consequences for the GPs Involved: Analysis of 75 Cases from Germany.**  
Fisseni G., Pentzek M., Abholz H.-H.  
Fam Pract. 2008(Feb); 25(1):9–13.  
*This study surveyed general practitioners in the North Rhine region of Germany regarding their handling of “serious” medical errors and the professional, legal, or other consequences of such errors for the physician involved. While respondents reported that medical errors had led to damaged reputation, loss of patients, and in some cases legal action, it was also reported that many patients remained with their GP despite the occurrence of an error—particularly in cases where other practitioners were involved in the error, and, notably, where the GP took initiative in disclosing the error to the patient. Three tables are included.*

- 18. Safety in Home Care: A Broadened Perspective of Patient Safety.**  
Lang A., Edwards N., Fleischer A.  
Int J Qual Health Care. 2008(Apr); 20(2):130–135.  
*This study sought to identify and examine key issues related to safety in home healthcare in Canada—a rapidly growing and understudied area of the healthcare system. Content analysis of data from a literature review as well as discussions with a multidisciplinary group of experts revealed a number of themes, outlined in the article. The authors argue that existing conceptualizations of patient safety, almost all of which presuppose a hospital context, will likely have limited applicability in the home-care setting: a new framework is therefore needed to address the safety concerns particular to the home-care environment.*
- 19. The Patient Safety and Quality Improvement Act of 2005: Developing an Error Reporting System to Improve Patient Safety.**  
Riley W., Liang B.A., Rutherford W., Hamman W.  
J Patient Saf. 2008(Mar); 4(1):13–17.  
*This article discusses the Patient Safety and Quality Improvement Act, adopted in 2005, and its potential impact on error reporting practice and benefits to patient safety. After outlining the provisions of the Act, the authors list the essential elements of a national error reporting system as stipulated by the Institute of Medicine and comment on how the Act will address these requirements. Finally, they consider the broader theoretical and practical implications of this legislation for patient safety and the healthcare system.*
- 20. Use of an Interactive, Telephone-Based Self-Management Support Program to Identify Adverse Events Among Ambulatory Diabetes Patients.**  
Sarkar U., Handley M.A., Gupta R., et al.  
J Gen Intern Med. 2008(Apr); 23(4):459–465.  
*This study tested the efficacy of a telephone self-management program as an instrument for detecting adverse events and safety issues among ambulatory diabetes patients. Records of telephone interactions for patients participating in an automated telephone self-management (ATSM) program were examined for indications of adverse or potential adverse events to determine how frequently events would be captured by this method. Results showed that monitoring through an ATSM system was capable of detecting adverse events and potential adverse events, suggesting that such a system could be used effectively as a means to improve ambulatory patient safety. Three tables and one figure are included.*

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Anita Spielman, Editor

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