

April (2) 2008
Volume 12, Issue 4:2

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- 1. 2007 National Healthcare Quality Report.**
Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; February 2008. AHRQ Pub. No. 08-0040.
Available at: <http://www.ahrq.gov/qual/nhqr07/nhqr07.pdf>
This fifth annual report from the Agency for Healthcare Research and Quality presents a portrait of current healthcare quality in the U.S., documents progress that has been made since the report's inception, and identifies areas still needing attention. The report assesses healthcare performance according to a set of measures comprising four dimensions of quality: effectiveness, patient safety, timeliness, and patient centeredness. National and state-level data are presented along with discussion of findings. The authors note that while there has been continual progress toward better-quality and safer healthcare in the U.S., the rate of progress has decreased, and many opportunities for improvement remain.
- 2. A Mixed Method Study of the Merits of E-Prescribing Drug Alerts in Primary Care.**
Lapane K.L., Waring M.E., Schneider K.L., Dubé C., Quilliam B.J.
J Gen Intern Med. 2008(Apr); 23(4):442–446.
Electronic prescribing (or e-prescribing) software often includes a built-in system of drug alerts to warn prescribers of potentially dangerous drug interactions or contraindications at the point of prescribing. As part of a larger study, this analysis used a combination of surveys and focus groups to assess primary care physicians' attitudes concerning the usefulness of drug alerts in e-prescribing. Results showed that while study participants acknowledged the value of drug alerts to patient safety, many reported overriding the alerts most or all of the time, and it was generally felt that existing applications could be improved by refinement of the drug-alert algorithms and by allowing prescribers to tailor the systems to the particulars of their practice settings. One table and one figure are included.
- 3. Alarm Interventions during Medical Telemetry Monitoring: A Failure Mode & Effects Analysis.**
Pennsylvania Patient Safety Authority.
Patient Safety Advisory. March 2008 (Supplementary Review).
Available at:
<http://www.psa.state.pa.us/psa/cwp/view.asp?a=1293&q=445966&psaNav=>
This report documents a failure mode and effects analysis (FMEA) investigating potential weaknesses in the medical telemetry monitoring and response process, in response to numerous reports of problems related to this process received by the Pennsylvania Patient Safety Reporting System (PA-PSRS) in recent years. A modified FMEA process was applied to data from a total of 277 reports submitted to PA-PSRS over a 2-year period. The FMEA procedure and findings are documented and discussed in detail. This report is intended to provide specific guidance on issues associated with medical telemetry monitoring response systems, as well as an instructive illustration of how to conduct a FMEA.

- 4. Complying With the 2008 National Patient Safety Goals.**
Catalano K., Fickenscher K.
AORN Journal. 2008(Mar); 87(3):547–556.
This commentary reviews the Joint Commission’s 2008 National Patient Safety Goals (NPSGs) for accredited facilities, with a focus on how healthcare information technology can assist healthcare organizations in meeting these requirements. The authors briefly explain each goal, note additions and updates for 2008, and comment on healthcare IT applications that may facilitate compliance with the goals.
- 5. Health Care at the Crossroads: Development of a National Performance Measurement Data Strategy.**
Oakbrook Terrace, IL: The Joint Commission; 2008.
Available at: http://www.jointcommission.org/PublicPolicy/Perf_Data_Strategy.htm
This white paper, a product of the Joint Commission’s Public Policy Initiative, sets forth a framework for the creation of a national performance measurement system for the collection, management, analysis, and dissemination of healthcare performance data to support performance evaluation and quality improvement. This paper articulates the principles of a national performance measurement data strategy and proposes guidelines for the creation of an infrastructure, capture and management of data, and fundamental rules for the operation and oversight of the system.
- 6. Hospital Progress in Reducing Error: The Impact of External Interventions.**
Hosford S.B.
Hospital Topics. 2008(Winter); 86(1):9–19.
This study assessed U.S. hospitals’ perceived progress in managing medical errors in relation to three factors—Joint Commission accreditation and patient safety standards, state error-reporting requirements, and public awareness concerning medical errors. A survey of hospital administrators across the country showed that most respondents reported considerable strides in the implementation of medical error management systems, and that Joint Commission-accredited hospitals consistently reported greater progress. Presence or absence of state error-reporting systems and level of public awareness about medical errors appeared to have no significant influence on reported progress. Multiple figures are included.

- 7. Human Factors Toolkit.**
Association of periOperative Registered Nurses (AORN) and the AORN Foundation in conjunction with Safer Healthcare. 2007.
Available at:
<http://www.aorn.org/PracticeResources/ToolKits/HumanFactorsInHealthCareToolKit/>
This toolkit, developed collaboratively by AORN and Safer Healthcare with funding from Kimberly-Clark, offers guidelines for the development and implementation of a human factors-based approach to team training. Drawing upon the principles of crew resource management, the kit provides a collection of tools and strategies to improve team members' individual and collective performance, including structured communication techniques, team briefings, and situational awareness. Five awareness posters and an extensive list of resources for further reading are included in the kit and may be accessed via the link above.
- 8. Learning More About the Science of Patient Safety.**
Beyea S.
AORN Journal. 2008(Mar); 87(3):633–635.
In this article, Beyea argues that familiarity with the scientific theory underlying patient safety practice is essential to nurses' ability to provide safe care. Beyea offers practical advice on recognizing one's educational needs, creating a study plan, and accessing the various educational resources available. This column is the third installment of a "Patient Safety First" series on patient safety goals for perioperative nurses.
- 9. Never Pay Never Again.**
DerGurahian J.
Mod Healthcare. 2008(Mar 10); 38(10):6–7,16.
This article discusses the implications of the recently announced change to CMS reimbursement policy, to take effect in October 2008, under which Medicare will no longer provide reimbursement for costs associated with the treatment of eight hospital-related conditions. The author highlights reactions to the change from several hospital administrators and touches upon some of the steps healthcare organizations are taking—and new services being offered—to help prepare for the new system.
- 10. Nursing M&M Reviews: Learning from Our Outcomes.**
Nolan S.
RN. 2008(Jan):36–40.
Available at: <http://rn.modernmedicine.com/rnweb/issue/issueDetail.jsp?id=13780>
Nursing morbidity and mortality (M&M) reviews, implemented five years ago at the author's hospital, are monthly conferences in which problematic cases are analyzed in order to identify and address potential issues in care. In this article, the author offers tips on establishing and conducting nursing M&M reviews and provides three case examples illustrating the review process.

- 11. Nursing Student Medication Errors: A Retrospective Review.**
Harding L., Petrick T.
J Nurs Educ. 2008(Jan); 47(1):43–47.
This study sought to characterize self-reported medication errors committed by students in an undergraduate nursing program. Incident reports involving a total of 77 medication errors from a 3-year period were retrospectively reviewed and analyzed with respect to type of error, contributing factors, and semester of the program during which the error occurred. Results, detailed in the article, identified three main types of contributing factors, as well as revealing a number of patterns in the incidence of errors. Pedagogical implications and possible educational strategies to encourage better understanding of medication safety practice are discussed.
- 12. Overdose Rate of Drugs Requiring Renal Dose Adjustment: Data Analysis of 4 Years Prescriptions at a Tertiary Teaching Hospital.**
Sheen S.S., Choi J.E., Park R.W., Kim E.Y., Lee Y.H., Kang U.G.
J Gen Intern Med. 2008(Apr); 23(4):423–428.
Dosing guidelines for certain medications stipulate dose adjustment based on the patient’s kidney function; evidence suggests that improper dosing of such drugs occurs frequently and may be a source of medication errors. This study sought to determine the frequency of overdose of drugs requiring renal dose adjustment and to pinpoint factors associated with this tendency at a tertiary teaching hospital. Retrospective analysis of relevant records from a 4-year period showed that the overall rate of overdose was 5.3%; among patients with moderate to severe renal impairment, the overdose rate was 28.2%. Additional findings and possible strategies to address this issue are discussed. The authors note that the feasibility of this study depended heavily on the construction of a “clinical data mart” to organize and analyze formidable quantities of electronic data. Three figures and one table are included.
- 13. Perceptions of Preventable Medical Errors in Alberta, Canada.**
Northcott H., Vanderheyden L., Northcott J., et al.
Int J Qual Health Care. 2008(Apr); 20(2):115–122.
This study examined perceptions and experiences pertaining to preventable medical error among adult healthcare consumers in Alberta, Canada. Participants in a telephone survey were asked to share their perceptions concerning frequency, causes, and healthcare system management of medical errors; to rate the overall quality of the healthcare system; and to indicate whether they or a family member had ever experienced a medical error. Results showed that, on average, respondents who had experienced a medical error perceived that medical errors occurred more frequently, were less confident that their doctor would disclose a medical error to them, and rated the quality of the healthcare system more negatively. Two figures and three tables are included.

- 14. Raising the Awareness of Inpatient Nursing Staff about Medication Errors.**
Elnour A.A., Ellahham N.H., Al Qassas H.I.
Pharm World Sci. 2008(Apr); 30(2):182–190.
This study aimed to develop, implement, and evaluate the efficacy of an educational program to increase nurses' knowledge and awareness concerning medication errors. A total of 370 nurses at a United Arab Emirates teaching hospital participated in a structured training program designed and conducted by clinical pharmacists. Results of pre- and post-intervention questionnaires showed that participation in the program significantly increased nurses' awareness about medication safety issues and self-reported adherence to medication-related safe practices. Multiple tables are included.
- 15. Reducing Diagnostic Errors through Effective Communication: Harnessing the Power of Information Technology.**
Singh H., Naik A.D., Rao R., Petersen L.A.
J Gen Intern Med. 2008(Apr); 23(4):489–494.
Many medical errors spring from errors related to the diagnostic process, but relatively little is known about the mechanisms whereby diagnostic errors occur. In this article, the authors hypothesize that lapses in clinical communication contribute significantly to diagnostic errors. They develop a conceptual framework for the occurrence of communication breakdowns in the diagnostic process, and, on the basis of this model, propose technology-based strategies to address these potential sources of error. One figure and one table are included.
- 16. SCIP: Making Complications of Surgery the Exception Rather than the Rule.**
Clancy C.M.
AORN Journal. 2008(Mar); 87(3):621–624.
This commentary gives an overview of the Surgical Care Improvement Project (SCIP)—a national, collaborative initiative to improve surgical safety by reducing the incidence of a set of common and costly surgical complications. Clancy briefly describes the background, objectives, and scope of the campaign and highlights several new SCIP process measures to be introduced in 2008–2009.
- 17. Testing the Technology Acceptance Model for Evaluating Healthcare Professionals' Intention to Use an Adverse Event Reporting System.**
Wu J.-H., Shen W.-S., Lin L.-M., Greenes R.A., Bates D.W.
Int J Qual Health Care. 2008(Apr); 20(2):123–129.
This study aimed to develop a social psychology-derived model to assess the determinants of healthcare workers' acceptance of and likeliness to use an adverse event reporting system. To test validity, the proposed model was applied to data from 290 responses to a survey of healthcare professionals in Taiwan. Results showed that perceived usefulness, perceived ease of use, subjective norm, and trust all contributed to subjects' inclination to use a reporting system; of these factors, subjective norm—the extent to which someone feels that people whose opinion they value want them to do something—was found to have the greatest influence. Results and implications for practice are discussed. Multiple figures and tables are included.

18. The Effect of Computerized Physician Order Entry with Clinical Decision Support on the Rates of Adverse Drug Events: A Systematic Review.

Wolfstadt J.I., Gurwitz J.H., Field T.S., et al.

J Gen Intern Med. 2008(Apr); 23(4):451–458.

This study sought to summarize existing evidence about the relationship between use of computerized physician order entry (CPOE) with clinical decision support (CDS) and incidence of adverse drug events (ADEs). Systematic review of the literature identified a total of ten eligible studies, with findings varying by study examined: five studies showed that the use of CPOE with CDS was associated with a statistically significant reduction in ADEs; four showed a non-significant reduction in ADEs; and one found no significant change in ADE rates. The authors note that no randomized controlled trials relating to this topic were identified, and that none of the included studies addressed the long-term care setting; further research in this area is therefore warranted.

19. The Relationship Between Nurse Education Level and Patient Safety: An Integrative Review.

Ridley R.T.

J Nurs Educ. 2008(Apr); 47(4):149–156.

This study sought to synthesize existing knowledge concerning the association between nurse educational background and patient outcomes. A total of 24 relevant studies covering a 20-year period were analyzed with respect to the relationship between nurse educational characteristics and patient safety as measured by the AHRQ Patient Safety Indicators. Results showed that, in general, greater RN dose and skill mix—both of which reflect the proportion of care provided by RNs as opposed to other nursing staff—were associated with improved patient safety. However, the author notes as a limitation of the present research that few existing studies have considered the range of nursing education level with sufficient specificity; further research in this area is therefore needed.

20. Use of a Handheld Computer Application for Voluntary Medication Event Reporting by Inpatient Nurses and Physicians.

Dollarhide A.W., Rutledge T., Weinger M.B., Dresselhaus T.R.

J Gen Intern Med. 2008(Apr); 23(4):418–422.

This study investigated whether a pocket-sized, computer-based device could be used effectively to enable documentation of medication safety events by clinicians. Physicians and nurses at four teaching hospitals carried the device for 1-week periods during which they were asked to use the tool to record medication events in which they were involved or that they witnessed. Over a total of 2,311 days of clinician participation, 76 events were reported; nurses and attending physicians reported events significantly more frequently than did resident physicians. On the basis of these results, the authors suggest that the use of a handheld computer device for documentation of medication events may have potential to enhance hospital event reporting systems. Several tables are included.

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<http://www.npsf.org/rc/pubs/ca/>

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