

May (1) 2008
Volume 12, Issue 5:1

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- 1. 5 Million Lives Campaign.**
McCannon J.
Future Healthcare. 2008(Q2):142–144.
In this interview, McCannon, Vice President of the Institute for Healthcare Improvement (IHI), offers a status report on the IHI's 5 Million Lives Campaign. McCannon reviews the campaign's objectives, notes accomplishments to date, and touches upon ongoing related initiatives and future direction for the program.
- 2. “Against the Silence”: Development and First Results of a Patient Survey to Assess Experiences of Safety-Related Events in Hospital.**
Schwappach D.L.
BMC Health Serv Res. 2008(Mar 20); 8:59.
Available at: <http://www.biomedcentral.com/content/pdf/1472-6963-8-59.pdf>
This article describes the development and initial testing of a survey to capture perceptions of safety and experiences of safety-related incidents among hospital inpatients in Switzerland. Focus groups and in-depth interviews with patients, in conjunction with pilot-testing among randomly selected patients in two Swiss hospitals, were used to evaluate acceptance and validity of the survey instrument. Results showed that while the survey was generally well accepted, many patients expressed ambivalence about reporting safety incidents or uncertainty about identifying or classifying events. Two tables are included.
- 3. An Observational Analysis of Surgical Team Compliance with Perioperative Safety Practices after Crew Resource Management Training.**
France D.J., Leming-Lee S., Jackson T., Feistritz N.R., Higgins M.S.
Am J Surg. 2008(Apr); 195(4):546–553.
This study investigated the effect of crew resource management (CRM) training on surgical team members' adherence to patient safety practices and tendency to behave in ways consistent with CRM principles of teamwork. At an academic medical center where CRM training for all clinical staff was ongoing, researchers analyzed data from direct observation of 30 surgical teams to assess their compliance with specified safety practices. Results showed relatively low compliance with the safety practices examined, even among CRM-trained individuals. The authors comment on these results and possible implications for the use of CRM training in healthcare. Multiple tables and figures are included.

- 4. Bacterial Pathogens in Ambulances: Results of Unannounced Sample Collection.**
Alves D.W., Bissell R.A.
Prehospital Emerg Care. 2008(Apr/Jun); 12(2):218–224.
While the issue of hospital-acquired infections has drawn much attention, few studies have considered the role of prehospital care as a potential source of nosocomial infection. This qualitative study examined bacterial samples from emergency medical services (EMS) vehicles to determine whether these vehicles were contaminated with harmful microorganisms. Laboratory analysis of samples from four ambulances detected four nosocomial pathogens, three of which exhibit antibiotic-resistant properties. Factors contributing to bacterial contamination of ambulances, the importance of compliance with routine hygiene and sterilization practices, and other strategies to minimize infection risk are discussed. One figure and two tables are included.
- 5. Can Patient Safety Be Measured by Surveys of Patient Experiences?**
Solberg L.I., Asche S.E., Averbeck B.M., et al.
Jt Comm J Qual Pt Saf. 2008(May); 34(5):266–274.
This study examined whether patient survey responses regarding medical errors could provide a meaningful assessment of patient safety in a large medical group. Patients who had recently visited member clinics were surveyed concerning satisfaction with their care and perceived errors experienced during care. Analysis showed that of almost 2,000 responses collected, 11% reported one or more errors; however, only a fraction of the reported incidents were deemed actual errors on further review. The authors conclude that while patient survey responses yield important information that should be incorporated in quality and safety evaluations, these reports do not by themselves provide an accurate measurement of patient safety. Multiple tables are included.
- 6. Cluster Randomised Trial of a Targeted Multifactorial Intervention to Prevent Falls Among Older People in Hospital.**
Cumming R.G., Sherrington C., Lord S.R., et al., for the Prevention of Older People's Injury Falls Prevention in Hospitals Research Group.
BMJ. 2008(Apr 5); 336(7647):758–760.
This study examined the effectiveness of a multifactorial program to prevent falls among elderly hospital patients in Sydney, Australia. A cluster randomized controlled trial was used to compare fall rates among patients in 24 elder-care wards at two hospitals. The intervention involved a number of fall-prevention measures including fall risk assessment, adjustments to medication and physical environment, and staff and patient education. Results, in contrast to some previous studies, showed no significant difference in fall rates between the control and intervention groups during the period examined. Possible reasons for these results and implications are discussed. Four tables and one figure are included.

7. Development, Testing, and Findings of a Pediatric-Focused Trigger Tool to Identify Medication-Related Harm in US Children's Hospitals.

Takata G.S., Mason W., Taketomo C., Logsdon T., Sharek P.J.

Pediatrics. 2008(Apr); 121(4):e927–e935.

Available at: <http://pediatrics.aappublications.org/cgi/reprint/121/4/e927>

This study sought to create and evaluate a trigger tool to identify adverse drug events (ADEs) among pediatric inpatients and to characterize ADEs at U.S. children's hospitals. The trigger tool developed by the Institute for Healthcare Improvement, which has proven effective at detecting ADEs in the adult population, was adapted to the pediatric context, and the modified tool was applied in a retrospective review of 960 charts from 12 U.S. children's hospitals. Results, consistent with previous findings, indicated that the pediatric-focused trigger tool detected considerably higher rates of ADEs than would have been found by traditional methods, suggesting that such a tool is effective at identifying ADEs in the inpatient pediatric population. Results and implications are discussed. Multiple tables and figures are included.

8. Effect of Computer Order Entry on Prevention of Serious Medication Errors in Hospitalized Children.

Walsh K.E., Landrigan C.P., Adams W.G., et al.

Pediatrics. 2008(Mar); 121(3):e421–e427.

Available at: <http://pediatrics.aappublications.org/cgi/reprint/121/3/e421>

This study sought to determine the effect of implementation of a computerized physician order entry (CPOE) system on the rate of medication errors among pediatric inpatients. Comprehensive error surveillance methods were used to examine records from before and after CPOE implementation at an urban medical center. Time-series analysis showed a 7% decrease in nonintercepted serious medication errors following implementation of CPOE; the incidence of injuries due to error did not change. The authors note that the observed reduction in errors is significantly smaller than was expected on the basis of previous studies. Results and possible reasons for this discrepancy are discussed. Several tables and figures are included.

9. Factors Influencing Bar-Code Verification by Nurses During Medication Administration in a Dutch Hospital.

van Onzenoort H.A., van de Plas A., Kessels A.G., Veldhorst-Janssen N.M., van der Kuy P.-H., Neef C.

Am J Health-Syst Pharm. 2008(Apr 1); 65(7):644–648.

This study examined variables affecting nurses' verification of bar codes when using a bar-code-enabled point-of-care (BPOC) system to document medication administration. Analysis of electronic medication administration records from a 3-week period showed that bar-code verification was performed in slightly more than half of applicable instances of medication administration. Multiple factors were found to influence whether bar-code verification was performed, including time of day, administration route of the drug, and number of nurses on duty. The authors discuss these results and consider possible explanations for the relatively low rate of compliance with bar-code verification observed. One table is included.

- 10. Health-Care-Associated Infections in Hospitals: Leadership Needed from HHS to Prioritize Prevention Practices and Improve Data on These Infections.**
Washington, DC: United States Government Accountability Office; March 2008.
Publication GAO-08-283.
Available at: <http://www.gao.gov/new.items/d08283.pdf>
Mounting evidence of the prevalence, virulence, and costs of hospital-acquired infections (HAIs) has prompted increasing worry and calls for national action to address this issue. This report presents findings and recommendations following an investigation by the U.S. Government Accountability Office (GAO) to assess federal guidelines, standards, and data collection methods concerning HAIs. On the basis of its findings, the GAO calls for clearer prioritization of HAI prevention and management guidelines to assist hospitals in implementing these practices, as well as efforts to synchronize data collection among the multiple agencies tracking data on HAIs.
- 11. High-Performance Teams for Current and Future Physician Leaders: An Introduction.**
Jain A.K., Thompson J.M., Chaudry J., McKenzie S., Schwartz R.W.
J Surg Educ. 2008(Mar/Apr); 65(2):145–150.
This article gives an overview of the use and benefits of high-performance teams as a mode of healthcare delivery. The team model, the authors argue, offers the ideal approach to providing patient-centered and well coordinated care in an increasingly complex and multidisciplinary system. The authors present a conceptual framework for team performance derived from meta-analysis of the current literature, with particular attention to the role of physician leaders in promoting and sustaining effective teamwork. This article is the first in a series that will elaborate on the model presented here and further explore the applications of teamwork in healthcare. One table is included.
- 12. Improving Patient Safety through a Multi-faceted Internal Surveillance Program.**
Matlow A., Stevens P., Urmson L., Wray R.
Healthcare Quarterly. 2008(Special Issue); 11:101–108.
This article highlights four key components of a patient safety surveillance program at the Hospital for Sick Children, Toronto, Ontario: an internal incident reporting system, monthly morbidity and mortality reviews, patient safety walkarounds, and “shoe leather” infection control rounds. The authors describe the design and implementation of each strategy and comment on improvements attributable to these measures, challenges encountered during implementation, and lessons learned. Five tables and one figure are included.

- 13. Medication Errors in a Neonatal Intensive Care Unit.**
Lerner R.B., de Carvalho M., Vieira A.A., Lopes J.M., Moreira M.E.
J Pediatr (Rio J). 2008(Mar/Apr); 84(2):166–170.
Available at: <http://www.jped.com.br/conteudo/08-84-02-166/ing.pdf>
Neonatal intensive care unit patients often require clinically and technologically complex treatment and may be disproportionately vulnerable to medical error. This study aimed to characterize errors and risk factors for errors in the care of infants in a neonatal intensive care unit at a hospital in Rio de Janeiro, Brazil. Retrospective chart analysis showed that errors occurred in 55% of the cases examined, that most of the errors that occurred were medication errors, and that very small or premature infants experienced higher rates of error. Two tables are included.
- 14. Off the Record—Avoiding the Pitfalls of Going Electronic.**
Hartzband P., Groopman J.
N Engl J Med. 2008(Apr 17); 358(16):1656–1658.
While electronic medical records have been hailed as a solution to a myriad of problems in today's healthcare system, this technology may also carry unintended consequences. In this editorial, the authors relate anecdotal reports concerning some of the disadvantages of electronic medical record use. Caution must be exercised, they argue, to ensure that compliance with administrative requirements—and the ability to easily access and reproduce volumes of medical data—do not supplant individualized care and autonomous clinical thinking.
- 15. Preventing Pediatric Medication Errors.**
The Joint Commission.
Sentinel Event Alert. Issue 39, April 11, 2008.
Available at:
http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_39.htm
Pediatric patients are particularly vulnerable to medication errors and associated harm, and recent research suggests that adverse drug events among pediatric patients may occur much more frequently than had previously been thought. This Sentinel Event Alert summarizes information on the nature and causes of pediatric medication errors, offers preventive strategies, and lists relevant Joint Commission requirements and suggested actions to address this issue.
- 16. “Product Safety” Compromises Patient Safety (an Unjustified Black Box Warning on Ultrasound Contrast Agents by the Food and Drug Administration).**
Grayburn P.A.
Am J Cardiol. 2008(Mar 15); 101(6):892–893.
In this editorial, the author criticizes the FDA's attempt to impose a “black box” warning on the ultrasound contrast agents Definity and Optison, on the basis of postmarketing evidence of several fatal adverse events associated with these substances. The author disputes the FDA's reasoning and argues that, when used appropriately, the benefits of these drugs as a diagnostic tool far outweigh their risks.

- 17. Redundant Publications in Surgery: A Threat to Patient Safety?**
Stahel P.F., Clavien P.-A., Smith W.R., Moore E.E.
Patient Saf Surg. 2008(Mar 19); 2(6).
Available at: <http://www.pssjournal.com/content/pdf/1754-9493-2-6.pdf>
Redundant publications—publications that present as “original” results that have been previously published or accepted for publication elsewhere—may be surprisingly common in the biomedical literature, and, excluding a few accepted forms where the duplication is clearly acknowledged, are widely regarded as unethical. In this editorial, the authors discuss why the factitious data associated with some redundant publications may also constitute a threat to patient safety.
- 18. Student Perceptions of Medical Errors: Incorporating an Explicit Professionalism Curriculum in the Third-Year Surgery Clerkship.**
Newell P., Harris S., Aufses A. Jr., Ellozy S.
J Surg Educ. 2008(Mar/Apr); 65(2):117–119.
This study involved the development and implementation of a curriculum on medical professionalism that focused on medical errors. The program aimed to explore students’ concerns about medical error and to use the issues relating to medical error to illustrate principles of medical professionalism. In the pilot phase of this program, a total of 123 medical students completed the curriculum as part of a third-year surgical clerkship. The authors summarize the rationale for teaching medical professionalism and discuss observed results, challenges, and possible future direction for the program.
- 19. The Vanishing Nonforensic Autopsy.**
Shojania K.G., Burton E.C.
N Engl J Med. 2008(Feb 28); 358(9):873–875.
This article comments on the diminishing use of the clinical autopsy and the possible ramifications of this trend. Previous work by the authors suggests that autopsy detects a significant number of diagnostic errors that would otherwise go undiscovered. The authors discuss this and other studies concerning the role of autopsy in verifying diagnosis and identifying diagnostic errors. They describe the clinical and educational benefits of autopsy, discuss possible reasons for the decrease in autopsy use at most hospitals, and offer suggestions for reintegrating the autopsy in current medical practice.

20. Trust but Verify: Cooperation Cannot Mean Abdication in the Operating Room.

Liang B.A., Tran K.M.

J Clin Anesth. 2008(Mar); 20(2):150–153.

This article reviews and comments on a medical malpractice case in which problems during the administration of anesthesia caused injury to a patient. A deciding factor in the case was the fact that one of the doctors involved had accepted, without verification, a colleague's assertion that a crucial step in the anesthesia process had been performed successfully—when in fact it had not. Although focusing on the legal aspects of the case, this article offers a thought-provoking commentary on the complex dynamics relating to concepts such as trust, cooperation, and accountability in the clinical context.

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