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- 1. A New Bundle for Preventing CRBSIs.**
Martin W.R., Harnage S.
Pat Saf Qual Healthcare. 2008(May/Jun); 5(3):20–23.
While many hospitals have reduced catheter-related bloodstream infection (CRBSI) rates to near-zero levels, complete eradication of this complication remains an elusive goal. This article describes an initiative at a California community hospital that has eliminated CRBSIs in the hospital's ICUs for a period of more than two years.
- 2. An Iconic Language for the Graphical Representation of Medical Concepts.**
Lamy J.-B., Duclos C., Bar-Hen A., Ouvrard P., Venot A.
BMC Med Inform Decis Mak. 2008(Apr 24); 8(16).
Available at: <http://www.biomedcentral.com/1472-6947/8/16>
This article describes the design and preliminary evaluation of an icon-based system for the representation of medical and pharmacologic information. The system, known as VCM (Visualisation des Connaissances Médicales, or Visualization of Medical Knowledge), uses combinations of pictograms and graphic symbols to succinctly convey—and thereby make more accessible—information such as is typically found in drug monographs. The authors describe in detail the development of VCM, evaluation of comprehension and usability of the system among physicians, and results of this evaluation; they discuss potential applications of VCM in practice and comment on lessons learned and possible future direction for this work. Multiple figures are included. A reference guide including a lexicon of VCM icons is provided separately.
- 3. ASHP National Survey of Pharmacy Practice in Hospital Settings: Prescribing and Transcribing—2007.**
Pedersen C.A., Schneider P.J., Scheckelhoff D.J.
Am J Health-Syst Pharm. 2008(May 1); 65(9):827–843.
This article reports results of the ASHP's national survey relating to medication prescribing and transcription in hospital pharmacy practice. Results, detailed in the article, showed marked increases in the use of medication reconciliation practices—likely in response to recently introduced accreditation standards—as well as continued growth in the adoption of computerized prescriber-order-entry and electronic communication systems. Numerous tables are included.
- 4. Barcoded Medication Administration: A Last Line of Defense.**
Cescon D.W., Etchells E.
JAMA. 2008(May 14); 299(18):2200–2202.
This commentary discusses the use of barcoded medication administration (BCMA) systems as a means of improving medication safety. The authors describe the components and function of BCMA technology and discuss potential benefits, as well as disadvantages and costs, of implementing such a system. The authors argue that the potential benefits of this technology remain largely unrealized; they call for further efforts to support the adoption and use of BCMA.

- 5. Doctors Say ‘I’m Sorry’ Before ‘See You in Court’.**
Sack K.
The New York Times. May 18, 2008.
Available at: <http://www.nytimes.com/2008/05/18/us/18apology.html>
This article discusses the experiences of several highly regarded academic medical centers that have adopted policies requiring prompt disclosure, apology, and an offer of financial compensation to the patient involved in the event of a medical error. Notwithstanding apprehensions about the legal and financial consequences of disclosure, the experiences of these institutions suggest that policies emphasizing transparency and appropriate compensation may result in reduced malpractice claims and associated costs.
- 6. Etiquette-Based Medicine.**
Kahn M.W.
N Engl J Med. 2008(May 8); 358(19):1988–1989.
The author argues that basic courtesy on the part of one’s physician—as much and perhaps even more than demonstration of qualities such as empathy and compassion—may powerfully influence patients’ satisfaction with their care. He recommends the creation of simple checklists, similar to clinical safety checklists, to promote the observance of good etiquette, and offers an example of an etiquette checklist for a physician-patient encounter in the hospital.
- 7. Fatal Care: Survive in the U.S. Health System.**
Kumar S.
Minneapolis, MN: IGI Press; 2008
This book by Sanjaya Kumar, MD, President and CMO of Quantros, Inc., relates the true stories of 11 patients who experienced serious, and in some cases, fatal, medical errors. As an educational tool for readers, each chapter includes a discussion of key factors and “fatal points”—instances of system or human error that led to harm— as well as pertinent practical tips on what healthcare consumers can do to improve the safety of their care. Helpful resources and materials for further reading are listed throughout the book.
- 8. How Do Hospitalized Patients Feel About Resident Work Hours, Fatigue, and Discontinuity of Care?**
Fletcher K.E., Wiest F.C., Halasyamani L.
J Gen Intern Med. 2008(May); 23(5):623–628.
This study examined hospital inpatients’ perceptions and anxieties concerning resident work hours, healthcare workers’ fatigue, and continuity of care, and the relationship of these perceptions to patients’ trust and satisfaction with their care. Results of a cross-sectional survey showed that a significant minority of respondents worried about the potential negative effects of healthcare personnel’s fatigue or discontinuity of care. In addition, a strong inverse association was observed between patients’ degree of concern about these issues and their ratings of trust and satisfaction with their care. Multiple tables are included.

9. Impact of Rapid Screening Tests on Acquisition of Methicillin Resistant *Staphylococcus aureus*: Cluster Randomized Crossover Trial.

Jeyaratnam D., Whitty C.J., Phillips K., et al.

BMJ. 2008(Apr 26); 336(7650):927–930.

This study investigated whether implementation of a rapid screening method for detection of methicillin-resistant Staphylococcus aureus (MRSA) would reduce nosocomial MRSA infection rates at a London teaching hospital. Patients admitted over a 14-month period were randomly assigned to receive either rapid polymerase chain reaction screening or culture screening for MRSA upon admission; standard infection control measures were applied for all patients. While rapid screening was associated with more appropriate use of isolation procedures, no significant difference in the incidence of MRSA acquisition was found between the intervention and control groups. One figure and multiple tables are included.

10. Minimizing Diagnostic Error: The Importance of Follow-up and Feedback.

Schiff G.D.

Am J Med. 2008(May); 121(Suppl 5A):S38–S42.

In this commentary, the author discusses the need for continual feedback and involvement of patients in the diagnostic process, identifies factors that may impede or complicate feedback, and calls for the creation of closed-loop systems that would systematically incorporate opportunities for follow-up and feedback from patients as part of the diagnostic process. Three tables are included. [See also item 11.]

11. Overconfidence as a Cause of Diagnostic Error in Medicine.

Berner E.S., Graber M.L.

Am J Med. 2008(May); 121(Suppl 5A):S2–S23.

This paper reviews current knowledge concerning the prevalence and consequences of diagnostic errors and examines the evidence regarding the role of physician overconfidence as a contributing factor in diagnostic error. The authors describe the various behavioral and cognitive components of overconfidence and how these tendencies may lead to an increased propensity for diagnostic error. Finally, they discuss individual and systems-based approaches to address the issue of overconfidence and to improve diagnostic accuracy, and offer suggestions for further research in this area. Two tables are included. [See also item 10.]

12. Patient Safety and Telephone Medicine.

Katz H.P., Kaltsounis D., Halloran L., Mondor M.
J Gen Intern Med. 2008(May); 23(5):517–522.

This descriptive study sought to gain insight regarding medical errors associated with telephone medicine in ambulatory care through analysis of closed claims from a major malpractice insurance provider. Researchers retrospectively analyzed all cases (a total of 32) from a ten-year period in which the alleged malpractice involved telephone-related error or mismanagement. Results showed that the most frequent types of error were poor or missing documentation, misjudgments in triage, and failures to follow up resulting from flawed office communication systems. The authors note as a limitation the small sample size in this study; further research is needed to confirm or qualify these results. Three cases studies are included in an appendix. Five tables are included.

13. Pennsylvania Patient Safety Authority 2007 Annual Report.

Harrisburg, PA: Patient Safety Authority; April 29, 2008.
Available at:

http://www.psa.state.pa.us/psa/lib/psa/annual_reports/annual_report_2007.pdf

This document gives an update on the activities of the Pennsylvania Patient Safety Authority, including development of a strategic plan, enactment of new legislation concerning prevention of healthcare-associated infections, and ongoing data collection and analysis. The report presents hospital safety data compiled from reports submitted during 2007 to the Pennsylvania Patient Safety Reporting System (PA-PSRS), the mandatory state reporting system administered by the Authority, along with brief explanations of the data and discussion of trends in reporting. Also included are condensed versions of selected Patient Safety Advisory articles from 2007.

14. Pharmacist- versus Physician-Obtained Medication Histories.

Reeder T.A., Mutnick A.

Am J Health-Syst Pharm. 2008(May 1); 65(9):857–860.

Incomplete or inaccurate medication histories may contribute significantly to medication errors in hospital patients. In this prospective study, medication histories elicited by a physician at admission were compared with medication histories subsequently obtained by a pharmacist for 55 patients admitted to the internal medical service of an academic medical center. Results identified a considerable number of discrepancies between physician- and pharmacist-obtained medication histories, most of which were resolved upon consultation between the pharmacist and physician during the intervention phase of the study. The authors discuss potential obstacles to obtaining accurate medication histories and offer suggestions for improving the process.

15. Recruitment of Hospitals for a Safety Climate Study: Facilitators and Barriers.

Rosen A.K., Gaba D.M., Meterko M., et al.
Jt Comm J Qual Pat Saf. 2008(May); 34(5):275–284.

To gain knowledge about the variables influencing hospitals' willingness to participate in research on patient safety culture, this study analyzed factors related to the recruitment of 30 Veterans Affairs (VA) hospitals enlisted for participation in a safety culture study. Results showed that hospitals with a strong "entrepreneurial" culture—i.e., those that espouse innovation and quality improvement—were more readily recruited. Better performance with respect to standardized patient safety indicators increased the likelihood of recruitment among VA hospitals; however, this effect was not observed among non-VA hospitals in a parallel study. The authors comment that these results underscore the need to ensure representative sampling when recruiting hospitals for participation in such studies. Multiple figures and tables are included.

16. Reevaluating the Safety Profile of Pediatrics: A Comparison of Computerized Adverse Drug Event Surveillance and Voluntary Reporting in the Pediatric Environment.

Ferranti J., Horvath M.M., Cozart H., Whitehurst J., Eckstrand J.
Pediatrics. 2008(May); 121(5):e1201–e1207.

Available at: <http://pediatrics.org/cgi/content/full/121/5/e1201>

This study compared the performance of two methods for capturing adverse drug events (ADEs) among pediatric inpatients at Duke University Hospital, which uses both computerized ADE surveillance and voluntary reporting systems to monitor ADEs. Researchers retrospectively analyzed all ADEs involving pediatric inpatients detected by the respective systems during a 1-year period. Results revealed strengths and weaknesses specific to each system, suggesting that use of the two systems together may provide the most effective method for detection of pediatric ADEs. Multiple tables are included.

17. Safety and Satisfaction: Where are the Connections?

Wolosin R.J.

Pat Saf Qual Healthcare. 2008(May/June); 5(3):28–36.

While the notion that patient safety and patient satisfaction are closely linked makes intuitive sense and seems to be supported by recent research findings, the precise relationship between safety and satisfaction is poorly understood. To gain insight into this connection, this study examined responses to Press Ganey surveys assessing patients' experience with their care (Inpatient Survey) and hospital personnel's perceptions concerning safety culture (Safety Culture Survey) from 44 facilities where both surveys were used. Statistical analysis revealed a number of correlations between items on the two surveys, suggesting that attitudes and practices associated with a safety culture and patients' perceptions concerning quality of care may be meaningfully linked. Three tables are included.

- 18. Safety & Technology Hand in Hand: Patient Safety Panel [podcast].**
Howard G., Witonsky P., Zink B., O'Donnell S.
Future Healthcare. 2008(Q2):132–140
Available at <http://www.futurehealthcareus.com/> [free registration required]
This podcast panel discussion focuses on recent developments in healthcare information technology, in particular, the increasing use of bedside point-of-care (BPOC) systems. Topics discussed include the safety benefits of BPOC and other health-IT applications, implementation challenges and solutions, trends in health IT adoption, and important considerations for purchasers.
- 19. The Wisdom and Justice of Not Paying for “Preventable Complications”.**
Pronovost P.J., Goeschel C.A., Wachter R.M.
JAMA. 2008(May 14); 299(18):2197–2199.
This commentary offers a critique of the impending CMS policy change, under which CMS will no longer reimburse hospitals for costs associated with the treatment of eight specified preventable adverse events. The authors argue that while the policy's application will likely be effective with respect to certain targeted complications, such as retention of objects after surgery, for other complications its success is much less certain. Many concerns remain as to how the occurrence of complications will be measured, how and whether “preventability” can be validly defined, and to what extent unintended consequences may offset the benefits of such a system.
- 20. Validation of Screening Questions for Limited Health Literacy in a Large VA Outpatient Population.**
Chew L.D., Griffin J.M., Partin M.R., et al.
J Gen Intern Med. 2008(May); 23(5):561–566.
This study assessed the validity of three screening questions to detect limited health literacy among ambulatory patients in the VA health system. Researchers conducted interviews with randomly selected patients at four VA medical centers in which patients were asked three health literacy screening questions and were administered two established health literacy assessments, the Short Test of Functional Health Literacy in Adults (S-TOFHLA) and the Rapid Estimate of Adult Literacy in Medicine (REALM). Based on correlation with the two validated screening tools, a single question—“How confident are you filling out medical forms by yourself?”—was found to be more effective than the other two, and as effective as any combination of the three questions, in identifying patients with poor health literacy. Three tables are included.

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