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- 1. Another Comparison Tool...with *Consumer Reports*' Online Hospital Rankings.**  
DerGurahian J.  
Mod Healthcare. 2008(Jun 2); 38(22):8-9.  
*This brief article highlights a new hospital ranking tool recently released by Consumer Reports. Based on data from the Dartmouth Atlas of Health Care, the tool does not assign evaluative ratings, but rather compares hospitals according to aggressiveness of treatment provided for patients with any of nine life-threatening chronic conditions. Hospitals within a state and region can be compared by ranking on a percentile-based scale from "conservative" to "aggressive," as well as by average cost of care. The free, web-based tool is available at ConsumerReportsHealth.org.*
- 2. Association of Numeracy and Diabetes Control.**  
Cavanaugh K., Huizinga M.M., Wallston K.A., et al.  
Ann Intern Med. 2008(May 20); 148(10):737-746.  
*Numeracy, or the ability to comprehend and apply information expressed numerically, plays an important role in patients' ability to understand and act upon health-related information. This study assessed the relationship between diabetes-related numeracy, diabetes self-management behaviors, and glycemic control in a sample of 398 ambulatory diabetes patients. Results showed that poor diabetes-related numeracy was common and was associated with lower perceived self-efficacy and less effective diabetes self-management; a weak association was found between numeracy and glycemic control. Several tables and figures are included.*
- 3. Becoming a High Reliability Organization: Operational Advice for Hospital Leaders.**  
Hines S., Luna K., Lofthus J., et al.  
Rockville, MD: Agency for Healthcare Research and Quality; February 2008. AHRQ Publication No. 08-0022.  
Available at: <http://www.ahrq.gov/qual/hroadvice/>  
*The High Reliability Organization (HRO) Learning Network was established in 2005 as an AHRQ-facilitated learning group consisting of hospital leaders dedicated to using high reliability principles to improve organizational performance in healthcare. This report synthesizes observations and insights gleaned from network members' experiences during the initiative. Numerous applications of high reliability theory in the hospital setting are described, along with practical advice on implementation. Site visit reports, case studies, and further information on the HRO Learning Network are provided in appendices (appendices available online only).*

**4. Charges and Lengths of Stay Attributable to Adverse Patient-Care Events Using Pediatric-Specific Quality Indicators: A Multicenter Study of Freestanding Children's Hospitals.**

Kronman M.P., Hall M., Slonim A.D., Shah S.S.

Pediatrics. 2008(Jun); 121(6):e1653–e1659.

Available at: <http://www.pediatrics.org/cgi/content/full/121/6/e1653>

*This study assessed the magnitude of excess charges and lengths of stay resulting from preventable adverse events among pediatric inpatients. Data from 38 tertiary care pediatric hospitals were analyzed using the Agency for Healthcare Research and Quality (AHRQ) pediatric-specific quality indicators (PDIs) and subsequent statistical analysis. Results showed that events detected by the PDIs were associated with significant excess costs and lengths of stay for many of the indicators examined. The authors note that this is the first study to use the PDIs to examine the impact of pediatric patient safety events on hospital resource use. Multiple tables are included. [For another study involving the PDIs, see item 11.]*

**5. Controversy and Quality Improvement: Lingerin Questions About Ethics, Oversight, and Patient Safety Research.**

Kass N., Pronovost P.J., Sugarman J., Goeschel C.A., Lubomski L.H., Faden R.

Jt Comm J Qual Pat Saf. 2008(Jun); 34(6):349–353.

*The recent intervention by the Office for Human Research Protections (OHRP) in a collaborative Johns Hopkins and Michigan Health & Hospital Association quality improvement project—in response to concerns about the project's compliance with regulatory requirements for human subjects research—engendered considerable discussion and debate. In this article, the authors review the Johns Hopkins-MHA project and discuss some of the ethical and regulatory issues brought to light by the recent controversy.*

**6. Correlates of Medication Error in Hospitals.**

Wilkins K., Shields M.

Ottawa, Ont.: Statistics Canada; May 2008. Catalogue no. 82-003-X Health Reports.

Available at: <http://www.statcan.ca/english/freepub/82-003-XIE/2008002/article/10565-en.pdf>

*This study examined the relationships between medication errors and variables relating to work environment in a national survey of hospital-based registered nurses in Canada. Analysis of survey responses from 18,676 nurses showed that medication errors were positively associated with a number of factors, including frequent overtime, excessive workload, and perceived lack of resources or support. Multiple tables and figures are included.*

**7. Design Thinking.**

Brown T.

Harvard Bus Rev. 2008(Jun); 86(6):84–92.

*This article by the CEO and president of IDEO, Tim Brown, describes the concept of design thinking—a human- and consumer-focused approach to design that emphasizes innovation, experimentation, and collaboration and in which an attunement to the needs, desires, and preferences of the customer or user informs each step in the creation of a product or service. Brown argues that the principles of design thinking have application in many fields, including healthcare: in an example discussed in the article, IDEO worked with Kaiser Permanente hospitals to develop innovative improvements, including a reconfiguration of the nursing shift-change process that measurably enhanced both patient care and nurses’ satisfaction.*

**8. Detection and Prevention of Medication Misadventures in General Practice.**

Tam K.W., Kwok K.H, Fan Y.M., et al.

Int J Qual Health Care. 2008(Jun); 20(3):192–199.

*This study sought to evaluate the efficacy of three methods for detecting adverse drug events (ADEs) and medication errors in the primary care setting, as well as to describe the incidence and nature of medication-related events. Researchers compared data on medication events collected concurrently by three methods—chart review, voluntary reporting, and patient survey—for a 2-month period at four primary care clinics. Results showed that each method had advantages and disadvantages, suggesting that the use of several methods in concert may provide the most comprehensive means of detecting medication events in this setting. Five tables and three appendices are included.*

**9. Development of a Patient Safety Climate Scale in Japan.**

Matsubara S., Hagihara A., Nobutomo K.

Int J Qual Health Care. 2008(Jun); 20(3):211–220.

*This study involved the development and validation of a patient safety climate survey instrument for use in Japan. Patient safety climate (or culture) surveys measure safety-related attitudes and perceptions among healthcare personnel as a reflection of an organization’s overall commitment to safety; while a number of such tools exist, a tool specific to the Japanese healthcare system had not yet been developed prior to this study. The resulting tool is a Japanese-language survey consisting of 33 items in 8 dimensions that showed sufficient validity and reproducibility for use at the workplace level. Four tables and two appendices are included.*

- 10. Educating Seniors to Be Patient Safety Self-Advocates in Primary Care.**  
Elder N.C., Regan S.L., Pallerla H., Levin L., Post D.M., Cegala D.J.  
J Patient Saf. 2008(Jun); 4(2):106–112.  
*This study involved the development and pilot testing of an intervention to teach elderly patients techniques for improving the safety of their care in the ambulatory care setting. The intervention consisted of group education followed by individual training sessions. Comparison of pre- and post-intervention scores on a validated survey showed significant improvement in safety-related attitudes and self-reported safety behaviors for most participants following the intervention. Strengths and limitations, implications for practice, and possible directions for further research are touched upon. One figure and several tables are included.*
- 11. Evaluation of the Agency for Healthcare Research and Quality Pediatric Quality Indicators.**  
Scanlon M.C., Harris J.M. II, Levy F., Sedman A.  
Pediatrics. 2008(Jun); 121(6):e1723–e1731.  
Available at: <http://pediatrics.org/cgi/content/full/121/6/e1723>  
*This study assessed the validity and utility of the recently developed AHRQ pediatric quality indicators (PDIs) as a means of detecting potentially preventable pediatric adverse events. PDI software was applied to national registry data representing over 1.75 million pediatric hospital discharges from 76 facilities over a 3-year period. Cases identified by the software as involving a PDI event then underwent chart review to evaluate correctness of the secondary diagnosis, whether the event was preventable, and whether it was present on admission. Results suggested that while the PDIs in their present form offer a screening tool that may assist hospitals with internal review and improvement initiatives, further refinement is needed to make them appropriate for use in inter-hospital comparison or public reporting. Two tables are included. [For another study involving the PDIs, see item 4.]*
- 12. Functional Health Literacy and Understanding of Medications at Discharge.**  
Maniaci M.J., Heckman M.G., Dawson N.L.  
Mayo Clin Proc. 2008(May); 83(5):554–558.  
*This study assessed health literacy with respect to newly prescribed medications among patients recently discharged from the hospital. A post-discharge telephone survey of 100 patients who had been prescribed at least one new medication at discharge showed that many had poor understanding of their medications: a significant number could not state the number, name, dosage, dosing schedule, or purpose of their medications, and only one-fifth could name an adverse effect associated with their medication. Implications of these results and suggestions for improving communication of drug information to patients are discussed. One figure and several tables are included.*

- 13. Health Literacy, Cognitive Abilities, and Mortality Among Elderly Persons.**  
Baker D.W., Wolf M.S., Feinglass J., Thompson J.A.  
J Gen Intern Med. 2008(Jun); 23(6):723–726.  
*This study examined the respective and combined influence of health literacy and cognitive ability on mortality among elderly adults. Previous research by the authors had shown an association between poor health literacy and increased mortality, but the potential moderating role of cognitive ability in this relationship remained uncertain. Results of a prospective cohort analysis involving 3,260 adults age 65 and older showed that both health literacy and cognitive ability independently predicted mortality in the study sample. Given this result, the authors note, it is important to address both patients' health literacy needs and potential cognitive constraints in efforts to improve health-related communication. One figure and two tables are included.*
- 14. Hospitals Move to Reduce Risk of Night Shift.**  
Landro L.  
Wall Street Journal. May 28, 2008:D1.  
*Mounting evidence suggests that medical errors and complications occur disproportionately during hospitals' off hours. To address these issues, a growing number of hospitals are staffing physicians known as nocturnists—hospitalists who work only during night hours—to ameliorate nighttime and weekend staffing shortages that are likely the source of the problem. This article discusses the trend and its safety and cost implications, as well as other measures that hospitals are taking to bolster safety during night shifts and weekends.*
- 15. One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations.**  
Wilson-Stronks A., Lee K.K., Cordero C.L., Kopp A.L., Galvez E.  
Oakbrook Terrace, IL: The Joint Commission; 2008.  
Available at:  
[http://www.jointcommission.org/PatientSafety/HLC/one\\_size\\_meeting\\_need\\_of\\_diverse\\_populations.htm](http://www.jointcommission.org/PatientSafety/HLC/one_size_meeting_need_of_diverse_populations.htm)  
*This document emerges from the Hospitals, Language, and Culture (HLC) study, which polled 60 healthcare facilities across the U.S. to identify useful, potentially transferable practices that hospitals have adopted to address the needs of culturally and linguistically heterogeneous patient populations. The report synthesizes findings of the HLC study and presents a framework for the development and implementation of practices that may aid in the provision of culturally and linguistically appropriate care. The framework is organized around four major themes, each of which forms a chapter in the report: building a foundation; collecting and using data to improve services; accommodating the needs of specific populations; and establishing internal and external collaborations. A hospital self-assessment tool keyed to the four themes is included.*

- 16. Perianesthesia Nursing Advocacy: An Influential Voice for Patient Safety.**  
Windle P.E., Mamaril M., Fossum S.  
J Perianesth Nurs. 2008(Jun); 23(3):163–171.  
*This article discusses the critical role of perianesthesia nurses as champions of patient safety. Aspects of this role include advocating on the patient’s behalf during treatment; understanding and voicing concerns about work environment factors that affect safety—in particular nurse staffing issues and fatigue; and engaging in both local efforts and global initiatives to promote patients’ and healthcare workers’ safety. The American Society of PeriAnesthesia Nurses (ASpan) Fatigue Evaluation Checklist is included as an appendix.*
- 17. Placing Patient Safety First.**  
Beyea S.C.  
AORN Journal. 2008(Apr); 87(4):829–831.  
*Time pressure and the exigencies of the clinical environment can sometimes threaten to preempt important safety practices. In this column, Beyea offers examples and suggestions of what nurses can do to ensure that patient safety remains the top priority in the perioperative setting. This article continues a “Patient Safety First” series focusing on patient safety goals for perioperative nurses.*
- 18. Relationship of Preventive Health Practices and Health Literacy: A National Study.**  
White S., Chen J., Atchison R.  
Am J Health Behav. 2008(May/Jun); 32(3):227–242.  
*Previous research has suggested that health literacy may predict preventive health behavior among certain demographics. This study sought to extend existing knowledge by examining the relationship between health literacy and the tendency to use preventive health services (checkups, screenings, and vaccinations) among a representative sample of U.S. adults. Selected data from the 2003 National Assessment of Adult Literacy (NAAL) for 18,100 adults were analyzed using probit regression models. Results showed an association between health literacy and preventive health behavior among adults 65 and older; health literacy was not associated with most preventive health behaviors among younger adults. One figure and multiple tables are included.*
- 19. Stop Orders to Reduce Inappropriate Urinary Catheterization in Hospitalized Patients: A Randomized Controlled Trial.**  
Loeb M., Hunt D., O’Halloran K., Carusone S.C., Dafoe N., Walter S.D.  
J Gen Intern Med. 2008(Jun); 23(6):816–820.  
*This study investigated whether the implementation of stop orders would reduce rates of unnecessary catheterization and urinary tract infection among hospitalized patients at three tertiary care hospitals in Ontario, Canada. A total of 692 patients with indwelling urinary catheters were randomly assigned to receive either a stop order or standard care. The stop orders required evaluation of the need for catheterization and removal of the catheter as soon as it was no longer indicated. Results showed a significant reduction in inappropriate catheterization in the group receiving stop orders as compared with the control group; however, no significant difference in the incidence of urinary tract infection was found between the two groups. One figure and one table are included.*

**20. Third Annual Nursing Leadership Congress “Designing Frameworks for Patient Safety” Conference Proceedings.**

Pinakiewicz D., Smetzer J., Thompson P., Steinbach P., Navarra-Sirio M.B., Lambert M. *J Patient Saf.* 2008(Jun); 4(2):54–60.

*This article presents proceedings from the third annual Nursing Leadership Congress, held in September 2007. This conference focused on the development of organizational infrastructures to support patient safety and the role of nurse leaders in this process. Plenary sessions were presented by executives from Ascension Health, Virginia Mason Medical Center, North Shore-Long Island Jewish Health System, Northwest Community Healthcare, and the Katalyst Consultancy. Roundtable topics included the role of patients and family members; external partnerships; physical design and workflow to support patient safety; measurement of safety; leadership competencies for effecting change; and strategic planning and organizational structure. A brief recommended reading section lists suggested resources for each roundtable topic.*

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Anita Spielman, Editor

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