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- 1. Actively Participating in an Organization’s Safety Initiatives.**  
Beyea SC.  
AORN Journal. 2008(May); 87(5):1011–1013.  
*In this column, Beyea discusses how nurses can enhance patient safety by understanding and engaging in safety and quality improvement initiatives adopted by their organizations. This article is the fifth in a “Patient Safety First” series focusing on patient safety goals for perioperative nurses.*
- 2. Attitudes toward the Large-Scale Implementation of an Incident Reporting System.**  
Braithwaite J, Westbrook M, Travaglia J.  
Int J Qual Health Care. 2008(Jun); 20(3):184–191.  
*An electronic incident reporting system, known as Incident Information Management System (IIMS), was deployed in healthcare facilities throughout New South Wales, Australia, in 2004–2005. This study assessed attitudes toward and utilization of the system among members of various health professions. Results of a survey of 2185 healthcare professionals showed that respondents overall were positively inclined to using the system. However, experiences and attitudes concerning the system varied significantly by professional group: nurses were significantly more likely than physicians to have undergone system training, to have reported incidents using the system, and to rate the system favorably. Multiple tables are included.*
- 3. Care at Discharge—A Critical Juncture for Transition to Posthospital Care.**  
Pennsylvania Patient Safety Authority.  
Pa Pat Saf Advis. 2008(Jun); 5(2):39–43.  
Available at:  
[http://www.psa.state.pa.us/psa/lib/psa/advisories/v5n2june\\_2008/jun\\_2008\\_v5\\_n2\\_article\\_discharge.pdf](http://www.psa.state.pa.us/psa/lib/psa/advisories/v5n2june_2008/jun_2008_v5_n2_article_discharge.pdf)  
*This article, occasioned by reports submitted to the Pennsylvania Patient Safety Reporting System, discusses errors and lapses in care associated with the hospital discharge process and the importance of thorough and timely discharge planning as a means of forestalling these problems. The authors outline the fundamental elements of the discharge process, discuss challenges to effective discharge management, and offer a list of strategies to improve the safety of these complex and error-prone transitions.*
- 4. Electromagnetic Interference from Radio Frequency Identification Inducing Potentially Hazardous Incidents in Critical Care Medical Equipment.**  
Van der Togt R, Van Lieshout EJ, Hensbroek R, Beinat E, Binnekade JM, Bakker PJM.  
JAMA. 2008(Jun 25); 299(24):2884–2890.  
*While radio frequency identification (RFID) applications in healthcare have been touted as a boon to patient safety, the risks associated with potential inference between RFID and other medical devices have been little examined. In this study, two RFID systems were tested in a controlled nonclinical setting to ascertain the impact of electromagnetic interference (EMI) from RFID on 41 medical devices. Results showed that EMI “incidents” occurred in 34 out of 123 tests; 22 incidents were considered hazardous. Implications and recommendations to ensure the safe use of RFID technology in practice are discussed. Three figures and one table are included.*

5. **Electronic Narcotic Prescription Writer: Use in Medical Error Reduction.**  
Zimmer KP, Miller MR, Lee BH, Yaster M, Miller RE, Lehmann CU.  
J Patient Saf. 2008(Jun); 4(2):98–105.  
*This study evaluated the efficacy of use of a Web-based narcotic prescribing application as a means of reducing medication errors. Researchers retrospectively analyzed prescriptions generated by the tool for a 10-month period following its implementation at a tertiary care pediatric hospital. Results suggested that use of the tool led to beneficial changes in prescribers' behavior and a significant reduction in inappropriate prescriptions. Multiple figures and tables are included.*
6. **Exploring Organizational Context and Structure as Predictors of Medication Errors and Patient Falls.**  
Mark BA, Hughes LC, Belyea M, Bacon CT, Chang YK, Jones CA.  
J Patient Saf. 2008(Jun); 4(2):66–77.  
*This study examined the relationships among various hospital and patient characteristics, safety climate, and the incidence of medication errors and patient falls in the acute care setting. A model drawn from structural contingency theory was applied to data from 278 medical-surgical units at 143 hospitals for a 1-year period. Results, detailed in the article, showed a number of associations among factors relating to organizational structure and context, safety climate, patient characteristics, and rates of medication errors and falls. One figure and two tables are included.*
7. **Health Literacy in Pharmacy.**  
Tkacz VL, Metzger A, Pruchnicki MC.  
Am J Health-Syst Pharm. 2008(May 15); 65:974–981.  
*As patients increasingly depend upon pharmacists as a source of health and medication-related information, it is of critical importance that pharmacists understand the issue of poor health literacy and its implications for pharmacy practice. This commentary provides an overview of the issue, describes several health literacy screening tools, and offers health literacy assessment and intervention techniques specific to the pharmacy setting. Two tables, two figures, and two appendices are included.*
8. **Impact of Patient Communication Problems on the Risk of Preventable Adverse Events in Acute Care Settings.**  
Bartlett G, Blais R, Tamblyn R, Clermont RJ, MacGibbon B.  
CMAJ. 2008(June 3); 178(12):1555–1562.  
*This study examined the relationship between patient communication problems and the risk of adverse events among inpatients at 20 hospitals in Quebec, Canada. Communication problems included various patient characteristics—physical disabilities, psychiatric conditions, and psychosocial circumstances—that might impede communication between the patient and providers. Analysis of data representing 2355 patients over a 1-year period showed that communication problems were associated with a significantly increased risk of preventable adverse events among the study sample. Several figures and tables are included.*

- 9. Impact of Patient Safety Mandates on Medical Education in the United States.**  
Kane JM, Brannen M, Kern E.  
J Patient Saf. 2008(Jun); 4(2):93–97.  
*Among the recommendations set forth in the Institute of Medicine report To Err is Human was a call for greater focus on patient safety in the training and education of medical professionals. This study assessed whether patient safety-related content in medical education in the United States has increased in the years since the publication of this report. Selected widely used medical textbooks were reviewed, and U.S. undergraduate and graduate medical school curricula were screened to identify patient safety content. Results suggested that while the attention given to patient safety in medical education materials and curricula has increased, these changes do not yet represent a shift in focus commensurate with the IOM report’s recommendations. Three figures are included.*
- 10. Improving Heparin Safety: A Multidisciplinary Invited Conference.**  
Peterson C, Ham CW, Vanderveen T.  
Hosp Pharm. 2008(Jun); 43(6):491–497.  
*This article summarizes proceedings from a recent conference sponsored by Cardinal Health that focused on understanding and addressing heparin-related safety issues. Topics covered include the epidemiology of heparin-associated errors; sources of error in the prescribing and administration processes; clinical and therapeutic considerations; and technological and human factors approaches to improving safety. One table and one figure are included.*
- 11. Incidence, Severity and Preventability of Medication-Related Visits to the Emergency Department: A Prospective Study.**  
Zed PJ, Abu-Laban RB, Balen RM, et al.  
CMAJ. 2008(June 3); 178(12):1563–1569.  
*This observational study sought to describe the frequency, nature, and preventability of adverse drug events leading to emergency department visits at a tertiary-care teaching hospital in Vancouver, BC. Prospective analysis of 1,017 patients over a 3-month period showed that 12% of emergency department visits were attributable to medication-related adverse events, a majority of which were deemed preventable. The authors note that the observed incidence of drug-related ED visits in this study is higher than has been reported in previous findings; possible reasons for this result, as well as directions for future research, are discussed. One figure and three tables are included.*

- 12. Information Environments for Supporting Consistent Registrar Medical Handover.**  
Alem L, Joseph M, Kethers S, Steele C, Wilkinson R.  
Health Info Manage J. 2008; 37(1):9–24.  
*This two-part study examined processes and patterns relating to the transmission of information among providers during patient handoffs at an urban tertiary-care hospital in Australia. Weekend handoff procedures were observed before and after the implementation of three information tools designed to facilitate more complete and uniform transmission of patient information. Results showed that while implementation of the tools resulted in increased consistency with respect to which patients were discussed during handoffs, some aspects of the process remained “fragmentary.” One figure and multiple tables are included; the three handoff forms used in the study are included as appendices.*
- 13. Leadership, Civility, and the ‘No Jerks’ Rule.**  
Kerfoot KM.  
Urol Nurs. 2008(Apr); 28(2):149–150.  
*Rude, disruptive, or otherwise inappropriate behavior in the workplace is unfortunately a common occurrence. In this article, Kerfoot comments on incivility and its destructive impact in the clinical environment. She underscores the importance of establishing an unequivocal “no jerks” policy, and offers strategies for coping when interaction with antagonistic individuals cannot be avoided.*
- 14. Meeting the Health Literacy Needs of Immigrant Populations.**  
Kreps GL, Sparks L.  
Patient Educ Couns. 2008(Jun); 71(3):328–332.  
*Limited health literacy and cultural barriers may compound the health disparities that afflict certain immigrant populations. This article reviews the literature concerning this issue and discusses strategies and techniques for improving healthcare-related communication with members of marginalized patient populations.*
- 15. N.Y. Medicaid Ups the Ante.**  
DerGurahian J.  
Mod Healthcare. 2008(Jun 16); 38(24):6–7.  
*This article comments on the recently announced change to New York State Medicaid policy under which N.Y. Medicaid will no longer reimburse hospitals for costs associated with 14 preventable medical errors. This change follows similar recent actions by Medicare and several other insurers and hospital associations and may herald an acceleration of this trend. Similarities and differences among the respective lists of non-reimbursable events and implementation methods are discussed. Of note, whereas the lists adopted by New York and other states focus on “never events” or occurrences almost universally regarded as avoidable errors, the Medicare list focuses on hospital-acquired conditions that some critics of the policy feel should not be construed as preventable.*

- 16. Non-Referral of Unnatural Deaths to Coroners and Non-Reporting of Unnatural Deaths on Death Certificates in Taiwan: Implications of Using Mortality Data to Monitor Quality and Safety in Healthcare.**  
Lu T-H, Shaw K-P, Hsu P-Y, Chen L-H, Huang S-M.  
Int J Qual Health Care. 2008(Jun); 20(3):200–205.  
*This study sought to estimate the frequency with which deaths due to unnatural causes were reported on death certificates and referred to coroners during a 2-year period in Taiwan. Analysis of nationally collected hospital discharge data in conjunction with cause of death information from death certificates indicated that 71% of unnatural deaths had been reported as such on death certificates, and 57% had been referred to a coroner, with considerable variation depending on type of injury and external cause. Referral and reporting rates were lowest for deaths attributed to medical or surgical complications. On the basis of these results, the authors suggest that the joint use of mortality data and hospital administrative data may be more effective than mortality data alone as a means of assessing healthcare quality and safety. Three tables are included.*
- 17. Optimizing Patient Safety by Preventing Combined Use of Intramuscular Olanzapine and Parenteral Benzodiazepines.**  
Naso AR  
Am J Health-Syst Pharm. 2008(Jun 15); 65:1180–1183.  
*The combined use of the injectable antipsychotic agents olanzapine and benzodiazepine has been linked to severe and fatal adverse events. This case study provides background on the issue and describes how a community hospital implemented policy and procedural changes to reduce the risks associated with these drugs.*
- 18. Patient Handoffs: The Pitfalls and Solutions of Transferring Patients Safely from One Caregiver to Another.**  
Runy LA.  
Hospitals & Health Networks. 2008(May); 82(5):after page 40 (foldout section).  
*This foldout section looks at patient handoffs and outlines tools and strategies to improve safety during these risk-prone transitions of care. A handoff communication model developed by the U.S. Department of Defense Patient Safety Program is included, as well as brief case studies from three hospitals that have implemented initiatives to improve the handoff process.*
- 19. Playing It Safe: Simulated Team Training in the OR.**  
Anderson M, Leflore J.  
AORN Journal. 2008(Apr); 87(4):772–779.  
*Teamwork and effective communication among members of clinical teams are recognized as critical factors in the prevention of medical errors. This article discusses the importance of teamwork in the OR environment, describes the use of simulation-based training to improve team performance, and offers guidelines for developing a simulation scenario. Several figures are included.*

**20. Sterile Water Should Not be Given “Freely”.**

Pennsylvania Patient Safety Authority.

Pa Pat Saf Advis. 2008(Jun); 5(2):53–56

Available at:

[http://www.psa.state.pa.us/psa/lib/psa/advisories/v5n2june\\_2008/jun\\_2008\\_v5\\_n2\\_article\\_sterilewater.pdf](http://www.psa.state.pa.us/psa/lib/psa/advisories/v5n2june_2008/jun_2008_v5_n2_article_sterilewater.pdf)

*This article discusses safety events involving the intravenous administration of sterile water—a potentially fatal error. The authors describe several instances of this type of error as reported to the Pennsylvania Patient Safety Reporting System and other reporting agencies. They discuss prescribing, packaging, and storage practices that may contribute to error, and outline risk reduction strategies. Three figures are included.*

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