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- 1. A New Model for Hospital Design Rises in an Ohio Cornfield.**
Edwards R.
Hospitals and Health Networks. 2008(Jul); 82(7):52–58.
This article profiles Dublin Methodist hospital, a facility recently opened by OhioHealth in Columbus, Ohio. Built according to the principles of evidence-based design, the hospital incorporates numerous architectural and design features intended to enhance patients' wellbeing and to improve the safety and efficiency of care. OhioHealth administrators hail the hospital as a model for the future of healthcare; detractors, however, have questioned the rationale for the hospital's construction, criticizing the project as being excessive.
- 2. Alternative Dispute Resolution in Healthcare: A Prescription for Increasing Disclosure and Improving Patient Safety.**
Balcerzak GA, Leonhardt KK.
Pat Saf Qual Healthcare. 2008(Jul/Aug); 5(4):44–48.
Alternative dispute resolution (ADR), a procedure that encompasses a variety of non-judicial conflict resolution methods, is increasingly being used in healthcare as an alternative to malpractice litigation. This article discusses several different ADR models and comments on the potential advantages and disadvantages of ADR with respect to patient safety, patient-provider communication, and hospital finances.
- 3. Are Patients Happier at Most Wired Hospitals?**
Solovy A, Hoppszallern S, Brown SB.
Hospitals and Health Networks. 2008(Jul); 82(7):30–45.
This article presents results of the tenth annual Most Wired Survey and Benchmarking Study, which found that US hospitals that scored higher on a variety of measures of IT use also had higher patient satisfaction ratings and better quality outcomes than did "less wired" facilities. Key findings and implications are discussed. Lists of the 100 Most Wired and other honorees are included in a pullout section.
- 4. Breaking Barriers: Hospitals Work to Make Sure Cultural Issues Don't Hinder Quality of Care.**
DerGurahian J.
Mod Healthcare. 2008(Jul 7); 38(27):28–30.
To accommodate the needs of the nearly 100,000 foreign patients annually who travel to the US for medical treatment—a relatively small but financially significant group—hospitals treating these patients have worked to surmount a variety of culture- and language-related barriers to the provision of effective care. With many hospitals caring for increasingly diverse populations of domestic patients, these examples provide valuable lessons on the importance of cultural sensitivity in the healthcare context.

- 5. Clostridium Difficile-Associated Disease in U.S. Hospitals, 1993–2005.**
Elixhauser A, Jhung M.
Healthcare Cost and Utilization Project. Statistical Brief #50. Rockville, MD: Agency for Healthcare Research and Quality; April 2008.
Available at: <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb50.pdf>
This Statistical Brief presents data from the Healthcare Cost and Utilization Project concerning the incidence and effects of clostridium difficile-associated disease (CDAD) among US hospital patients between 1993 and 2005. This analysis found that the incidence of CDAD in hospital patients more than doubled between 2001 and 2005. Elderly patients were disproportionately affected by CDAD; and patients with CDAD overall were hospitalized longer and had worse outcomes than did non-CDAD patients.
- 6. Comparing Patient-Reported Hospital Adverse Events with Medical Record Review: Do Patients Know Something That Hospitals Do Not?**
Weissman JS, Schneider EC, Weingart SN, et al.
Ann Intern Med. 2008(Jul 15); 149(2):100–108.
This study investigated whether post-discharge interviews could identify adverse events in care not detected by medical record review. Comparison of patient-reported events with events captured through chart review for a sample of 998 patients showed that patients reported a number of significant events that were not documented in the medical record. One figure and four tables are included.
- 7. Cost of Hospital-wide Activities to Improve Patient Safety and Infection Control: A Multi-Centre Study in Japan.**
Fukuda H, Imanaka Y, Hayashida K.
Health Policy. 2008(Jul); 87(1):100–111.
This study sought to estimate the overall costs associated with patient safety and infection control activities at seven teaching hospitals in Japan. An incremental analysis method was applied to data from questionnaires and structured interviews to assess relevant costs for the period between 1999 and 2004. Results showed that total estimated costs per hospital ranged from \$1.1 to 2.5 million per year. Details of these findings and the economic and policy implications are discussed. Five tables are included.
- 8. Effect of Dissemination of Evidence in Reducing Injuries from Falls.**
Tinetti ME, Baker DI, King M, et al.
N Engl J Med. 2008(Jul 17); 359(3):252–261.
This study investigated the impact of exposure to practice-change interventions on rates of fall-related patient injuries at a regional level. Researchers compared rates of fall-related injury in elderly patients in two similar, geographically discrete regions in Connecticut: one region (intervention region) had been exposed to an extensive campaign to increase awareness and encourage adoption of fall-prevention strategies; the other (usual-care region) had not. Results showed that rates of fall-related injury and fall-related use of medical services were lower in the intervention region than in the usual-care region during the period examined. Three figures and two tables are included.

- 9. Electronic Health Records in Ambulatory Care — A National Survey of Physicians.**
DesRoches CM, Campbell EG, Rao SR, et al.
N Engl J Med. 2008(Jul 3); 359(1):50–60.
This study examined US physicians' adoption of electronic health records and factors influencing adoption in the ambulatory care setting. Results of a national survey of physicians showed that among 2,758 respondents, 13% reported having a basic system and only 4% reported having an advanced system with features such as clinical decision support. Respondents with electronic-records systems overall perceived these systems as having a beneficial impact on quality of care, and a large majority reported high levels of satisfaction with their systems. Those without electronic-records systems most frequently cited costs as a barrier to adoption. One figure and five tables are included.
- 10. Evidence for the Impact of Quality Improvement Collaboratives: Systematic Review.**
Schouten LMT, Hulscher MEJL, Van Everdingen JJE, Huijsman R, Grol RPTM.
BMJ. 2008(Jun 28); 336(7659):1491–1494.
This study examined current evidence concerning the effects of healthcare quality improvement collaboratives on quality of care. Results of a systematic review of 72 published studies showed positive but limited evidence of the collaboratives' efficacy; the authors feel that further research is needed to better evaluate the impact and cost-effectiveness of quality improvement collaboratives as a means of fostering healthcare improvement. Multiple figures and tables are included.
- 11. Hospital Mortality: When Failure Is Not a Good Measure of Success.**
Shojania KG, Forster AJ.
CMAJ. 2008(Jul 15); 179(2):153–157.
The hospital standardized mortality ratio (HSMR), a measure that compares observed hospital mortality rates with expected rates calculated from national averages, has been promoted as a valuable tool for measuring patient safety and hospital performance. In this commentary, the authors describe the limitations of the HSMR as a means of assessing hospital quality and discuss what would be needed to develop a more accurate measurement of performance. One table and one figure are included.
- 12. Hospital Pulse Report: Patient Perspectives on American Health Care.**
South Bend, IN: Press Ganey Associates, Inc.; 2008.
Available at:
http://www.pressganey.com/galleries/default-file/2008_Hospital_Pulse_Report.pdf
This annual report assesses patient satisfaction with inpatient hospital care across the US. The 2008 edition highlights findings of the latest analysis (representing data for the 2007 calendar year). Results showed that patient satisfaction overall once again increased, continuing the previous four years' upward trend; however, satisfaction varied according to a number of factors, including hospital size, patient age, and type of admission. As in previous years, hospital responsiveness to patient concerns emerged as a crucial determinant of patient satisfaction. Also included is an analysis relating the Press Ganey results to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey items.

- 13. Keeping Nurses Safe.**
Beyea SC.
AORN Journal. 2008(Jun); 87(6):1237–1239.
This article, the sixth and final installment in a series about patient safety goals for perioperative nurses, discusses the Institute of Medicine publication Keeping Patients Safe: Transforming the Work Environment of Nurses. Beyea recommends that all nurses familiarize themselves with this book as a means to better understand how the healthcare workplace environment and culture may affect the safety of providers as well as patients.
- 14. Mix of Methods Is Needed to Identify Adverse Events in General Practice: A Prospective Observational Study.**
Wetzels R, Wolters R, Van Weel C, Wensing M.
BMC Fam Pract. 2008(Jun 15); 9:35.
Available at: <http://biomedcentral.com/1471-2296/9/35>
This study compared five methods for the detection of adverse events among patients of five general practice physicians at two practices in Nijmegen, the Netherlands. The methods examined included reporting of events by physicians, by pharmacists, and by patients, review of randomly selected medical records, and review of all records for deceased patients. Results showed that each method identified a number of events with no overlap between methods, suggesting that the use of several methods in combination may be necessary to ensure comprehensive detection of adverse events. Two tables are included.
- 15. Patient Safety in an English Pre-registration Nursing Curriculum.**
Attree M, Cooke H, Wakefield A.
Nurs Educ Pract. 2008(Jul); 8(4):239–248.
This case study used content analysis and focus group interviews to examine how patient safety was addressed in an English undergraduate nursing curriculum. Findings indicated that patient safety principles were recognized as implicit in aspects of the teaching, but that patient safety as such was not included in the formal curriculum or assessment procedure. Suggestions for increasing the prominence of patient safety in healthcare curricula are discussed. Multiple tables are included.
- 16. Pharmacologically Inappropriate Prescriptions for Elderly Patients in General Practice: How Common?**
Brekke M, Rognstad S, Straand J, et al.
Scand J Prim Health Care. 2008(Jun); 26(2):80–85.
This study sought to determine the frequency and nature of inappropriate prescriptions for elderly patients among general practitioners in Norway. Analysis of prescription data for a one-year period for a group of 454 participating physicians showed that 18.4% of patients 70 years and older were prescribed drugs or combinations of drugs considered inappropriate. The authors comment on these results with respect to previous related studies and implications for practice. Five tables are included.

17. Routine Care of Peripheral Intravenous Catheters versus Clinically Indicated Replacement: Randomised Controlled Trial.

Webster J, Clarke S, Paterson D, et al.

BMJ. 2008; 337:a339 [(Jul 19); 337(7662):157–160].

This study investigated whether clinically indicated replacement of intravenous peripheral catheters would reduce the incidence of phlebitis and infiltration (common catheter-related complications) as compared with routine catheter replacement, in which catheters are replaced according to a fixed schedule. A total of 755 patients at an Australian tertiary care hospital who had peripheral intravenous catheters for a period of sufficient duration were randomized to receive either routine replacement (control group) or replacement only when clinically indicated (intervention group). Results showed no significant difference in outcomes between the intervention and control groups; the authors suggest that larger studies focusing on phlebitis as the sole outcome may shed further light on this question. Three tables and one figure are included.

18. Unit-based Clinical Pharmacists' Prevention of Serious Medication Errors in Pediatric Inpatients.

Kaushal R, Bates DW, Abramson EL, Soukup JR, Goldmann DA.

Am J Health-Syst Pharm. 2008(Jul 1); 65:1254–1260.

This study investigated the impact of the introduction of unit-based clinical pharmacists on the incidence of serious inpatient medication errors at an urban pediatric teaching hospital. Unit-based clinical pharmacists were introduced on three units: in the ICU on a full-time basis and in the general medical and general surgical units on a part-time basis. Results showed that the addition of a full-time unit-based clinical pharmacist in the ICU was associated with a sizable reduction in serious medication errors; however, the involvement of part-time pharmacists on the general medical and surgical units was not associated with reductions in errors. Two tables are included.

19. Using Principles of Health Literacy to Enhance the Informed Consent Process.

Lorenzen B, Melby CE, Earles B.

AORN Journal. 2008(Jul); 88(1):23–29.

Typical healthcare consent processes do little to ensure that patients actually understand the terms to which they are agreeing, jeopardizing the possibility of true informed consent. This article describes how Iowa Health System redesigned its surgical consent forms and procedures to address health literacy needs and improve patient understanding of the consent process. The new forms use straightforward language and reader-friendly layout and include a space in which the provider records the patient's description of the procedure in the patient's own words, encouraging use of the "teach-back" technique. Several tables and figures are included.

20. Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008.

The Commonwealth Fund Commission on a High Performance Health System.
New York, NY: The Commonwealth Fund; July 2008.

Available at:

http://www.commonwealthfund.org/usr_doc/Why_Not_the_Best_national_scorecard_2008.pdf?section=4039

First published in 2006, the National Scorecard assesses U.S. health system performance as measured by 37 indicators in five dimensions: healthy lives, quality, access, efficiency, and equity. In the first update since the 2006 publication, the 2008 scorecard presents current data and trends for each dimension and each indicator, along with discussion of key findings and their implications. Findings showed that access to care has worsened and that overall healthcare system performance has not improved since the previous assessment, indicating that despite increased healthcare spending the U.S. healthcare system as a whole continues to underachieve.

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