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- 1. Agreement Between Patient-Reported Symptoms and Their Documentation in the Medical Record.**
Pakhomov SV, Jacobsen SJ, Chute CG, Roger VL.
Am J Manag Care. 2008(Aug); 14(8):530–539.
This study sought to determine whether documentation of symptoms in the electronic medical record (EMR) accurately reflected the information reported on patient-provided information forms for patients at the Mayo Clinic, Rochester, MN. Patient-reported symptoms were compared with corresponding information extracted by natural language processing from the text of the patient’s EMR for 1,119 patients during a 6-month period. Results showed significant disagreement between patient-reported symptoms and the symptoms documented in the EMR for each of the symptoms examined. The authors discuss the implications of this discrepancy for research that uses EMR data as a source of patient information, as well as its potential impact on safety and quality of care. Multiple tables and figures are included.
- 2. Annoyances, Disruptions, and Interruptions in Surgery: The Disruptions in Surgery Index (DiSI).**
Sevdalis N, Forrest D, Undre S, Darzi A, Vincent C.
World J Surg. 2008(Aug); 32(8):1643–1650.
This article describes the development and preliminary testing of the Disruptions in Surgery Index (DiSI), a survey tool that elicits operating room personnel’s perceptions concerning various types of disruptions encountered during surgery. For each type of disruption listed in the survey, respondents rate for themselves and for other OR staff how frequently the disruption occurs, its conduciveness to error, and its interference with surgical goals. Analysis of responses from a total of 62 operating room staff (16 surgeons, 26 nurses, and 20 anesthetists/anesthetist assistants) who completed the questionnaire showed significant differences in perceived disruptions among the professional groups; respondents also tended to perceive certain types of disruptions as affecting others more frequently and to a greater extent than themselves. Three tables and an appendix are included.
- 3. Avoiding Underdiagnosis, Overdiagnosis, and Misdiagnosis of Lung Carcinoma.**
Butnor KJ.
Arch Pathol Lab Med. 2008(Jul); 132(7):1118–1132.
Incorrect interpretation of histopathological data is frequently implicated in the underdiagnosis, overdiagnosis, or misdiagnosis of lung cancer. This article presents examples of commonly misidentified lung neoplasms and offers strategies for avoiding this type of diagnostic error. Multiple figures are included.

- 4. Cultural Competence in the Era of Evidence-Based Practice.**
Engebretson J, Mahoney J, Carlson ED.
J Prof Nurs. 2008(May–Jun); 24(3):172–178.
While healthcare regulators and professional bodies have urged providers to embrace culturally competent practices, there have been a number of conceptual barriers to the implementation of these practices in the clinical setting. This article attempts to elucidate the meaning of cultural competence by explaining its relationship to fundamental precepts and values in healthcare; the authors discuss the challenges of implementing culturally competent care and present an integrative model that relates cultural competency to evidence-based practice. One figure is included.
- 5. Four Country Healthcare Associated Infection Prevalence Survey 2006: Overview of the Results.**
Smyth ETM, McIlvenny G, Enstone JE, et al., on behalf of the Hospital Infection Society Prevalence Survey Steering Group.
J Hosp Infect. 2008(Jul); 69(3):230–248.
This article presents a summary of results from a national prevalence assessment of healthcare-associated infections (HCAIs) in England, Wales, Northern Ireland, and the Republic of Ireland. Surveillance took place at acute care hospitals throughout the four countries between February and May 2006 and involved a total of 75,694 patients. Study methods and findings, including results by country and by various patient and hospital characteristics, are detailed in the article. Infection-specific findings showed that the overall prevalence of HCAI was 7.59%; the prevalence of methicillin-resistant Staphylococcus aureus (MRSA) was 1.15%; and the prevalence of Clostridium difficile was 1.21%. One figure and multiple tables are included. [See also item 6.]
- 6. Four Country Healthcare Associated Infection Prevalence Survey 2006: Risk Factor Analysis.**
Humphreys H, Newcombe RG, Enstone J, et al., on behalf of the Hospital Infection Society Steering Group.
J Hosp Infect. 2008(Jul); 69(3):249–257.
A four-country national prevalence survey of healthcare-associated infections (HCAIs) was conducted in England, Wales, Northern Ireland, and the Republic of Ireland in February–May 2006. This article presents findings of a risk factor analysis of survey data pertaining to various patient-, procedure-, and device-related risk factors for HCAI overall and for four HCAI subcategories: primary bloodstream infection, pneumonia, surgical site infection, and urinary tract infection. Results showed that HCAI risk increased significantly with patient age and that almost all of the risk factors considered were associated with substantially increased prevalence of HCAI. Multiple tables are included. [See also item 5.]

- 7. Impact of Electronic Prescribing in a Hospital Setting: A Process-Focused Evaluation.**
Cunningham TR, Geller ES, Clarke SW.
Int J Med Inform. 2008(Aug); 77(8):546–554.
This study assessed the impact of implementation of CPOE (computerized physician [or prescriber] order entry) on prescribers' compliance with medication order documentation protocols and efficiency of antibiotic administration at a tertiary care hospital in southwest Virginia. Comparisons within the CPOE hospital and with a non-equivalent control site showed that the use of CPOE was associated with significantly improved compliance with medication-ordering protocols as well as significantly faster delivery of antibiotics, corroborating previous findings on the favorable impact of CPOE adoption. The authors note that the focus on process measurement distinguishes this study from previous CPOE investigations and may provide a useful model for future research in this area. Two figures and one table are included.
- 8. Improving Handoff Communications in Critical Care: Utilizing Simulation-Based Training Toward Process Improvement in Managing Patient Risk.**
Berkenstadt H, Haviv Y, Tuval A, et al.
Chest. 2008(Jul); 134(1):158–162.
A medication-related adverse event at a hospital in Israel prompted a retrospective analysis of the incident as well as a prospective risk analysis, leading ultimately to the development and implementation of an intervention aimed at improving patient handoff procedures. This article describes the event, the subsequent analysis, and the intervention, which involved simulation-based teamwork and communication training as well as the introduction of a standardized handoff protocol. Three tables are included; the handoff protocol checklist used in the intervention is provided in an appendix.
- 9. Maternal Death in the 21st Century: Causes, Prevention, and Relationship to Cesarean Delivery.**
Clark SL, Belfort MA, Dildy GA, Herbst MA, Meyers JA, Hankins GD.
Am J Obstet Gynecol. 2008(Jul); 199(1):36–38.
This study examined maternal deaths among nearly 1.5 million deliveries at Hospital Corporation of America (HCA) facilities during the period 2000–2006. Of 95 maternal deaths identified among the study sample, 17 deaths were deemed attributable to preventable errors or lapses in medical care. On the basis of their analysis, the authors conclude that most maternal deaths in the US are not preventable and that an estimated 2 per 100,000 maternal deaths are directly attributable to cesarean delivery, compared with 0.2 per 100,000 attributable to vaginal delivery, a statistically significant difference. The authors comment on the implications of these results and discuss what measures would need to be taken to reduce the maternal mortality rate in the US. One table is included.

- 10. Measurement for Improvement: A Survey of Current Practice in Australian Public Hospitals.**
Brand CA, Tropea J, Ibrahim JE, et al.
Med J Aust. 2008(Jul 7); 189(1):35–40.
This study, conducted in support of the development of a Measurement for Improvement Toolkit by the Australian Council for Safety and Quality in Health Care (ACSQHC), assessed patient safety measurement activities and use of patient safety measurement tools in Australian public hospitals. Results of a nationwide survey of hospitals identified a variety of patient safety measurement tools currently in use; while most hospitals measured some aspect of patient safety, there was significant variability from hospital to hospital as to the types of measurement tools employed and the domains of safety measured. Limited resources and insufficient access to appropriate measurement tools were frequently cited as barriers to effective measurement. Several tables and figures are included.
- 11. Medication Errors Reported by US Family Physicians and Their Office Staff.**
Kuo GM, Phillips RL, Graham D, Hickner JM.
Qual Saf Health Care. 2008(Aug); 17(4):286–290.
While hospital medication errors have been extensively examined, comparatively little is known about medication errors in the outpatient setting. This study analyzed 194 medication-related error reports abstracted from a total of 1,265 medical error reports submitted by 52 physician practices in two prior studies conducted by the American Academy of Family Physicians National Research Network. Results showed that the majority of reported medication errors (70%) stemmed from mistakes in prescribing; more than half of errors (59%) reached patients, although only a few caused patient harm (none of the reported errors resulted in permanent harm or death); and over half of the reported errors were deemed to have been preventable. Two figures and three tables are included.
- 12. Patient- and Family-Centered Care of Children in the Emergency Department.**
O'Malley PJ, Brown K, Krug SE, and the Committee on Pediatric Emergency Medicine.
Pediatrics. 2008(Aug); 122(2):e511–e521.
Available at: <http://www.pediatrics.org/cgi/content/full/122/2/e511>
Patient- and family-centered care (PFCC) is a model for the design and provision of healthcare that promotes the development of a collaborative and mutually respectful relationship among patients, families, and care providers. This technical report from the American Academy of Pediatrics summarizes current guidelines on PFCC and discusses opportunities and challenges concerning the use of PFCC in the pediatric emergency medicine context. Three appendices provide additional resources, including advice on addressing difficult scenarios, a sample policy on family presence in the ED, and resources for further reading.

- 13. Potentially Inappropriate Prescribing to Hospitalised Patients.**
Radošević N, Gantumur M, Vlahović-Palčevski V.
Pharmacoepidemiol Drug Saf. 2008(Jul); 17(7):733–737.
This study sought to determine the frequency of potentially inappropriate prescriptions and to identify risk factors for inappropriate prescribing for patients at University Hospital Rijeka, Rijeka, Croatia. A review of all hospital inpatient prescriptions that were initiated during a one-day period (representing a total of 1301 drugs received by 225 patients) showed that 22% of patients in the sample received potentially harmful combinations of drugs, with older patients and those taking multiple medications at greater risk for this occurrence; in addition, 25% of patients aged 65 and over received a drug considered inappropriate for use in this age group. One table is included.
- 14. Prevention of Hospital-Acquired Infections: Review of Non-Pharmacological Interventions.**
Curtis LT.
J Hosp Infect. 2008(Jul); 69(3):204–219.
This article aims to synthesize recent literature concerning non-pharmacological methods for the reduction and prevention of hospital-acquired infections (HAIs). The author briefly discusses the morbidity, mortality, and economic impact of HAIs and the mechanisms by which HAIs are spread; he then reviews research on a variety of proven or promising non-pharmacological infection control strategies, including hand hygiene, appropriate cleaning of surfaces and equipment, improved patient nutrition, pathogen surveillance and isolation, and a number of others. Two tables are included.
- 15. Redefining and Redesigning Hospital Discharge to Enhance Patient Care: A Randomized Controlled Study.**
Balaban RB, Weissman JS, Samuel PA, Woolhandler S.
J Gen Intern Med. 2008(Aug); 23(8):1228–1233.
This study assessed the impact of a low-cost intervention aimed at improving continuity of care associated with hospital discharge for patients discharged from Somerville Hospital, a Harvard Medical School–affiliated community teaching hospital. The intervention involved a series of steps to ensure post-discharge coordination with the patient’s primary care “medical home,” including the use of a comprehensive Patient Discharge Form. Results showed that patients who received the intervention were considerably less likely than those in control groups to experience one or more of four unwanted outcomes; in particular, failure to follow up with primary care providers was much lower among patients in the intervention group than in the control group. Three tables are included.

16. Reliability of the Assessment of Preventable Adverse Drug Events in Daily Clinical Practice.

Van Doormaal JE, Mol PGM, Van den Bemt PMLA, et al.
Pharmacoepidemiol Drug Saf. 2008(Jul); 17(7):645–654.

This study evaluated the inter-rater reliability of an assessment tool for the classification of preventable adverse drug events among hospital patients at two academic hospitals in Groningen and Tilburg, the Netherlands. The assessment tool uses a combination of two algorithms to evaluate the severity of an error and to determine whether the error caused preventable harm to the patient. A total of ten raters (five physicians and five pharmacists) evaluated 30 cases of potential medication error using the assessment algorithm; statistical analysis showed only fair agreement among raters with respect to severity of errors and occurrence of preventable harm. Results and implications for practice are discussed. Two figures, three tables, and an appendix are included.

17. Retained Forceps: An Unusual Cause of Intestinal Obstruction.

Godara R, Sen J, Singh R, Ahuja V, Dhingra A, Godara S.
Asian J Surg. 2008(Jul); 31(3):148–150.

Available at: http://ajws.elsevier.com/ajws_archive/20087313A4480.pdf

This case report describes an adverse event involving the retention of a forceps in a patient following surgery; the source of the problem was discovered two years after the surgery when the patient presented in the emergency room with acute abdominal pain. The authors briefly discuss the issue of retained foreign bodies and comment on strategies for preventing this type of error. Four figures are included.

18. Teaching Medication Reconciliation Through Simulation: A Patient Safety Initiative for Second Year Medical Students.

Lindquist LA, Gleason KM, McDaniel MR, Doeksen A, Liss D.
J Gen Intern Med. 2008(Jul); 23(7):998–1001.

This article describes the development and implementation of the Medication Reconciliation Simulation, a hands-on educational activity designed to increase medical students' proficiency in obtaining medication histories and conducting medication reconciliation. The program was piloted in a class of 170 second-year medical students at Northwestern University Feinberg School of Medicine, Chicago, IL. Participants' reactions and possibilities for refinement and future expansion of the program are discussed. Four tables are included.

19. The Increased Incidence of Anesthetic Adverse Events in Late Afternoon Surgeries.

Johnson J.

AORN J. 2008(Jul); 88(1):79–87.

Recent research at Duke University suggests that anesthesia-related adverse events occur more frequently during surgeries performed in the late afternoon than during those performed earlier in the day. This article discusses these findings and reviews other current literature concerning the prevalence, nature, and causes of anesthetic adverse events. Recommendations for increasing awareness of this issue and improving the safety of late-afternoon surgeries are offered.

20. United States Level I Trauma Centers Are Not Created Equal — A Concern for Patient Safety?

Ziran BH, Barrette-Grischow M-K, Hileman B.

Pat Saf Surg. 2008(Jul 21); 2(18).

Available at: <http://www.pssjournal.com/content/2/1/18>

In this study, a survey of 136 level I trauma centers in 37 US states revealed considerable variations in staffing, equipment, and services among the facilities examined. Whether and how this heterogeneity may affect safety and quality of care is not known; the authors suggest that further research into this issue is needed. Multiple tables and figures are included.

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