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- 1. Considering the Introduction of Universal MRSA Screening.**
Dancer SJ.
J Hosp Infect. 2008(Aug); 69(4):315–320.
This commentary discusses the practical, methodological, clinical, and ethical considerations relating to the use of universal screening for methicillin-resistant Staphylococcus aureus. While a growing number of hospitals are adopting universal surveillance for MRSA on hospital admission, the relative advantages and disadvantages of this practice are not yet fully understood. Emphasizing that more conclusive evidence of its benefits is still needed, the author cautions against the temptation to view universal screening as a panacea for the problem of MRSA.
- 2. Demographic Disparities in Numeracy among Emergency Department Patients: Evidence from Two Multicenter Studies.**
Ginde AA, Clark S, Goldstein JN, Camargo Jr. CA.
Patient Educ Couns. 2008(Aug); 72(2):350–356.
This research sought to determine the prevalence of and contributing factors for limited numeracy among emergency department (ED) patients. Two cross-sectional studies assessed numeracy skills in a total of 959 adult ED patients from 28 EDs in 17 US states. Results showed that ED patients were more likely to have limited numeracy than members of the general population and that the likelihood of limited numeracy was independently predicted by patient age, ethnicity, and education level, indicating that demographically determined differences in numeracy mimic the pattern of disparities in overall health literacy observed in previous studies. Six tables are included.
- 3. Detection of Adverse Events in Surgical Patients Using the Trigger Tool Approach.**
Griffin FA, Classen DC.
Qual Saf Health Care. 2008(Aug); 17(4):253–258.
This article describes the development and evaluation of an Institute for Healthcare Improvement (IHI) “Trigger Tool” for the detection of surgical adverse events (SAEs). The Trigger Tool approach is a method of retrospective record review that screens for items indicative of a possible adverse event (“triggers”) to identify cases where an event may actually have occurred. In this study, the Surgical Trigger Tool was applied to patient records submitted by 11 hospitals participating in a year-long IHI Perioperative Safety Collaborative. Among 854 patients, 138 SAEs were detected in 125 records, including many events that participating hospitals said had not been detected by their existing reporting systems. One figure and multiple tables are included. A variety of IHI-developed Trigger Tools, including the Surgical Trigger Tool, may be viewed and downloaded at www.ihf.org (free registration required).

4. Effect of Crew Resource Management Training in a Multidisciplinary Obstetrical Setting.

Haller G, Garnerin P, Morales M-A, et al.

Int J Qual Health Care. 2008(Aug); 20(4):254–263.

This study examined the impact of a Crew Resource Management (CRM) training program on participants' knowledge and attitudes with respect to teamwork, communication, and patient safety at Geneva University Hospitals, Switzerland. Participants were 239 hospital staff including midwives, nurses, physicians, and technicians from the departments of anesthesia, obstetrics, and pediatrics. Comparison of pre- and post-training survey results showed overall improvement in knowledge of teamwork and team communication following the training; significant improvement in organizational safety climate as measured by the Safety Attitudes Questionnaire was observed over the course of the year in which the training took place. One figure and three tables are included.

5. “Every Error Counts”: A Web-Based Incident Reporting and Learning System for General Practice.

Hoffmann B, Beyer M, Rohe J, Gensichen J, Gerlach FM.

Qual Saf Health Care. 2008(Aug); 17(4):307–312.

This article discusses the development and early results of Jeder Fehler Zaehlt (“Every Error Counts”), a web-based voluntary and anonymous medical event reporting system designed for use by general practitioners in German-speaking countries. Findings from an analysis of reports collected in the first 17 months following the system's deployment are presented and discussed. Three tables, one figure, and several sample incident reports are included. The reporting system may be accessed at <http://www.jeder-fehler-zaehlt.de/> (in German).

6. Fault/No Fault: Bearing the Brunt of Medical Mishaps.

Silversides A.

CMAJ. 2008(Aug 12); 179(4):309–311.

This article compares tort-based and no-fault medical malpractice systems and discusses the advantages and disadvantages of each type of system. The author comments on the differing medical malpractice compensation systems used in Canada, the US, and various European countries and considers the arguments for and against the enactment of a no-fault compensation system in Canada, which currently uses a tort-based system. [See also item 7.]

7. Fault/No Fault Part 2: Uneasy Bedfellows.

Silversides A.

CMAJ. 2008(Aug 26); 179(5):407–409.

In this article, the author describes how the burgeoning patient safety movement in Canada—and the growing realization that the movement's goals may be incompatible with a tort-based medical malpractice system—is prompting some experts to reexamine the country's malpractice laws and to consider the potential benefits of adopting a no-fault system. [See also item 6.]

8. In-Hospital Falls of Newborn Infants: Data from a Multihospital Health Care System.

Monson SA, Henry E, Lambert DK, Schmutz N, Christensen RD.

Pediatrics. 2008(Aug); 122(2):e277–e280.

Available at: <http://www.pediatrics.org/cgi/content/full/122/2/e277>

This study examined in-hospital falls among neonates, a safety issue that the authors argue has received insufficient attention. The authors reviewed electronic and risk-management records from an 18-hospital healthcare system for a 3-year period to determine the incidence of in-hospital neonatal falls and the conditions under which each fall occurred. Results showed that 14 such falls, or approximately 1.6 falls per 10,000 live births, occurred during the period examined and that a relatively limited number of conditions and scenarios (such as a parent falling asleep while holding their child) appeared to account for the majority of falls. On the basis of this result, the authors suggest that interventions targeting specific fall-conducive situations may be an effective preventive measure. Three tables are included.

9. Medication Errors Made by Health Care Professionals. Analysis of the Finnish Poison Information Centre Data between 2000 and 2007.

Kuitunen T, Kuisma P, Hoppu K.

Eur J Clin Pharmacol. 2008(Aug); 64(8):769–774.

This study sought to quantify and describe medication errors reported to the Finnish Poison Information Centre (PIC), a national service, between June 2000 and May 2007. Analysis of the PIC database showed that of 189,956 reported instances of acute poisoning in humans, 1270 (0.7%) involved medication errors. The distribution of errors varied by age group, with wrong drug the most common type of error in adult patients and wrong dose the most common in children, and errors overall occurred most frequently in patients 80–89 years and children under 10 years old; frequency of errors also appeared to increase during holiday seasons. Two figures and two tables are included.

10. New Rules Drawing Fire: Hospitals Say CMS' New Policies Lack Direction.

DerGurahian J.

Mod Healthcare. 2008(Aug 11); 38(32):8–9.

This article highlights industry reactions to the most recently announced Centers for Medicare & Medicaid Services (CMS) policy change, which adds three items to the list of hospital-acquired conditions for which CMS will no longer provide compensation as of October 1, 2008, and introduces 13 new reporting requirements that hospitals must fulfill in order to receive full reimbursement. The agency maintains that its policy will promote improvements in quality and safety, but some healthcare administrators have objected, criticizing the rationale behind the additional reporting requirements and questioning whether many of the hospital-acquired conditions included on the CMS list are in fact preventable.

- 11. Predicting Computerized Physician Order Entry System Adoption in US Hospitals: Can the Federal Mandate Be Met?**
Ford EW, McAlearney AS, Phillips MT, Menachemi N, Rudolph B.
Int J Med Inform. 2008(Aug); 77(8):539–545.
While the Institute of Medicine has called for the implementation of computerized physician order entry (CPOE) systems in all US hospitals by 2010, the cost and complexity of implementing currently available systems have thus far deterred widespread adoption. This study applied three empirically derived statistical models to three years' worth of Leapfrog Group hospital survey data in order to estimate future CPOE adoption rates in the US. Results suggested that it is unlikely that the IOM's goal of nationwide CPOE adoption by 2010 will be met if present trends continue. One figure and two tables are included.
- 12. Preliminary Assessment of Pediatric Health Care Quality and Patient Safety in the United States Using Readily Available Administrative Data.**
McDonald KM, Davies SM, Haberland CA, Geppert JJ, Ku A, Romano PS.
Pediatrics. 2008(Aug); 122(2):e416–e425.
Available at: <http://www.pediatrics.org/cgi/content/full/122/2/e416>
This article describes the design and preliminary evaluation of a set of pediatric-specific quality indicators (PDIs) derived from the Agency for Healthcare Research and Quality (AHRQ) quality indicators, used primarily to assess healthcare quality in the adult patient population. The resulting 18 PDIs were applied to Healthcare Cost and Utilization Project pediatric data to determine national rates for each indicator. The PDI development process, results of the preliminary assessment, and possibilities for further applications and refinement of this tool are discussed. Three figures and two tables are included.
- 13. Preparing for an Epidemic of Limited Health Literacy: Weathering the Perfect Storm.**
Parker RM, Wolf MS, Kirsch I.
J Gen Intern Med. 2008(Aug); 23(8):1273–1276.
A recent report from the Educational Testing Service predicts that a combination of trends—including declining adult literacy, an expanding immigrant population, and economic shifts that are likely to exacerbate existing disparities—may soon bring about a “perfect storm” that will threaten the nation's social and economic wellbeing. In this commentary, the authors argue that these forces may also lead to unprecedented rates of limited health literacy, with potentially dire effects on public health; they issue a call to action to the healthcare community and discuss steps that could be taken to avert this risk. One figure is included.

- 14. Promoting Patient Safety Using an Early Warning Scoring System.**
Higgins Y, Maries-Tillott C, Quinton S, Richmond J.
Nurs Stand. 2008(Jul 9); 22(44):35–40.
This article describes an initiative developed and implemented by the Heart of England NHS Foundation Trust (HEFT) to improve compliance with organizational standards for observation taking and recording of early warning scores at HEFT hospitals. Observation taking refers to the process by which nurses systematically monitor patients' clinical condition and document their observations; used as part of this process, early warning scoring systems provide a standardized means of patient assessment and an algorithm for identifying and responding to patients whose condition is deteriorating. The authors report significant improvements in compliance with observation taking and early warning score documentation requirements following implementation of the HEFT project. Multiple tables and figures are included.
- 15. Rationing of Nursing Care and Its Relationship to Patient Outcomes: the Swiss Extension of the International Hospital Outcomes Study.**
Schubert M, Glass TR, Clarke SP, et al.
Int J Qual Health Care. 2008(Aug); 20(4):227–237.
Rationing of nursing care, defined as the inability of nurses to perform indicated patient care because of constraints on time, staffing, or skill mix, is a measurement of the effects of nurse staffing and work environment factors on the quality and safety of patient care. This study, an extension of the International Hospital Outcomes Study, examined the relationship between rationing of nursing care and selected patient outcomes at eight acute care hospitals in Switzerland. Analysis of survey data representing 1,338 nurses and 779 patients at the participating hospitals showed a significant association between rationing of nursing care and negative patient outcomes and events of care such as falls, medication administration errors, and nosocomial infections. One figure and five tables are included; survey instruments used in the study are provided as appendices.
- 16. Single-Patient Rooms for Safe Patient-Centered Hospitals.**
Detsky ME, Etchells E.
JAMA. 2008(Aug 27); 300(8):954–956.
This commentary discusses evidence for the benefits of single-patient rooms with respect to patient safety, patient-centeredness, and efficiency of care. The authors argue that the considerable costs associated with the construction of single-patient rooms may be justified by the superior safety and quality advantages conferred.
- 17. Speaking Up for Quality and Safety.**
Beyea SC.
AORN J. 2008(Jul); 88(1):115–116.
Nurses can play a crucial role in protecting patients' safety by voicing their concerns when they notice that a breach of safe practice has occurred, but they must communicate convincingly in order for these interventions to succeed. In this article, Beyea discusses how nurses can arm themselves with knowledge and communication skills that will help them to "speak up" effectively in these situations.

- 18. The Transforming Care at the Bedside (TCAB) Toolkit.**
Princeton, NJ: The Robert Wood Johnson Foundation; June 4, 2008.
Available at: <http://www.rwjf.org/qualityequality/product.jsp?id=30051>
Transforming Care at the Bedside (TCAB) is a national initiative aimed at creating innovative models for improving care in medical/surgical units, with an emphasis on engaging the participation of frontline care providers in this process. This toolkit, recently made available online, provides background on the TCAB program and offers guidelines for implementing TCAB-developed methods, including sections on engaging leadership, frontline staff, and physicians; selecting targets for improvement and establishing measurements; and implementing, sustaining, and disseminating change. Additional program materials including video and PowerPoint presentations and brochures may be accessed at the link above.
- 19. Using Nurses and Office Staff to Report Prescribing Errors in Primary Care.**
Kennedy AG, Littenberg B, Senders JW.
Int J Qual Health Care. 2008(Aug); 20(4):238–245.
This study assessed the effects of a voluntary prescribing-error-reporting system implemented at seven primary care practices in Chittenden County, Vermont, and analyzed error reports submitted through the system. Nurses and office staff at participating practices were instructed to report throughout a 6-month period any communications with community pharmacists regarding prescription problems, using existing paper-based office communication mechanisms. Results showed that a total of 216 reports were submitted, most of which involved errors that did not reach the patient. While all practices submitted reports, reporting rates declined over the course of the study, and no practices continued to submit reports after the study had ended. Further findings and the strengths and limitations of such a reporting system are discussed. One figure and five tables are included.
- 20. Will Patients Agree to Have Their Literacy Skills Assessed in Clinical Practice?**
Ryan JG, Leguen F, Weiss BD, et al.
Health Educ Res. 2008(Aug); 23(4):603–611.
This study assessed patients' willingness to undergo literacy screening during routine doctor's office visits. A randomized controlled comparison among 20 South Florida medical practices found that more than 98% of patients at practices that implemented a literacy assessment consented to the screening, and that there was no apparent difference in patient satisfaction between practices where the assessment was performed and those where it was not. Four tables are included.

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