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**1. Anticoagulation Management Service: Safer Care, Maximizing Outcomes.**

Pennsylvania Patient Safety Authority.

Pa Patient Saf Advis. 2008(Sep); 5(3):81–84.

Available at:

<http://www.psa.state.pa.us/psa/cwp/view.asp?a=1293&q=445966&psaNav=#53>

*This article discusses anticoagulant-related medication errors and adverse events and recommends the development of anticoagulation management services (AMS) as a means of addressing these patient safety issues. The authors review evidence in support of AMS and outline key elements of the AMS development and implementation process. One table is included.*

**2. Are Patient Safety Indicators Related to Widely Used Measures of Hospital Quality?**

Isaac T, Jha AK.

J Gen Intern Med. 2008(Sep); 23(9):1373–1378.

*This study investigated whether hospitals' performance on selected Agency for Healthcare Research and Quality (AHRQ) patient safety indicators (PSIs) correlated with their scores on several other assessments of healthcare quality. Analysis of data for 4,504 acute care hospitals with respect to four medical PSIs showed weak or inverse relationships between PSI performance and performance on the other quality measures for all but one of the PSIs examined. The authors compare these results to previous study findings on the PSIs and discuss their implications. Two figures, four tables, and an appendix are included.*

**3. Building Physician Work Hour Regulations from First Principles and Best Evidence.**

Volpp KG, Landrigan CP.

JAMA. 2008(Sep 10); 300(10):1197–1199.

*The implementation of resident work hour restrictions in 2003 by the Accreditation Council for Graduate Medical Education aimed to improve patient and provider safety by reducing the chances that providers would be obligated to deliver care while in a fatigued state, a known contributor to medical error. However, evidence about the impact of this legislation on patient safety has been inconclusive, and the federal government has recently appointed an Institute of Medicine Committee to reexamine the issue of work hour regulations. In this commentary, the authors outline prerequisites for the effective implementation of work hour reform and set forth principles that they feel should guide the discussion of this issue and the development of further plans of action.*

- 4. Classifying and Predicting Errors of Inpatient Medication Reconciliation.**  
Pippins JR, Gandhi TK, Hamann C, et al.  
J Gen Intern Med. 2008(Sep); 23(9):1414–1422.  
*This prospective study sought to determine the incidence and nature of and contributing factors for medication reconciliation errors among inpatients at two large academic hospitals. Medication lists documented by admitting physicians and subsequent medication orders were compared with an authoritative preadmission medication history for each study participant to identify medication discrepancies. Results showed that among 180 patients, 2,066 medication discrepancies occurred, of which 257 (12%) were deemed potentially harmful, and that the majority of discrepancies stemmed from errors or omissions in obtaining the medication history. Four tables, one figure, and two appendices are included.*
- 5. Does Error and Adverse Event Reporting by Physicians and Nurses Differ?**  
Rowin EJ, Lucier D, Pauker SG, Kumar S, Chen J, Salem DN.  
Jt Comm J Qual Pat Saf. 2008(Sep); 34(9):537–545.  
*This study compared physicians' and nurses' error reporting behavior through an analysis of data from a vendor-administered electronic error reporting system (e-ERS) used by multiple facilities. Results showed significant differences between the patterns of error reporting exhibited by physicians and those exhibited by nurses: physician reports tended to involve events with greater impact on the patient, while nurse reports were more evenly distributed across levels of impact. Multiple tables and figures are included.*
- 6. Evaluation of Electronic Discharge Summaries: A Comparison of Documentation in Electronic and Handwritten Discharge Summaries.**  
Callen JA, Alderton M, McIntosh J.  
Int J Med Inform. 2008(Sep); 77(9):613–620.  
*This study assessed electronic and handwritten structured patient discharge summaries and compared the quality of the two types of summaries at a small Sydney, Australia, hospital that had recently implemented an electronic discharge summary system. Evaluation of a total of 245 electronic and handwritten discharge summaries from a 3-month period showed that errors and omissions occurred frequently in both types of summaries, but were more likely to occur in the electronic summaries. Possible explanations for this result and implications are discussed. Four tables and one figure are included.*
- 7. Hospitals' Mistakes Are Going Unreported.**  
Goldstein J.  
The Philadelphia Inquirer. September 12, 2008.  
Available at:  
[http://www.philly.com/inquirer/home\\_top\\_stories/20080912\\_Hospitals\\_mistakes\\_are\\_going\\_unreported.html?viewAll=y](http://www.philly.com/inquirer/home_top_stories/20080912_Hospitals_mistakes_are_going_unreported.html?viewAll=y)  
*This news article discusses public error reporting among hospitals in Pennsylvania and New Jersey. While hospitals in Pennsylvania and New Jersey are required by law to report medical errors to state patient safety authorities, some facilities are underreporting or failing to report serious events.*

**8. Interprofessional Handover and Patient Safety in Anaesthesia: Observational Study of Handovers in the Recovery Room.**

Smith AF, Pope C, Goodwin D, Mort M.

Br J Anaesth. 2008(Sep); 101(3):332–337.

*This study qualitatively examined patient care handoffs between anesthetists and recovery room nurses at a northern UK hospital through an analysis of transcripts of 45 handoffs collected over a 1-year period. The authors detail their observations concerning the structure and content of handoffs, the environment in which handoffs occur, and the various functions of the handoff (transfer of information, transfer of responsibility for the patient). The authors note that the handoffs examined in their study tended to be informal and that the dynamics of the professional relationship between the handoff participants dictated how certain aspects of the procedure would be carried out. Three figures are included.*

**9. Medication Errors Associated with Documented Allergies.**

Pennsylvania Patient Safety Authority.

Pa Patient Saf Advis. 2008(Sep); 5(3):75–80.

Available at:

<http://www.psa.state.pa.us/psa/cwp/view.asp?a=1293&q=445966&psaNav=#53>

*This article discusses medication errors and adverse events in which better communication about a known patient allergy could have averted the event. On the basis of an analysis of reports submitted to the Pennsylvania Patient Safety Reporting System (PA-PSRS), the authors describe the prevalence and characteristics of errors involving documented allergies, discuss the failures in the documentation and communication of patient or drug information that contribute to such errors, and offer preventive strategies. Two tables are included.*

**10. Medication Errors in Pediatric Inpatients: Prevalence and Results of a Prevention Program.**

Otero P, Leyton A, Mariani G, Cernadas JMC, and the Patient Safety Committee.

Pediatrics. 2008(Sep); 122(3):e737–e743.

Available at: <http://www.pediatrics.org/cgi/content/full/122/3/e737>

*This study assessed the prevalence and nature of neonatal and pediatric inpatient medication errors before and after the implementation of a program aimed at reducing such errors in the Department of Pediatrics of the Hospital de Italiano de Buenos Aires. The intervention employed various educational activities aimed at improving attitudes and institutional culture with respect to medication safety, as well as process changes targeting specific types of error identified in the analysis. Results showed that the frequency of medication errors decreased from 11.4% of all prescriptions and administrations in the pre-intervention period to 7.3% post-intervention. One figure, five tables, and two appendices are included.*

- 11. Nurses' Perceptions of Error Communication and Reporting in the Intensive Care Unit.**  
Elder NC, Brungs SM, Nagy M, Kudel I, Render ML.  
J Patient Saf. 2008(Sep); 4(3):162–168.  
*This study used focus groups and a safety culture survey to explore ICU nurses' attitudes and practices related to reporting and other communication about medical errors. The authors found that many nurses struggled with the conflict between the moral imperative to disclose errors and the mental discomfort of admitting their own errors or confronting a nurse peer or physician about their mistakes, and that an absence of feedback from hospital administration in response to error reports led many to question the utility of reporting. Two tables and one figure are included.*
- 12. Patient-Centered Approach for Improving Prescription Drug Warning Labels.**  
Webb J, Davis TC, Bernadella P, et al.  
Patient Educ Couns. 2008(Sep); 72(3):443–449.  
*This study engaged direct input from a group of patients/consumers to guide the evaluation and redesign of ten commonly used US drug warning labels. Participants, a number of whom were identified as having low health literacy, found the text and icons on many of the existing labels confusing; the revised labels featured simplified text and in some cases different icons. Two tables, including a side-by-side comparison of the original and revised labels, are included.*
- 13. Preventing Deep Vein Thrombosis: A Perioperative Nursing Imperative.**  
Dipaola CA.  
AORN J. 2008(Aug); 88(2):283–285.  
*Hospital-associated deep vein thrombosis (DVT) is a leading cause of preventable hospital death and is recognized as a serious patient safety issue. This article discusses strategies for DVT risk assessment and prevention with an emphasis on the perioperative nurse's role.*
- 14. Problem-Oriented Patient Record Model as a Conceptual Foundation for a Multi-Professional Electronic Patient Record.**  
De Clercq E.  
Int J Med Inform. 2008(Sep); 77(9):565–575.  
*This article describes a conceptual model for a patient-centered electronic medical record to be used in the hospital setting. The model is organized around the patient's health status and events in his or her treatment and is intended to integrate nursing and medical approaches, thus providing a system usable by the multiple providers involved in the patient's care. Three tables and one figure are included.*

- 15. Safety Skills for Clinicians: An Essential Component of Patient Safety.**  
Taylor-Adams S, Brodie A, Vincent C.  
J Patient Saf. 2008(Sep); 4(3):141–147.  
*This review article seeks to define the cognitive skills that enable individuals to effectively manage error and maintain safety in high-risk environments. The authors discuss safety-skills training programs used in other industries and how these models might be applied in healthcare; they stress that the current focus on systems-based error prevention methods should not eclipse the critical role of individuals as the “last line of defense” against error-induced harm.*
- 16. Severity of Medication Administration Errors Detected by a Bar-Code Medication Administration System.**  
Sakowski J, Newman JM, Dozier K.  
Am J Health-Syst Pharm. 2008(Sep 1); 65(17):1661–1666.  
*This study sought to describe errors identified by a bar-code medication administration (BCMA) system with respect to the predicted impact had these errors actually reached a patient. Analysis of a total of 945 errors captured by BCMA systems at six hospitals showed that most errors detected by the system were of minimal severity. In the context of this result, the authors discuss the benefits and limitations of BCMA systems as a medication error prevention tool. One table is included.*
- 17. Sleep and Errors in a Group of Australian Hospital Nurses at Work and during the Commute.**  
Dorrian J, Tolley C, Lamond N, et al.  
Appl Ergon. 2008(Sep); 39(5):605–613.  
*This study examined the relationship between sleep and fatigue levels and propensity to commit error at work and during the homebound commute among a group of nurses at an Australian metropolitan hospital. Analysis of nurses’ self-reported data from a one-month period showed that work schedules significantly affected sleep, fatigue, and ability to remain alert, and that nurses frequently reported difficulty remaining awake at work and during the commute home. Self-reported difficulty staying awake and psychophysiological stress were associated with a greater likelihood of error at work and during the commute. Three figures and three tables are included.*
- 18. Standardization of Infusion Solutions to Reduce the Risk of Incompatibility.**  
Nemec K, Kopelent-Frank H, Greif R.  
Am J Health-Syst Pharm. 2008(Sep 1); 65(17):1648–1654.  
*This article describes an intervention that aimed to improve IV-related medication safety in the ICU by standardizing IV drug preparations and eliminating opportunities for the administration of incompatible drugs. Two tables are included.*

**19. Surgical Site Infections in Cardiac Surgery after a Hospital Catastrophe.**

Fernández-Ayala M, Nan DN, Fariñas-Álvarez C, et al.  
J Hosp Infect. 2008(Sep); 70(1):48–52.

*This study examined nosocomial infection and surgical site infection (SSI) rates among cardiac surgery patients at an acute care teaching hospital in Santander, Spain, following the collapse of a portion of the building adjacent to the cardiovascular surgery unit. Contrary to predictions that this disaster would jeopardize patient safety, results showed that nosocomial infection rates remained unchanged and SSI rates decreased significantly during the post-accident period; the authors attribute this unexpected positive outcome to the hospital's implementation of heightened infection surveillance and control procedures following the accident. One figure and two tables are included.*

**20. The Pitfalls of Linking Doctors' Pay to Performance.**

Jauhar S.

The New York Times. September 9, 2008.

Available at: <http://www.nytimes.com/2008/09/09/health/09essa.html>

*In this commentary, the author argues that while the notion of pay for performance—providing financial rewards for excellent healthcare performance—appeals in theory, the P4P models thus far developed may be unable to achieve this intended effect in practice, and may in fact lead to serious unintended consequences.*

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