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- 1. A Multifaceted Approach to Safety: The Synergistic Detection of Adverse Drug Events in Adult Inpatients.**
Ferranti J, Horvath MM, Cozart H, et al.
J Patient Saf. 2008(Sep); 4(3):184–190.
This study compared the performance of two adverse drug event (ADE) detection systems currently in use at Duke University Hospital: voluntary reporting and computerized data surveillance. Analysis of ADE data from a 7-month period showed that the two systems together detected 875 ADEs, of which 710 were identified by surveillance and 205 by voluntary reporting, with little overlap between the systems. The authors discuss the strengths and weaknesses of each system and conclude that the use of the two methods in combination offers “synergistic” benefits. Five tables and two figures are included.
- 2. Applying Patient Perspectives on Caring to Curriculum Development.**
Hatem D, Mazor K, Fischer M, Philbin M, Quirk M.
Patient Educ Couns. 2008(Sep); 72(3):367–373.
This study explored patients’ perceptions of physicians’ caring behavior in three difficult care scenarios: conveying medical bad news, discussing palliative care, and disclosing a medical error. Focus-group findings were applied to the development of a caring curriculum for medical trainees. The authors found that patients’ perceptions of caring behavior were highly individualized and context-specific, suggesting that medical trainees must learn not just an all-purpose set of caring behaviors, but also the ability to respond flexibly and intuitively to individual patients’ needs. Three tables are included. [See also item 9.]
- 3. Documentation of Drug Allergy on Drug Chart in Patients Presenting for Surgery.**
Farooq M, Kirke C, Foley K.
Ir J Med Sci. 2008(Sep); 177(3):243–245.
This study assessed documentation of drug allergy information in the charts of elective surgery patients at Adelaide and Meath National Children’s Hospital (AMNCH) Dublin, Dublin, Ireland. Analysis of 300 charts from a two-month period showed that 70% contained documentation of drug allergy or a notation indicating no known drug allergy; 30% contained no documentation of drug allergy status. Implications for patient safety and possible strategies for improving documentation compliance are discussed. One table is included.
- 4. Drug Name Recognition and Classification in Biomedical Texts: A Case Study Outlining Approaches Underpinning Automated Systems.**
Segura-Bedmar I, Martínez P, Segura-Bedmar M.
Drug Discov Today. 2008(Sep); 13(17/18):816–823.
This article describes the development and preliminary evaluation of a system for automated identification and classification of drug names in biomedical texts. The authors discuss the potential applications of such a system to pharmacological and patient safety research; they propose their method as the basis for technology that would enable automated analysis of more complex drug-related information, such as data about drug interactions and medication adverse events. Multiple tables and figures are included.

- 5. Errors, Near Misses, and Adverse Events in the Emergency Department: What Can Patients Tell Us?**
Friedman SM, Provan D, Moore S, Hanneman K.
CJEM. 2008(Sep); 10(5):421–427.
This study assessed patients' and family members' ability to identify adverse events during emergency department care and compared patient-reported events with hospital-documented events for 201 ED patients at a quaternary care urban teaching hospital in Toronto, Ontario, Canada. Results showed that patients were able to identify adverse events and near misses that occurred during their care and that many events identified by patients had not been recorded in the medical record. Three tables are included.
- 6. Fault/No Fault, Part 3: Vested Interests and the Silence of Suffering Patients Cited as Obstacles to System Change.**
Silversides A.
CMAJ. 2008(Sep 9); 179(6):515–517.
This article, the third in a three-part series, comments on the prospects for adoption of a no-fault medical injury compensation system in Canada and reflects on why the existing system has consistently resisted reform.
- 7. Health-Care-Associated Infections in Hospitals: An Overview of State Reporting Programs and Individual Hospital Initiatives to Reduce Certain Infections.**
Washington, DC: United States Government Accountability Office; September 2008.
Publication GAO-08-808.
Available at: <http://www.gao.gov/new.items/d08808.pdf>
This report presents findings from a Government Accountability Office (GAO) study of state reporting systems and hospital-level initiatives that address healthcare-associated infections (HAIs). The GAO reviewed HAI reporting systems in the 23 states that had implemented mandatory HAI public reporting systems as of February 2008 and examined MRSA reduction initiatives at 14 diverse hospitals and healthcare systems throughout the US. The report provides an overview of the structure and function of the various programs examined, describes their similarities and differences, and discusses implementation challenges and how they were managed.
- 8. Hospital Bracelets Face Hurdles as They Fix Hazard.**
Hartocollis A.
New York Times. September 25, 2008.
Available at:
http://www.nytimes.com/2008/09/25/nyregion/25bracelets.html?_r=1&emc=eta1
Many US hospitals are implementing a standardized wristband color-coding scheme in an effort to eliminate confusion and error when patients or providers move between facilities that use different color-coding conventions. This article discusses the benefits and pitfalls of a standardized system and highlights challenges encountered and solutions devised by hospitals that have adopted the new bracelets.

- 9. How Patients Perceive a Doctor's Caring Attitude.**
Quirk M, Mazor K, Haley H-L, et al.
Patient Educ Couns. 2008(Sep); 72(3):359–366.
This study sought to develop a conceptual representation of caring in the clinical context based on patients' reactions to three hypothetical patient–provider interactions: conveying bad news about a patient's condition or prognosis, discussing palliative care, and communicating about a medical error. While participants collectively identified a set of behaviors as being central to the notion of caring, whether a physician's actions were perceived as caring in any given instance varied considerably depending on context and specific personal preferences. Results and implications for practice are discussed. Five tables are included. [See also item 2.]
- 10. Implementation Manual – WHO Surgical Safety Checklist (First Edition).**
Geneva, Switzerland: World Health Organization; 2008.
Checklist and manual available at:
http://www.who.int/patientsafety/safesurgery/ss_checklist/en/index.html
The WHO Surgical Safety Checklist, developed as part of the Safe Surgery Saves Lives initiative, is a tool designed to support the performance of recognized safety-promoting practices during surgical procedures and to enhance communication and situational awareness among operating room personnel. This manual provides general advice on implementing the checklist as well as item-by-item instructions on its use.
- 11. Incident Reporting in Surgical Trainees—Revisited.**
Sharma A, Jain P, Parmar B, Muzaffar J, Monson JRT.
J Patient Saf. 2008(Sep); 4(3):191–194.
This study surveyed behaviors and attitudes related to patient safety event reporting among 85 surgical residents at a UK National Health Service Trust and compared responses with findings of a 2003 study. Results showed that while self-reported awareness and use of the reporting system had increased somewhat since the previous study, uncertainty about which events to report and skepticism about the utility of reporting remained significant challenges. Five tables are included.
- 12. Missed Injuries in Trauma Patients: A Literature Review.**
Pfeifer R, Pape H-C.
Patient Saf Surg. 2008(Aug 23); 2(20).
Available at: <http://www.pssjournal.com/content/2/1/20>
This study reviewed literature from the past three decades relating to the incidence, nature, and severity of missed injuries, a common type of diagnostic error in the trauma setting. Analysis of 17 studies showed that incidence rates of missed injuries varied widely and that an estimated 15 to 22.3% of missed injuries were clinically significant. Additional findings, strategies for reducing missed injuries, and recommendations for further work in this area are discussed; the authors note that greater uniformity among study designs and definitions would enable more meaningful analysis. Four tables are included.

- 13. Never-Ending Questions: Kickoff Date Draws Near for ‘Never Events’ Policy.**
DerGurahian J.
Mod Healthcare. 2008(Sep 15); 38(37):36–37.
The Centers for Medicare and Medicaid Services (CMS) policy stipulating non-reimbursement for care associated with certain preventable hospital-acquired conditions is scheduled to take effect October 1, 2008, and many insurers have or will soon put in place similar policies. This article continues an ongoing commentary on the details of the policy changes, the practical and financial implications for hospitals, and the controversy that the proposed changes have provoked.
- 14. Pharmacists’ Role in Improving Quality of Care.**
Bohenek WS, Grossbart SR.
Am J Health-Syst Pharm. 2008(Aug 15); 65(16):1566–1570.
This commentary discusses major healthcare quality and safety improvement initiatives launched in the US in recent years and comments on the role of the pharmacy profession in advancing these efforts.
- 15. Preventing Errors Relating to Commonly Used Anticoagulants.**
The Joint Commission.
Sentinel Event Alert. Issue 41, September 24, 2008.
This Alert addresses preventable adverse events associated with the widely used anticoagulants heparin, warfarin, and enoxaparin. The authors discuss the incidence, nature, and causes of anticoagulant-related safety incidents and offer error avoidance and risk reduction strategies.
- 16. Reuse of Single Use Medical Devices in Canada: Clinical and Economic Outcomes, Legal and Ethical Issues, and Current Hospital Practice.**
Hailey D, Jacobs PD, Ries NM, Polisena J.
Int J Technol Assess Health Care. 2008(Fall); 24(4):430–436.
This study examined questions related to the repeated use of single-use medical devices (SUDs) in Canadian healthcare facilities. The authors review the literature concerning the clinical and economic impact of reuse of SUDs, analyze the financial impact of this practice, and discuss legal and ethical considerations. In addition, the authors report results of a survey of current SUD reuse in Canadian acute care hospitals. On the basis of their findings, the authors conclude that current evidence does not support multiple use of SUDs as a safe or cost-effective practice. Two tables are included.
- 17. Revving Up the Quality Campaign.**
Bush H.
Hospitals & Health Networks. 2008(Sep); 82(9):44–46.
This article comments on the status of healthcare quality improvement efforts in the US and highlights key policy developments, approaches, and initiatives that, experts hope, will help accelerate improvements.

18. The Doctor's Hands Are Germ-Free. The Scrubs Too?

Parker-Pope T.

New York Times. September 23, 2008.

Available at: <http://www.nytimes.com/2008/09/23/health/23well.html?em>

As worries about healthcare-associated infections such as MRSA prompt increasingly intense scrutiny of healthcare providers' hand hygiene, the role of clinicians' clothing as a transmitter of pathogens is also generating discussion. Despite limited evidence, concern about the potential risks has led some countries to adopt new infection control measures, such as the National Health Service's "bare below the elbows" policy instituted earlier this year. This article discusses what is known about the issue and comments on clothing-related infection control policies in the US and abroad.

19. The Effect of Electronic Prescribing on Medication Errors and Adverse Drug Events: A Systematic Review.

Ammenwerth E, Schnell-Inderst P, Machan C, Siebert U.

J Am Med Inform Assoc. 2008(Sep/Oct); 15(5):585–600.

This systematic review examined evidence from 27 studies concerning the impact of computerized physician order entry (CPOE) systems on medication errors and medication-related adverse events in a variety of types of systems and clinical settings. The authors note that while many of the studies reviewed found evidence of a link between CPOE and reduced risk of medication errors and/or adverse drug events, variations in study terminology, design, and quality may hinder meaningful comparison; the authors suggest that further and more rigorous research is therefore needed in this area. Multiple tables and figures are included.

20. The Medical Home: Growing Evidence to Support a New Approach to Primary Care.

Rosenthal TC.

J Am Board Fam Med. 2008(Sep/Oct); 21(5):427–440.

This article presents findings from an extensive literature review concerning the effectiveness of "medical homes" as a means of improving quality and safety in primary care. The authors discuss the fundamental elements of the medical home and comment on the cost and regulatory implications of widespread adoption of this care delivery model. One table is included.

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Anita Spielman, Editor

aspelman@npsf.org