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- 1. 2009 Patient Safety Goals: A Perioperative Nursing Priority.**
Beyea SC.
AORN J. 2008(Sep); 88(3):459–462.
This article reviews the Joint Commission’s 2009 National Patient Safety Goals for hospitals, office-based surgery practices, and ambulatory care facilities. Changes and updates to the goals introduced in 2009 are noted.
- 2. Advances in Patient Safety: New Directions and Alternative Approaches.**
Rockville, MD: Agency for Healthcare Research and Quality; July 2008. AHRQ Publication Nos. 08-0034 (1-4).
Available at: <http://www.ahrq.gov/qual/advances2/>
This collection presents reports from completed and ongoing AHRQ-funded research addressing diverse patient safety topics. The 115 articles are divided thematically into four volumes: Assessment; Culture and Redesign; Performance and Tools; and Technology and Medication Safety. The new publication joins a previous collection, Advances in Patient Safety: From Research to Implementation, published in 2005.
- 3. An Educational and Audit Tool to Reduce Prescribing Error in Intensive Care.**
Thomas AN, Boxall EM, Laha SK, Day AJ, Grundy D.
Qual Saf Health Care. 2008(Oct); 17(5):360–363.
This article describes the design and implementation of a provider education program aimed at reducing prescription errors in the intensive care unit of a UK hospital. Three figures are included.
- 4. An Intervention to Decrease Narcotic-Related Adverse Drug Events in Children’s Hospitals.**
Sharek PJ, McClead RE Jr, Taketomo C, et al.
Pediatrics. 2008(Oct); 122(4):e861–e866.
Available at: <http://www.pediatrics.org/cgi/content/full/122/4/e861>
This study assessed the impact of a collaborative initiative aimed at improving narcotic-related drug safety in a 14-member group of children’s hospitals. The program followed the model of the Institute for Healthcare Improvement quality improvement collaboratives and implemented facility-specific combinations of expert-recommended practices at each participating hospital over a one-year period. Results showed significant post-intervention decreases in narcotic-related adverse drug events throughout the collaborative. Five tables are included.
- 5. Coming Clean: Waterless Hand Cleaners—Which to Choose?**
Silver MR.
Am J Med. 2008(Oct); 121(10):831–832.
This editorial comments on the advantages and risks associated with the use of various alcohol-based hand cleaners. Because some common formulations contain ingredients whose safety or toxicity with long-term use is not yet known, the author recommends that only those products proven safe and effective be used until further data on the alternatives is available.

- 6. Development and Implementation of a Program to Assess Medical Patients' Need for Venous Thromboembolism Prophylaxis.**
Sobieraj DM.
Am J Health-Syst Pharm. 2008(Sep); 65(18):1755–1760.
Effective risk assessment and prophylaxis for venous thromboembolism (VTE) is recognized as an important strategy for reducing thrombotic complications and improving patient safety. This case study describes the development and implementation of a program to improve VTE risk assessment and prophylaxis at Hartford Hospital, Hartford, CT. Two tables and two figures are included.
- 7. Health Literacy and Adolescents: A Framework and Agenda for Future Research.**
Manganello JA.
Health Educ Res. 2008(Oct); 23(5):840–847.
Health literacy in adolescents is a little-studied issue. This article presents a rationale for the study of health literacy issues specific to the adolescent population and sets forth a model for future research in this area. One figure is included.
- 8. Health-Care-Associated Infections in Hospitals: Number Associated with Medical Devices Unknown, but Experts Report Provider Practices as a Significant Factor.**
Washington, DC: United States Government Accountability Office; September 2008.
Publication GAO-08-1091R.
Available at: <http://www.gao.gov/new.items/d081091r.pdf>
This report presents results of federally mandated research concerning the frequency and causes of healthcare-associated infections (HAIs) related to the use of medical devices. The authors identified federal and state bodies that collect HAI-related information but found that none of the existing data sources provided a national estimate of the number of HAIs linked to medical devices. They also found that both expert opinion and the medical literature pointed to healthcare providers' treatment practices and hospital disinfection techniques as the most important factors in the incidence of medical device-related HAIs.
- 9. Impact of Miscommunication in Medical Dispute Cases in Japan.**
Aoki N, Uda K, Ohta S, Kiuchi T, Fukui T.
Int J Qual Health Care. 2008(Oct); 20(5):358–362.
This study explored the role of documented miscommunication between patient and provider in 155 closed medical dispute cases from a 10-year period in Japan. The authors found that many of the cases examined did not involve medical negligence or error; miscommunication figured frequently and was associated with higher compensation in the non-negligent cases. The authors therefore argue that improving patient-provider communication issues may be a useful strategy for avoiding medical disputes and the associated costs. Two tables are included.

- 10. Indiana Medical Error Reporting System: Report for 2007.**
Whitson T, Garten B, Azbill M.
Indianapolis, IN: Indiana State Department of Health; August 25, 2008.
Available at: <http://www.in.gov/isdh/24056.htm>
Indiana requires healthcare facilities to publicly report all occurrences of serious adverse events. This publication presents data on patient care events reported to the state medical error reporting system during 2007. Summary and facility-specific data are provided in appendices.
- 11. Interruptions and Distractions: Workflow Intrusions at a Level-One Trauma Center.**
Brixy JJ, Robinson DJ, Zhang J, Turley JP.
Focus on Patient Safety. 2008(Fall); 11(3):3–5.
Available at: http://npsf.org/paf/npsfp/fo/pdf/Focus_Volume_11_Issue_3.pdf
This article describes a study that sought to analyze workflow interruptions in the trauma section of the emergency department at a large academic hospital. The authors discuss the types of interruptions observed and outline strategies for minimizing the negative impact of disruptions on productivity and safety.
- 12. Misdiagnosis of Acute Eye Diseases by Primary Health Care Providers: Incidence and Implications.**
Statham MO, Sharma A, Pane AR.
Med J Aust. 2008(Oct 6); 189(7):402–404.
This study examined diagnostic histories of patients presenting with acute eye complaints at two Brisbane hospitals to assess how accurately the patients' conditions had been diagnosed by their primary health care providers (PCHPs) and the consequences of misdiagnosis. Researchers analyzed medical records for a total of 1062 patients treated by the hospitals' ophthalmologic emergency services over a 15-month period. Results showed that misdiagnosis or mismanagement of the eye condition by the patient's PCHP occurred frequently and led to preventable adverse outcomes in approximately 11.6% of the cases evaluated. Implications for practice and recommendations for improving the accuracy of ophthalmologic diagnosis are discussed. Four figures are included.
- 13. Nosocomial Infection, the Deficit Reduction Act, and Incentives for Hospitals.**
Graves N, McGowan JE Jr.
JAMA. 2008(Oct 1); 300(13):1577–1579.
This article discusses the recently implemented change in CMS payment policy according to which CMS will no longer reimburse hospitals for care associated with certain hospital-acquired infections. The authors explain the legislative origins and objectives of the regulation and comment on its benefits, limitations, and potential unintended consequences.

- 14. Older Patients Perceptions of “Unnecessary” Tests and Referrals: A National Survey of Medicare Beneficiaries.**
Herndon MB, Schwartz LM, Woloshin S, et al.
J Gen Intern Med. 2008(Oct); 23(10):1547–1554.
While the avoidance of unnecessary medical tests and interventions may reduce preventable medical harm, patients and clinicians do not always agree about what constitutes “necessary” or “unnecessary” treatment. In this study, a survey of 2,847 elderly Medicare recipients showed that many respondents would want tests or referrals that their general practitioner considered unnecessary in two hypothetical scenarios. The authors discuss their findings in the context of the current healthcare consumer climate and comment on their implications for the objectives of patient-centered care. Two tables and three figures are included.
- 15. Patient Care, Square-Rigger Sailing, and Safety.**
Henkind SJ, Sinnett JC.
JAMA. 2008(Oct 8); 300(14):1691–1693.
This brief essay draws an analogy between the safety environments of a hospital and of a US Coast Guard training ship and comments on lessons that healthcare personnel could learn from the Coast Guard’s approach to safety.
- 16. Patient Reported Receipt of Medication Instructions for Warfarin Is Associated with Reduced Risk of Serious Bleeding Events.**
Metlay JP, Hennessy S, Localio AR, et al.
J Gen Intern Med. 2008(Oct); 23(10):1589–1594.
This study examined the relationship between patient-recollected receipt of medication instructions and the incidence of warfarin-related bleeding events in a group of 2,346 older adult outpatients taking warfarin. The authors found that over a one-year period, patients who reported receiving medication instructions from both a clinician and a pharmacist were at considerably reduced risk of experiencing a serious warfarin-related bleeding event as compared with other patients in the study sample. Three tables are included.
- 17. Quality of Informed Consent for Invasive Procedures.**
Brezis M, Israel S, Weinstein-Birenshtock A, Pogoda P, Sharon A, Tauber R.
Int J Qual Health Care. 2008(Oct); 20(5):352–357.
This study evaluated informed consent procedures at a university hospital and ten ambulatory clinics in Jerusalem, Israel. A total of almost 800 hospitalized and ambulatory patients who had undergone procedures requiring informed consent were surveyed regarding their experiences and preferences with respect to the consent procedure and the treatment decision-making process. Results showed that although most patients reported satisfaction with the decision-making process, few recalled receiving the requisite information about treatment risks and alternatives; preferred level of involvement in treatment decision-making varied considerably from patient to patient. Results and recommendations for improving the consent process are discussed. Four tables are included.

- 18. Standardised Proformas Improve Patient Handover: Audit of Trauma Handover Practice.**
Ferran NA, Metcalfe AJ, O’Doherty D.
Patient Saf Surg. 2008(Sep 25); 2(24).
Available at: <http://www.pssjournal.com/content/2/1/24>
This study assessed patient handoffs in the orthopedics department at University Hospital of Wales, Cardiff, UK, before and after implementation of a standardized handoff form. Results showed that use of the forms, which provided a structured documentation format and prompted the use of computer-generated patient information labels, measurably improved transfer of information during handoffs. One table and two figures are included; the handoff form developed in the study is provided as an appendix.
- 19. The Use of Medical Emergency Teams in Medical and Surgical Patients: Impact of Patient, Nurse and Organisational Characteristics.**
Schmid-Mazzoccoli A, Hoffman LA, Wolf GA, Happ MB, Devita MA.
Qual Saf Health Care. 2008(Oct); 17(5):377–381.
This study compared medical emergency team (MET) use between medical and surgical units and sought to identify factors contributing to delayed MET activation in 108 MET calls at a University of Pittsburgh Medical Center tertiary care hospital. The authors found significant differences in patterns of MET use between medical and surgical patients and that multiple and interrelated factors were associated with delayed MET activation. Implications of these results for practice and for further research are discussed. Five tables and two figures are included.
- 20. Time Out: An Analysis.**
Dillon KA.
AORN J. 2008(Sep); 88(3):437–442.
This article discusses the preoperative time out, a surgical safety procedure mandated by the Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™. The author illustrates correct and incorrect time outs and highlights a time out checklist developed by Mount Carmel Health System, Columbus, Ohio. One figure is included.

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