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- 1. A Clinician's Guide to Electronic Prescribing.**  
Washington, DC: eHealth Initiative; Alexandria, VA: Center for Improving Medication Management; October 2008.  
Available at: [http://www.ehealthinitiative.org/assets/Documents/e-Prescribing\\_Clinicians\\_Guide\\_Final.pdf](http://www.ehealthinitiative.org/assets/Documents/e-Prescribing_Clinicians_Guide_Final.pdf)  
*This guide gives an overview of electronic prescribing for office practices considering or preparing for adoption of an e-prescribing system. The authors discuss the capabilities, benefits, and limitations of e-prescribing and offer practical advice on the adoption process, including evaluating practice readiness for e-prescribing, choosing the right product, and implementing the system. A buyer's guide, a list of state and national e-prescribing initiatives, and further information are included in appendices.*
- 2. A Model for Quality Improvement Programs in Academic Departments of Medicine.**  
Aronson MD, Neeman N, Carbo A, et al.  
Am J Med. 2008(Oct); 121(10):922–929.  
*This article describes a quality and patient safety improvement program at Beth Israel Deaconess Medical Center (BIDMC), Boston, MA, that involves active participation by the institution's academic medical department. The authors also provide insight into the traditional reticence of academic departments to participate actively in institutional quality improvement efforts; they offer the BIDMC program as a prototype for further efforts to overcome disincentives and obstacles to engagement. Multiple figures are included.*
- 3. Bedside Manner: Advocating for a Relative in the Hospital.**  
Beck M.  
Wall Street Journal. October 28, 2008.  
Available at: <http://online.wsj.com/article/SB122514012478473347.html>  
*Patient safety experts and proponents of family-centered care have long argued that the presence of a patient advocate—a trusted individual who accompanies a hospital patient and is empowered to interact with healthcare providers on the patient's behalf—can be a crucial defense against medical mishaps. This brief article highlights efforts by hospitals to accommodate increased family involvement in patient care and provides straightforward suggestions on how best to protect the safety and wellbeing of a hospitalized family member or friend.*
- 4. Clostridium difficile — More Difficult Than Ever.**  
Kelly CP, LaMont JT.  
N Engl J Med. 2008(Oct 30); 359(18):1932–1940.  
*Recent increases in the incidence and severity of Clostridium difficile infections have prompted considerable concern and debate about how best to curtail the spread of the bacterium in the healthcare setting. This article summarizes evidence concerning the changing epidemiology of C. difficile infection, discusses clinical and pharmacological considerations in its treatment, and gives an overview of new approaches to C difficile-associated disease management. Two tables and four figures are included.*

- 5. Complaints Handling in Hospitals: An Empirical Study of Discrepancies between Patients' Expectations and Their Experiences.**  
Friele RD, Sluijs EM, Legemaate J.  
BMC Health Serv Res. 2008(Sep 30); 8(199).  
Available at: <http://www.biomedcentral.com/1472-6963/8/199>  
*This study sought to explain patients' levels of satisfaction with hospitals' handling of complaints through a survey of 279 patients at 74 hospitals in the Netherlands who had filed complaints with hospital complaints departments. The authors found that a number of factors beyond the disposition of the complaint influenced patients' satisfaction with the process and their perceptions as to whether justice had been done. While a majority of subjects were satisfied with the conduct of the complaints committee, many felt that the responses of hospital management and of individual providers did not adequately redress their complaint. Of note, the authors found that patient satisfaction increased when a provider apologized, explained why a problem had occurred, or took steps to reestablish rapport following an error. One figure and multiple tables are included.*
- 6. Contributing Factors Identified by Hospital Incident Report Narratives.**  
Nuckols TK, Bell DS, Paddock SM, Hilborne LH.  
Qual Saf Health Care. 2008(Oct); 17(5):368–372.  
*This study sought to describe information about contributing factors in incident reports from an academic and a community hospital that used voluntary, non-anonymous reporting systems. The authors examined more than 2,200 incident reports to determine how frequently contributing factors that related to systems, patients, or providers were identified. They found that while most of the reports mentioned one or more contributing factors, this information was frequently lacking in detail, particularly in the case of provider factors. Three tables are included.*
- 7. DNV Setting New Standard: Watch Out Joint Commission. There's a New Accreditor in Town, and Some Hospitals Say They're Willing to Give It a Try.**  
DerGurahian J.  
Mod Healthcare. 2008(Oct 27); 38(43):6–7, 16.  
*A new hospital accreditation program, administered by DNV Healthcare and known as the National Integrated Accreditation for Healthcare Organizations (NIAHO), has recently been approved by the Centers for Medicare & Medicaid Services (CMS). This article describes the DNV program's approach, highlights industry reactions to the new arrival, and comments on the implications for hospitals and for other accrediting bodies.*

**8. Evaluating a Case Study Using Bloom's Taxonomy of Education.**

Larkin BG, Burton KJ.

AORN J. 2008(Sep); 88(3):390–402.

*This article presents a case study involving a narrowly averted failure-to-rescue incident at a southeast Wisconsin teaching hospital. The authors then describe a staff-education workshop conducted following the event that was structured according to Bloom's Taxonomy of Educational Objectives, a conceptual model that classifies learning processes and objectives into cognitive, affective, and psychomotor domains. Results indicated that using Bloom's Taxonomy was very successful in helping staff address the underlying issues and in preparing them to better handle similar situations in the future. Multiple figures are included.*

**9. International Essentials of Health Care Quality and Patient Safety™.**

Oakbrook Terrace, IL: Joint Commission International; 2008.

Available at: <http://www.jointcommissioninternational.org/33378/> [free registration required]

Press release available at: <http://www.jointcommissioninternational.org/33922/>

*This document sets forth a framework representing the essential elements of a healthcare safety and quality improvement program, centered on five major areas around which improvement efforts should be organized: Leadership Process and Accountability; Competent and Capable Workforce; Safe Environment for Staff and Patients; Clinical Care of Patients; and Improvement of Quality and Safety. Each area is subdivided into ranked criteria that spell out specific goals for improvement. The Essentials framework is intended as a fundamental tool to assist healthcare organizations and government agencies around the world in targeting and prioritizing healthcare improvement efforts, according to a JCI press statement accompanying its release.*

**10. Medication Errors in the Ambulatory Treatment of Pediatric Attention Deficit Hyperactivity Disorder.**

Bundy DG, Rinke ML, Shore AD, Hicks RW, Morlock LL, Miller MR.

Jt Comm J Qual Patient Saf. 2008(Sep); 34(9):552–559.

*This study analyzed 361 MEDMARX® reports of medication errors related to the treatment of attention deficit hyperactivity disorder (ADHD) in pediatric ambulatory patients over a two-year period. The authors sought to characterize reported errors according to type, cause, and severity; to identify the medications most frequently associated with errors; and to ascertain whether error characteristics varied depending on the type of medication involved. Results, detailed in the article, showed that most reported errors reached patients but did not cause harm, and that two frequently prescribed drugs accounted for the majority of reported errors. Six tables are included.*

- 11. Patient Safety and Quality: An Evidence-Based Handbook for Nurses.**  
Hughes RG, ed.  
Rockville, MD: Agency for Healthcare Research and Quality; April 2008. AHRQ Publication No. 08-0043.  
Available at: <http://www.ahrq.gov/qual/nursesfdbk/>  
*This expert-developed reference brings together literature reviews and analyses covering a wide range of patient safety and quality topics of interest to nurses. The handbook consists of 51 chapters in six sections: (1) Patient Safety and Quality; (2) Evidence-based Practice; (3) Patient-centered Care; (4) Working Conditions and the Work Environment for Nurses; (5) Critical Opportunities for Patient Safety and Quality Improvement; and (6) Tools for Quality Improvement and Patient Safety.*
- 12. Patient-Centered Care Improvement Guide.**  
Frampton S, Guastello S, Brady C, et al.  
Derby, CT: Planetree; Camden, ME: Picker Institute; 2008.  
Available at: <http://www.planetree.org/Patient-Centered%20Care%20Improvement%20Guide%202010.10.08%20Final.pdf>  
*This 250-page manual provides a compendium of practical advice on developing and implementing patient-centered practices in the hospital setting. Chapters 1 and 2 introduce the concept of patient-centered care and describe the development of the Guide; Chapter 3 contains a hospital self-assessment tool keyed to sections of the guide; Chapters 4–6 focus on the role of organizational culture in relation to patient-centered care; and Chapters 7–9 offer detailed strategies and implementation tools. Examples of readily transferable tools and patient-centered practices are featured throughout the guide.*
- 13. Patients' Perception of Hospital Care in the United States.**  
Jha AK, Orav EJ, Zheng J, Epstein AM.  
N Engl J Med. 2008(Oct 30); 359(18):1921–1931.  
*The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey was developed by the Hospital Quality Alliance program as part of its extensive efforts to gather and disseminate information on healthcare quality in the US. This study looked at the first published set of HCAHPS data to examine patients' general perceptions of hospital performance, the relationships between certain hospital characteristics and patient satisfaction, and the relationship between HCAHPS performance and quality of clinical care. Detailed findings of a statistical analysis are reported in the article. In general, results suggested that while patients were reasonably satisfied with their hospital care, performance varied significantly and left considerable room for improvement. Five tables and one figure are included.*

- 14. Prevention of Intravenous Drug Incompatibilities in an Intensive Care Unit.**  
Bertsche T, Mayer Y, Stahl R, Hoppe-Tichy T, Encke J, Haefeli WE.  
Am J Health-Syst Pharm. 2008(Oct 1); 65(19):1834–1840.  
*This article describes an intervention aimed at identifying and preventing intravenous drug incompatibilities in the ICU of the teaching hospital at University of Heidelberg, Heidelberg, Germany. A retrospective analysis of IV drug administration data identified potential incompatibilities and guided the design of new standard operating procedures (SOPs). Pre- and post-intervention comparison showed a significant reduction in the co-administration of incompatible drugs following implementation of the SOPs. Three tables are included.*
- 15. Reducing Medication Prescribing Errors in a Teaching Hospital.**  
Garbutt J, Milligan PE, McNaughton C, et al.  
Jt Comm J Qual Patient Saf. 2008(Sep); 34(9):528–536.  
*This study assessed the impact of an intervention aimed at improving the quality of handwritten medication orders at an urban teaching hospital. The intervention used a combination of educational and behavioral techniques to encourage the adoption of safe prescription-writing habits among medical and surgical house staff. Pre- and post-intervention comparison showed that errors in the surgeons' prescriptions decreased following the intervention, but that, contrary to expectations, errors in non-surgeons' prescriptions increased. Possible explanations for this result and implications are discussed. Four tables and one figure are included.*
- 16. Reducing the Risk of Catheter-Related Urinary Tract Infection.**  
Nazarko L.  
Br J Nurs. 2008(Sep 11); 17(16):1002–1010.  
*This article addresses infection risks associated with the use of urinary catheters in hospital inpatients. The author describes the incidence and causes of catheter-related urinary tract infections and discusses risk reduction strategies, such as avoiding unnecessary catheterization, using silver-coated catheters, and ensuring proper insertion and maintenance. Two tables and three figures are included.*
- 17. Specimen Labeling Errors: A Q-Probes Analysis of 147 Clinical Laboratories.**  
Wagar EA, Stankovic AK, Raab S, Nakhleh RE, Walsh MK.  
Arch Pathol Lab Med. 2008(Oct); 132(10):1617–1622.  
*Mistakes in the labeling of laboratory samples are implicated in a variety of medical errors. This study sought to determine the frequency of labeling errors and to identify institutional factors predictive of labeling error in a sample of more than 3.3 million specimen labels from 147 institutional laboratories. Results showed that errors occurred in 3,043 labels (approximately .92 per 1,000) in the study sample; laboratories that participated in quality surveillance programs targeting specimen identification and those that had round-the-clock phlebotomy services tended to have lower rates of labeling error. Additional findings and implications for practice are discussed. Multiple tables are included.*

- 18. Systems Ambiguity and Guideline Compliance: A Qualitative Study of How Intensive Care Units Follow Evidence-Based Guidelines to Reduce Healthcare-Associated Infections.**  
Gurses AP, Seidl KL, Vaidya V, et al.  
Qual Saf Health Care. 2008(Oct); 17(5):351–359.  
*This study used semistructured interviews to examine the factors influencing healthcare workers' observance of guidelines for the prevention of nosocomial infections in the surgical intensive care unit setting. Noting that perceived ambiguity about various aspects of the guidelines formed a common thread in these discussions, the authors posit the concept of systems ambiguity as a framework for the etiology of guideline noncompliance. Examples of various types of ambiguity that inhibit compliance and interviewees' strategies for resolving these ambiguities are discussed. Multiple tables are included.*
- 19. The Application of Crime Science to the Prevention of Medication Errors.**  
Cox K.  
Br J Nurs. 2008(Jul 24–Aug 13); 17(14):924–927.  
*This article describes how rational choice theory, a framework widely used in sociology and economics, could be applied to error management in healthcare. The author discusses the correspondences between rational choice theory and system-based approaches to error and proposes that use of the two theories in conjunction could provide a better understanding of the personal and environmental dynamics of error in the healthcare context.*
- 20. Tort Claims and Adverse Events in Emergency Medical Services.**  
Wang HE, Fairbanks RJ, Shah MN, Abo BN, Yealy DM.  
Ann Emerg Med. 2008(Sep); 52(3):256–262.  
*This study sought to describe adverse events in emergency medical services (EMS) care through an analysis of tort claims from a national insurer of EMS providers. Retrospective review of claims data from a two-year period showed that two types of events—emergency vehicle crashes and patient handling accidents—accounted for the majority of tort claims against EMS providers; relatively few claims involved clinical management issues. Implications of these findings and possibilities for further research are discussed. Three tables are included.*

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