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1. A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals.

Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America.

Infect Control Hosp Epidemiol. 2008(Oct); 29(Suppl 1):901–994.

Available at: <http://www.journals.uchicago.edu/toc/iche/2008/29/s1>

This special issue presents evidence-based recommendations and strategies for the prevention of six common healthcare-associated infections in the acute care setting. Developed by the Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America, the compendium is intended to augment previously published guidelines with practical, implementation-focused strategies, supplementary approaches for situations where basic infection control practices prove insufficient, and suggested performance measures for internal and external reporting.

2. Adverse Events During Hospitalization: Results of a Patient Survey.

Fowler FJ Jr., Epstein A, Weingart SN, et al.

Jt Comm J Qual Patient Saf. 2008(Oct); 34(10):583–590.

This study sought to characterize patient-reported adverse events during hospitalization and to identify factors associated with the frequency of reported events in a sample of almost 2,600 patients discharged from 16 acute care hospitals in Massachusetts. Analysis of patient interview data showed that approximately one fourth of patients reported having experienced incidents that were deemed adverse events by physician reviewers—a rate that is significantly higher than has been calculated in studies using record review alone, the authors note. Of these events, 75% were rated as “significant” or worse in severity, and 31% were judged preventable; several hospital-, treatment-, and patient-related factors were associated with an increased likelihood of reported adverse events. Six tables are included.

3. Assuring the Quality of Clinical Microbiology Test Results.

Wilson ML.

Clin Infect Dis. 2008(Oct 15); 47(8):1077–1082.

This article discusses the role of the clinical microbiology laboratory in promoting patient safety and quality of care. The author describes how laboratory data can inform clinical quality improvement efforts and emphasizes the importance of laboratory quality control in ensuring the accuracy and prompt reporting of microbiological test results.

- 4. Evaluation of Critical Incidents in General Surgery.**
Zingg U, Zala-Mezoe E, Kuenzle B, et al.
Br J Surg. 2008(Nov); 95(11):1420–1425.
This study involved the design and assessment of a method for analyzing surgical safety incidents at a tertiary referral hospital in Zurich, Switzerland. The system used error classification schemes derived from Reason, Leape, and Vincent to describe the type, frequency, causes, and severity of reported errors, along with a risk analysis. The system was applied to the analysis of surgical incident reports from an 18-month period; descriptive data are reported in the article. The authors found that the system was an effective albeit resource-intensive method for the analysis of surgical events. Multiple tables are included.
- 5. Handoffs Causing Patient Harm: A Survey of Medical and Surgical House Staff.**
Kitch BT, Cooper JB, Zapol WM, et al.
Jt Comm J Qual Patient Saf. 2008(Oct); 34(10):563–570.
This study examined resident physicians' perceptions concerning the nature and quality of patient handoffs and the frequency of patient harm resulting from problems with the handoff process. A survey of 161 medical and surgical house staff at Massachusetts General Hospital, Boston, MA, found that 59% of respondents reported instances of patient harm attributable to flawed handoffs during their most recent rotation. Almost one third of respondents assessed overall handoff quality as fair or poor, and many reported that environmental distractions such as noise and other disruptions during handoffs were common. Results and implications are discussed. Three tables and one figure are included.
- 6. Hospitals Collaborate to Prevent Falls.**
Pelczarski K, Wallace C.
Patient Saf Qual Healthc. 2008(Nov/Dec); 5(6):30–38.
Available at: <http://www.psqh.com/novdec08/falls.html>
This article highlights an ongoing fall prevention initiative led by the Partnership for Patient Care and involving 15 Philadelphia-area hospitals. Participants met in workshops and online interactions to share experiences and ideas and used these insights to collectively develop a repertoire of fall prevention strategies. The authors comment on the impact and ramifications of the initiative; they note that facility self-assessments have indicated significant improvements brought about by participation in the program.
- 7. Impact of an Antimicrobial-Impregnated Gauze Dressing on Surgical Site Infections Including Methicillin-Resistant *Staphylococcus aureus* Infections.**
Mueller SW, Krebsbach LE.
Am J Infect Control. 2008(Nov); 36(9):651–655.
This study compared surgical site infection (SSI) rates before and after an institution-wide change from non-medicated to antimicrobial gauze dressings at a 606-bed Midwestern medical center. Results showed that implementation of antimicrobial dressings was associated with a significant reduction in overall SSI rates, including a reduction in MRSA SSIs of almost 50%, with associated reductions in post-surgical morbidity, lengths of stay, and costs of care. Three tables are included.

- 8. Improving Patient Safety in Radiology: A Work in Progress.**
Sze RW.
Pediatr Radiol. 2008(Nov); 38(Suppl 4):693–699.
This article gives a firsthand account of the author’s experiences in developing and implementing a multidisciplinary patient safety program in the radiology department of a Washington, DC, pediatric hospital. Dr. Sze candidly describes challenges, successes, and lessons learned during the program’s first year and gives detailed examples of obstacles encountered and how they were overcome. In the second part of the essay, he comments on potential approaches to addressing some of the broader safety issues facing pediatric radiology and healthcare as a whole. Two tables are included.
- 9. Information Exchange among Physicians Caring for the Same Patient in the Community.**
Van Walraven C, Taljaard M, Bell CM, et al.
CMAJ. 2008(Nov 4); 179(10):1013–1018.
Coordination of care in the ambulatory setting depends upon effective communication between multiple providers who care for the same patient. This study assessed provider-to-provider information sharing for a total of 3,250 patients discharged from 11 Ontario hospitals who saw two or more different physicians during the six months following discharge. The authors surveyed physicians who treated these patients to determine how frequently information about a given patient’s previous doctor visits was available to the subsequently visited doctor at the time of his or her encounter with the patient. Results indicated that information about previous visits was available in only 22% of 39,469 instances examined, suggesting that communication between providers was often lacking. Possible explanations for this result and suggestions for improvement are discussed. Three tables and one figure are included.
- 10. Medication Reconciliation in a Rural Trauma Population.**
Miller SL, Miller S, Balon J, Helling TS.
Ann Emerg Med. 2008(Nov); 52(5):483–491.
This prospective study assessed the accuracy of medication histories documented on admission for patients admitted to a rural Level 1 trauma center. Medication histories obtained during initial evaluation by trauma personnel were compared with medication lists subsequently established by a clinical pharmacist for 234 patients admitted to the facility over a 13-month period (patients who were not taking medications at the time of admission were excluded from the study). Results showed that almost all of the initial medication histories were inaccurate as compared against the pharmacist-obtained lists and that multiple factors contributed to medication history errors. The authors discuss these results and comment on aspects of the trauma setting that may pose particular challenges to accurate medication reconciliation. Five tables and one figure are included.

- 11. Monitoring and Feedback of Hand Hygiene Compliance and the Impact on Facility-Acquired Methicillin-Resistant *Staphylococcus aureus*.**
Cromer AL, Latham SC, Bryant KG, et al.
Am J Infect Control. 2008(Nov); 36(9):672–677.
This study assessed the effects of an intervention aimed at improving hand hygiene at a South Carolina teaching hospital. Motivated by findings that MRSA infection rates had increased in spite of previous hand hygiene and infection control efforts, the intervention used peer observation of hand hygiene behavior along with ongoing analysis and feedback to encourage compliance. Results showed increased compliance with hand hygiene protocols as well as a statistically significant reduction in rates of facility-acquired MRSA following implementation of the program. Multiple tables and figures are included.
- 12. MRI Safety Update 2008: Part 1, MRI Contrast Agents and Nephrogenic Systemic Fibrosis.**
Shellock FG, Spinazzi A.
AJR Am J Roentgenol. 2008(Oct); 191(4):1129–1139.
This article, the first in a two-part update, discusses recent evidence concerning nephrogenic systemic fibrosis and the implications for MRI safety. Nephrogenic systemic fibrosis (NSF) is a rare condition affecting patients with renal failure that appears to be linked to exposure to the gadolinium-based contrast agents (GBCAs) used in MRI. The authors describe the clinical and histological symptoms of NSF, review current knowledge about the epidemiology of NSF and the link between NSF and the use of GBCAs, and discuss risk reduction strategies. Multiple tables and figures are included. [See also item 13.]
- 13. MRI Safety Update 2008: Part 2, Screening Patients for MRI.**
Shellock FG, Spinazzi A.
AJR Am J Roentgenol. 2008(Oct); 191(4):1140–1149.
This article, the second in a two-part update, discusses pre-procedure screening policies and practices that help to ensure safety in the MRI environment. The authors review the latest information concerning written screening forms, MRI safety terminology, and safety specifications for various implants, devices, and body-piercing jewelry. One figure and one table are included. [See also item 12.]

- 14. Patient Safety Indicators for England from Hospital Administrative Data: Case-Control Analysis and Comparison with US Data.**
Raleigh VS, Cooper J, Bremner SA, Scobie S.
BMJ. 2008(Oct 17); 337:a1702. doi: 10.1136/bmj.a1702.
This study investigated whether patient safety indicators widely used in the US could be used successfully to identify adverse events in National Health Service (NHS) hospital patients in England. Nine selected indicators from the Agency for Healthcare Research and Quality (AHRQ) set were adapted and applied to NHS hospital administrative data from three one-year periods. Results of a case-control analysis suggested that the indicators provided a potentially useful means of measuring safety, although further validation and improvements in event reporting would be needed. Findings and implications, including results of a comparison between English and US statistics, are discussed. Three tables are included.
- 15. Public Health Law for the Collection and Reporting of Health Care-Associated Infections.**
Meier BM, Stone PW, Gebbie KM.
Am J Infect Control. 2008(Oct); 36(8):537–551.
Requirements for the reporting of healthcare-associated infections (HAIs) in the US are determined at the state level, and many states have introduced legislation related to HAI reporting during the past few years. In this study, the authors first identified and systematically classified proposed and existing legislation related to HAI reporting in each state. They then analyzed this data to assess progress and patterns in the adoption of HAI reporting legislation and the policy and practice implications. One table is included; a comprehensive table detailing current reporting requirements state by state is provided in an appendix.
- 16. Safety in Obstetric Critical Care.**
Scholefield H.
Best Pract Res Clin Obstet Gynaecol. 2008(Oct); 22(5):965–982.
This article discusses patient safety issues in obstetric critical care and describes how risk management techniques can be applied to address these issues. The author presents a seven-step framework for patient safety improvement, including building a safety culture; leading and supporting staff; integrating risk management activity; promoting reporting of events; involving and communicating with patients; learning from adverse events; and implementing safety solutions. Two appendices are included.
- 17. The Art of Communication: Strategies to Improve Efficiency, Quality of Care and Patient Safety in the Emergency Department.**
Krug SE.
Pediatr Radiol. 2008(Nov); 38(Suppl 4):655–659.
This article discusses patient safety issues in pediatric emergency care, specifically the risks associated with the use of radiologic imaging in pediatric patients. The author proposes that improvements in interdisciplinary teamwork could help to mitigate these issues; he outlines goals and opportunities for improving communication and collaboration between emergency physicians and radiologists.

- 18. The Daily Goals Communication Sheet: A Simple and Novel Tool for Improved Communication and Care.**
Schwartz JM, Nelson KL, Saliski M, Hunt EA, Pronovost PJ.
Jt Comm J Qual Patient Saf. 2008(Oct); 34(10):608–613.
This article describes the development and implementation of the Daily Goal Communication Sheet (DGCS), a checklist designed to help clinical team members communicate about daily treatment goals and recommended safety practices for each patient under their care. Based on work by Dr. Pronovost, the DGCS was implemented in the Johns Hopkins pediatric ICU in July 2005. Results, lessons learned, and potential further applications of the tool are discussed. Three figures are included.
- 19. The Effect of Clinical Experience on the Error Rate of Emergency Physicians.**
Berk WA, Welch RD, Levy PD, et al.
Ann Emerg Med. 2008(Nov); 52(5):497–501.
This study examined the relationship between clinical experience and tendency to commit medical errors in a group of emergency physicians at an urban university hospital. Statistical analysis of hospital peer review data from a 7-year period showed that more experienced physicians (those with at least 1.5 years of experience) were less prone to commit errors than were physicians with less experience; physician age and gender did not influence rates of error. The authors contrast this result with study findings that have linked greater physician experience to higher rates of error; possible explanations for this discrepancy and implications are discussed. One table and two figures are included.
- 20. The Safety Competencies: Enhancing Patient Safety Across the Health Professions.**
Frank JR, Brien S, eds, on behalf of The Safety Competencies Steering Committee.
Ottawa, ON: Canadian Patient Safety Institute; 2008.
Available at:
http://www.patientsafetyinstitute.ca/uploadedFiles/Safety_Competencies_16Sep08.pdf
This document presents a framework delineating the essential abilities and attitudes that enable healthcare professionals to practice safe care. The framework identifies key and supporting competencies in six safety domains and proposes strategies for incorporating the competencies in healthcare education.

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