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- 1. A Robust Clinical Review Process: The Catalyst for Clinical Governance in an Australian Tertiary Hospital.**
Mitchell IA, Antoniou B, Gosper JL, Mollett J, Hurwitz MD, Bessell TL.
Med J Aust. 2008(Oct 20); 189(8):451–455.
This article describes the design and implementation of a process for the systematic detection and clinical review of adverse events at a tertiary care university hospital in Canberra, Australia. The authors describe the incidents reviewed during a 4-year period, comment on practice changes undertaken as a result of the review process, and discuss implications for the role of clinical leadership in the management of adverse events. Four tables are included.
- 2. An Intensive Care Unit Quality Improvement Collaborative in Nine Department of Veterans Affairs Hospitals: Reducing Ventilator-Associated Pneumonia and Catheter-Related Bloodstream Infection Rates.**
Bonello RS, Fletcher CE, Becker WK, et al.
Jt Comm J Qual Patient Saf. 2008(Nov); 34(11):639–645.
This article describes an ICU quality improvement program carried out in a collaborative group of nine Veterans Affairs (VA) hospitals. The initiative involved the implementation of “bundles” for ventilator and central line management along with techniques such as interdisciplinary rounds and the use of a checklist to track daily patient care goals. Results showed self-reported improvements in guideline compliance as well as reductions in rates of ventilator-associated pneumonia and catheter-related bloodstream infections during and following participation in the program. One table and two figures are included.
- 3. Antimicrobial-Resistant Pathogens Associated with Healthcare-Associated Infections: Annual Summary of Data Reported to the National Healthcare Safety Network at the Centers for Disease Control and Prevention, 2006–2007.**
Hidron AI, Edwards JR, Patel J, et al., for the National Healthcare Safety Network Team and Participating National Healthcare Safety Network Facilities.
Infect Control Hosp Epidemiol. 2008(Nov); 29(11):996–1011.
This study sought to determine the frequency of healthcare associated infections (HAIs) attributable to selected drug-resistant pathogens in hospitals participating in the CDC’s National Healthcare Safety Network (NHSN). The authors analyzed HAI surveillance data and microbiology laboratory data reported by NHSN hospitals during 2006–2007 to calculate the rates of various device- and procedure-associated HAIs and the percentages of these infections that were associated with certain antimicrobial-resistant pathogens. Detailed findings are reported in the article; results are discussed in comparison with historical data and with findings from other ongoing infection surveillance systems. Multiple tables are included.

4. Characteristics of Medication Errors and Adverse Drug Events in Hospitals Participating in the California Pediatric Patient Safety Initiative.

Takata GS, Taketomo CK, Waite S, for the California Pediatric Patient Safety Initiative. *Am J Health-Syst Pharm.* 2008(Nov 1); 65(21):2036–2044.

This study was conducted to collect baseline data on medication-related errors and adverse events in hospitals involved in the California Pediatric Patient Safety Initiative, a 5-hospital medication safety improvement collaborative. Each participating hospital contributed incident data from a 6-month period for three types of medication incidents: pharmacy intervention medication errors (PIMEs), adverse drug events (ADEs) detected by automated trigger surveillance (TADEs), and ADEs documented by voluntary incident reports. Descriptive analysis of the aggregated data is presented in the article; characteristics of the identified errors and ADEs and the implications for improvement efforts are discussed. As a secondary result, the trigger tool was found to identify ADEs more effectively than did voluntary reporting. One table is included.

5. Documentation of Clinical Review and Vital Signs after Major Surgery.

McGain F, Cretikos MA, Jones D, et al. *Med J Aust.* 2008(Oct 6); 189(7):380–383.

This study evaluated the quality of clinical documentation for surgical patients at five hospitals in Victoria and New South Wales, Australia. The authors examined patient records to assess how frequently medical and nursing review and patient vital signs were documented during the postsurgical hospital stay for a total of 211 patients who had undergone surgery at the study hospitals over a 2-year period. Results showed that incomplete documentation occurred frequently and was associated with several hospital- and patient-related factors. Possible explanations for these findings and the implications for practice are discussed. Four tables are included.

6. Drawing the Line: Effective Management Strategies for Disruptive Behavior.

Porto G, Deen J.

Patient Saf Qual Healthcare. 2008(Nov/Dec); 5(6):20–28.

Available at: <http://www.psqh.com/novdec08/drawing.html>

Disruptive or inappropriate clinician behavior jeopardizes the safety of patients and healthcare staff and, despite increasing awareness of the issue, can be difficult to eradicate. This article describes how a large US healthcare system (Ohio-based Catholic Healthcare Partners) addressed disruptive behavior in its facilities and outlines prevention and management techniques derived from this organization's model.

7. Fundamentals of a Patient Safety Program.

Frush KS.

Pediatr Radiol. 2008(Nov); 38(Suppl 4):685–689.

In this commentary, the author distills some of the essential elements of a hospital-based patient safety program, with a focus on safety issues specific to the pediatric population. Dr. Frush draws upon the published literature as well her own experience as a pediatric emergency physician to illustrate these safety prerequisites and approaches to achieving these goals.

- 8. Hand-Off Communication: A Requisite for Perioperative Patient Safety.**
Amato-Vealey EJ, Barba MP, Vealey RJ.
AORN J. 2008(Nov); 88(5):763–770.
Surgical care processes are particularly vulnerable to error because of the complexity of the care and the need for intricate coordination of schedules and information among multiple providers. This article describes how the use of structured communication, in particular the SBAR (situation, background, assessment, recommendation) technique, can help improve inter-provider communication and reduce the risk of errors in each phase of the surgical continuum. A case study involving a surgical scheduling error is included. Three tables are included.
- 9. Identity Crisis: An Examination of the Costs and Benefits of a Unique Patient Identifier for the U.S. Health Care System.**
Hillestad R, Bigelow JH, Chaudhry B, et al.
Santa Monica, CA: RAND Corporation; 2008.
Available at: <http://www.rand.org/pubs/monographs/MG753/>
The adoption of a unique patient identifier (UPI) as part of a health information technology framework has been proposed as a means of improving quality and reducing errors in the US healthcare system. This monograph examines the possibilities for realizing a UPI approach and considers the potential benefits and costs of a UPI system in comparison with other patient identification methods.
- 10. Improving America’s Hospitals: The Joint Commission’s Annual Report on Quality and Safety 2008.**
Oakbrook Terrace, IL: The Joint Commission; November, 2008.
Available at: http://www.jointcommissionreport.org/pdf/JC_2008_Annual_Report.pdf
This publication presents national data on the safety and quality performance of Joint Commission-accredited hospitals in 2007 and analyzes trends in performance for the years 2002–2007. The Joint Commission’s assessment examines hospitals’ performance with respect to 25 measures in four categories of care (heart attack, heart failure, pneumonia, and surgical care) as well as compliance with the National Patient Safety Goals. The authors note that while overall performance on all measures has shown significant and steady improvement during the past six years, considerable regional variations in quality persist, and many opportunities for improvement remain.
- 11. Infection Dejection: HHS’ Plan to Release Guidelines on Infection Control Has Some Saying that Coordination Would Be of More Value.**
DerGurahian J.
Mod Healthcare. 2008(Sep 29); 38(39):6–7.
This article reports on the recent announcement by the US Department of Health and Human Services (HHS) of an action plan focusing on the management and prevention of healthcare-associated infections. The author highlights industry reactions to the announcement and notes that while healthcare executives regard the HHS initiative as a useful first step, some worry that it may not in itself be enough to spur improved performance.

12. International Nosocomial Infection Control Consortium Report, Data Summary for 2002–2007, Issued January 2008.

Rosenthal VD, Maki DG, Mehta A, et al., and International Nosocomial Infection Control Consortium Members.

Am J Infect Control. 2008(Nov); 36(9):627–637.

This article presents findings from a 6-year prospective study that monitored rates of device-associated infection (DAI) in hospital ICUs belonging to the International Nosocomial Infection Control Consortium (INICC). Surveillance data from 98 participating ICUs in Latin America, Asia, Africa, and Europe were analyzed and compared with data from hospitals in the US National Healthcare Safety Network (NHSN). Results indicated notably higher rates of DAI in INICC ICUs than in similar NHSN ICUs for all types of infections examined; in addition, rates of antimicrobial resistance for several types of pathogens were higher in the INICC ICUs. Possible explanations for these results and the implications for infection control and patient safety practice in the developing world are discussed. Multiple tables are included. [See also item 19.]

13. Medication Reconciliation in a Community, Nonteaching Hospital.

Wortman SB.

Am J Health-Syst Pharm. 2008(Nov 1); 65(21):2047–2054.

This article describes the development and implementation of a medication reconciliation program at a 250-bed community hospital. The program involved the adoption of facility-wide policies and procedures, including the use of standardized medication reconciliation forms, along with staff education and monthly audits to gauge progress. Strengths, weaknesses, and prospects for future expansion of the program are discussed. Two figures are included.

14. National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare.

National Priorities Partnership. Washington, DC: National Quality Forum; 2008.

Available at: [http://nationalprioritiespartnership.org/uploadedFiles/NPP/08-253-NQF%20ReportLo\[6\].pdf](http://nationalprioritiespartnership.org/uploadedFiles/NPP/08-253-NQF%20ReportLo[6].pdf)

This document, developed by a task force of the National Quality Forum, sets forth goals and recommendations for improving the quality and safety of the US healthcare system. The report identifies objectives and strategies for change in six target areas: patient and family engagement; population health; safety; care coordination; palliative and end-of-life care; and overuse. Examples of national and facility-based reform initiatives are included throughout.

- 15. Prevention of Pediatric Drug Calculation Errors by Prehospital Care Providers.**
Bernius M, Thibodeau B, Jones A, Clothier B, Witting M.
Prehosp Emerg Care. 2008(Oct-Dec); 12(4):486–494.
This study investigated whether the use of a quick reference chart would help prehospital care providers more accurately calculate appropriate medication doses for pediatric patients. A total of 523 emergency medical services personnel were asked to complete a questionnaire involving calculations of weight-based doses, volumes of administration, and endotracheal tube sizes either with or without access to the reference chart. Results showed that providers who used the chart had significantly more correct answers than those who did not, suggesting that use of such a tool provides a simple and low-cost means of improving safety in the prehospital care setting. Multiple tables and figures are included.
- 16. Reflections of a Patient Safety Officer.**
Shook J.
Pediatr Radiol. 2008(Nov); 38(Suppl 4):690–692.
In this essay, the author shares insights from her experience serving as patient safety officer (PSO) at a pediatric hospital in Houston, TX. Dr. Shook comments on the challenges and rewards of the role and describes how both her personal understanding and her organization’s approach to safety have evolved during her 5-year tenure as PSO.
- 17. The Business Case for Preventing Ventilator-Associated Pneumonia in Pediatric Intensive Care Unit Patients.**
Brilli RJ, Sparling KW, Lake MR, et al.
Jt Comm J Qual Patient Saf. 2008(Nov); 34(11):629–638.
This study sought to assess hospital costs and resource usage associated with the treatment of ventilator-associated pneumonia (VAP) in pediatric ICU (PICU) patients at Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio. Case-control analysis of thirteen matched pairs of PICU patients showed that patients who developed VAP incurred significantly higher costs and lengths of stay than did non-VAP patients during the 1-year period examined. The study also found statistically significant reductions in VAP rates in the PICU following implementation of a pediatric-specific VAP prevention “bundle”; the cost and resource savings associated with these reductions for hospitals and for third-party payers were estimated using the outputs of the case-control analysis. The authors argue that their findings illustrate a strong business case for use of the pediatric VAP prevention bundle as well as for other VAP prevention efforts. Five tables and one figure are included.

- 18. The Emotional Impact of Medical Error Involvement on Physicians: A Call for Leadership and Organisational Accountability.**
Schwappach DLB, Boluarte TA.
Swiss Med Wkly. Early online publication: 2008(Oct 14).
Available at: <http://www.smw.ch/docs/pdf200x/aop/smw-aop12417.pdf>
This review article synthesizes evidence from 32 studies concerning the effects of involvement in a medical error on physicians' health, emotional wellbeing, and work performance. Results indicated that physicians involved in errors experience a variety of serious and lasting emotional consequences, and that stress and burnout associated with having committed an error may undermine physicians' work performance and increase susceptibility to future errors. Noting the paucity of evidence about physicians' needs and institutional provision of support in the aftermath of an error, the authors call for organizational leadership and research to address these issues. One table and one figure are included.
- 19. The International Nosocomial Infection Control Consortium (INICC): Goals and Objectives, Description of Surveillance Methods, and Operational Activities.**
Rosenthal VD, Maki DG, Graves N.
Am J Infect Control. 2008(Nov); 36(9):e1–e12.
The International Nosocomial Infection Control Consortium (INICC), established in 1998, is an international partnership for surveillance and prevention of healthcare-associated infections (HAIs) in the ICU setting, with a focus on the dissemination of evidence-based infection control techniques in resource-poor areas. This article gives an overview of the consortium's history and mission, outlines membership requirements, and describes the methods for HAI surveillance and data reporting currently in use in INICC member hospitals. Two figures are included. [See also item 12.]
- 20. Underutilization of Information and Knowledge in Everyday Medical Practice: Evaluation of a Computer-Based Solution.**
Zakim D, Braun N, Fritz P, Alscher MD.
BMC Med Inform Decis Mak. 2008(Nov 5); 8(50).
Available at: <http://www.biomedcentral.com/1472-6947/8/50>
Evidence suggests that errors in medical history taking occur frequently and may negatively affect patient outcomes. This study compared physician-obtained medical histories with histories obtained via an interactive computer program for 45 patients at Robert-Bosch-Hospital, Stuttgart, Germany. Results showed that the computer-obtained histories documented a considerable amount of clinical information not captured by the physician-obtained histories; a comparatively small number of items were identified by physicians but not by the computer program. On the basis of these findings, the authors suggest that the use of such a computer program as a complement to traditional history taking could have significant benefits. Multiple tables and figures are included.

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Anita Spielman, Editor

aspelman@npsf.org