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- 1. A Method to Quantify Residents' Jargon Use During Counseling of Standardized Patients about Cancer Screening.**  
Deuster L, Christopher S, Donovan J, Farrell M.  
J Gen Intern Med. 2008(Dec); 23(12):1947–1952.  
*Physicians' overreliance on medical jargon is widely recognized as an impediment to effective provider-patient communication. In this study, the authors developed a novel text-abstraction method for measuring the prevalence of jargon words in transcribed dialogue; they then used the process to assess jargon use in transcripts of 86 simulated clinical encounters between medical residents and standardized patients. Results showed that the residents used jargon frequently and often did not explain the specialized terms. The authors comment on related research efforts and the potential applications of their method to large-scale assessment and quality improvement initiatives. Three tables and two figures are included.*
- 2. A Multidisciplinary Teamwork Training Program: The Triad for Optimal Patient Safety (TOPS) Experience.**  
Sehgal NL, Fox M, Vidyarthi AR, et al.  
J Gen Intern Med. 2008(Dec); 23(12):2053–2057.  
*This article describes the development, implementation, and evaluation of a team training program encompassing a comprehensive range of patient care disciplines. The program, developed as part of the collaborative initiative Triad for Optimal Patient Safety (TOPS), was designed to improve team coordination and communication and to increase team members' understanding of the relationship between team performance and patient safety. Participants' assessment of the program and insights learned from the experience are discussed. Two tables and one figure are included.*
- 3. Addressing Physicians' Impaired Communication Skills.**  
Egener B.  
J Gen Intern Med. 2008(Nov); 23(11):1890–1895.  
*This article describes a counseling technique designed by the author to assist physicians struggling to overcome poor communication skills and other types of problematic interpersonal behavior. The author—a physician and a consultant specializing in healthcare communication training—describes the development, implementation, and evaluation of the method and illustrates its application using two composite case studies. Three tables are included.*
- 4. Adverse Events in Hospitals: Overview of Key Issues.**  
Washington, DC: US Department of Health and Human Services, Office of Inspector General; December 2008. Publication OEI-06-07-00470.  
Available at: <http://www.oig.hhs.gov/oei/reports/oei-06-07-00470.pdf>  
*This study sought to define key considerations relating to the management of adverse events in US hospitals. The report synthesizes information from the published literature and from interviews with a wide range of healthcare and patient safety stakeholders in order to examine seven technical, organizational, and policy-related issues. [See also item 5.]*

**5. Adverse Events in Hospitals: State Reporting Systems.**

Washington, DC: US Department of Health and Human Services, Office of Inspector General; December 2008. Publication OEI-06-07-00471.

Available at: <http://www.oig.hhs.gov/oei/reports/oei-06-07-00471.pdf>

*This report presents findings of a government study that sought to systematically describe state-based adverse event reporting systems in the US. The study ascertained which states had implemented event reporting systems and classified the existing systems according to various factors, including system structure and oversight, event reporting criteria and requirements, and applications of collected data. Results showed that 26 states had reporting systems as of January 2008, and that states varied considerably with respect to definitions of reportable events and the information required to be included in event reports; most states were found to have strategies to improve reporting and to use collected data in similar ways. [See also item 4.]*

**6. Clinical Outcomes from the Use of Medication Report when Elderly Patients are Discharged from Hospital.**

Midlöv P, Deierborg E, Holmdahl L, Höglund P, Eriksson T.

Pharm World Sci. 2008(Dec); 30(6):840–845.

*This study investigated the impact of introduction of a standardized medication report for elderly patients discharged from a university hospital in Sweden. The authors compared post-discharge medical visits by patients discharged during two two-month periods: one group in which the medication report was used for all subjects, and a retrospective control group for whom no report was used. Results showed that patients in the intervention group had significantly fewer clinical visits attributable to medication error than did those from the control group, suggesting that use of the medication report may help improve medication safety during the discharge process. Two tables and one figure are included.*

**7. Defining Systems Expertise: Effective Simulation at the Organizational Level—Implications for Patient Safety, Disaster Surge Capacity, and Facilitating the Systems Interface.**

Kaji AH, Bair A, Okuda Y, Kobayashi L, Khare R, Vozenilek J.

Acad Emerg Med. 2008(Nov); 15(11):1098–1103.

*This article, which derives from a presentation at the 2008 Academic Emergency Medicine Consensus Conference on the Science of Simulation, seeks to articulate critical research questions concerning the application of simulation-based training as a means to improve patient safety and to enhance disaster risk assessment and response readiness. Drawing upon evidence from published literature as well as expert opinion, the authors present six key questions along with recommendations as to how research in each of these areas might proceed.*

- 8. Economic Evaluations of Maintaining Patient Safety Systems in Teaching Hospitals.**  
Fukuda H, Imanaka Y, Hirose M, Hayashida K.  
Health Policy. 2008(Dec); 88(2-3):381-391.  
*This study sought to assess the costs associated with hospital-wide patient safety and infection control activities at teaching hospitals in Japan. The authors conducted a national survey of Japan's teaching hospitals to assess hospital resource expenditures related to patient safety in ten domains of activity. They then used data from this survey to estimate the costs of maintaining a patient safety system at the hospital and national levels. Results showed that the activities required to maintain a patient safety system were associated with substantial costs at both the facility and national levels. Details of the results and possible applications of this research are discussed. Five tables and one figure are included.*
- 9. Household-Related Hazardous Conditions with Implications for Patient Safety in the Home Health Care Sector.**  
Gershon RRM, Canton AN, Raveis VH, et al.  
J Patient Saf. 2008(Dec); 4(4):227-234.  
*This study sought to describe the nature and frequency of conditions that could compromise patient safety in the home healthcare environment. The authors conducted a survey of 738 home healthcare nurses in New York State that asked respondents whether they had observed any of various detrimental conditions in the homes of patients for whom they provided care. Results showed that respondents frequently reported having encountered potentially hazardous conditions related to home hygiene and maintenance; many respondents also perceived threats of violence from a patient's neighborhood, household pets, or family members. Possible approaches to addressing these issues and recommendations for further research in this area are discussed. Three tables and one figure are included.*
- 10. Identifying Methods to Improve Heart Surgery: An Operative Approach and Strategy for Implementation on an Organizational Level.**  
ElBardissi AW, Wiegmann DA, Henrickson S, Wadhera R, Sundt TM III.  
Eur J Cardiothorac Surg. 2008(Nov); 34(5):1027-1033.  
*This study used methods from human factors analysis to investigate the relationship between surgical team characteristics and the incidence of errors in cardiac surgery. A previous study by the same authors analyzed data from direct observation of thirty-one cardiac operations and found that failures in teamwork were strongly correlated with surgical error. The present study further analyzed the observation data to identify team factors associated with error. Results indicated, among other findings, that teams whose members regularly worked together experienced fewer errors than did those whose members were less familiar with each other and/or with the operating surgeon. On the basis of these results, the authors suggest that strategies targeting team structure and communication may be a useful tool for reducing surgical errors; several potential such strategies are described. Four figures are included.*

- 11. Interprofessional Conflict and Medical Errors: Results of a National Multi-Specialty Survey of Hospital Residents in the US.**  
Baldwin DC Jr, Daugherty SR.  
J Interprof Care. 2008(Dec); 22(6):573–586.  
*This article explores the relationship between interprofessional conflict and medical error as depicted in findings from a national survey of more than 6,000 first- and second-year medical residents that examined multiple aspects of the resident experience. Survey results showed that respondents who reported having experienced conflict with other residents or medical personnel during their current year of residency were more likely to report having made a significant error during the same period. The authors comment on the implications of this result and propose several conceptual approaches to guide further consideration of this issue. Four tables and one figure are included.*
- 12. Medical Simulation: A Tool for Recognition of and Response to Risk.**  
Ruddy RM, Patterson MD.  
Pediatr Radiol. 2008(Nov); 38(Suppl 4):S700–S706.  
*This article provides an overview on the role of medical simulation as a tool for reducing errors and improving safety in the delivery of care. In the first part of the article, the authors summarize the ethical and pedagogical arguments supporting the use of simulation-based training as a component of medical education. In the second part, they describe the simulation program developed at their facility and highlight team-training and communication techniques that can be used effectively as part of a simulation exercise. Three tables and one figure are included.*
- 13. Medication Errors Involving Patient-Controlled Analgesia.**  
Hicks RW, Heath WM, Sikirica V, Nelson W, Schein JR.  
Jt Comm J Qual Patient Saf. 2008(Dec); 34(12):734–742.  
*This study sought to characterize medication errors associated with patient-controlled analgesia (PCA) in comparison with other types of medication errors and with respect to multiple factors. The authors analyzed MEDMARX® medication error data from a 5-year period with respect to severity, type, and cause of error, contributing factors, and other variables for PCA- and non-PCA-related errors. Results, detailed in the article, indicated that PCA errors differed from non-PCA errors with respect to both nature and severity; PCA errors were associated with a greater relative risk of harm than were non-PCA errors. Implications of these findings and strategies for improving PCA-related safety are discussed. Multiple tables and figures are included.*

- 14. Numeracy and Communication with Patients: They Are Counting on Us.**  
Apter AJ, Paasche-Orlow MK, Remillard JT, et al.  
J Gen Intern Med. 2008(Dec); 23(12):2117–2124.  
*Numeracy—a measure of quantitative ability or capacity to interpret and apply information presented in numerical form—is an important component of health literacy and, as with health literacy, may significantly influence healthcare outcomes. In this article, the authors review current findings on numeracy levels and associated health outcomes; they then present a conceptual model of numerical comprehension along with recommended practices for improving communication of numerical information. Two tables and one figure are included.*
- 15. Patients’ and Family Members’ Experiences of Open Disclosure Following Adverse Events.**  
Iedema R, Sorensen R, Manias E, et al.  
Int J Qual Health Care. 2008(Dec); 20(6):421–432.  
*As part of a national initiative organized by the Australian Commission on Safety and Quality in Healthcare, hospitals in five Australian States have recently implemented policies requiring open disclosure to patients involved in adverse medical events. In this study, the authors interviewed 23 patients at hospitals participating in the open disclosure initiative who had experienced adverse events and subsequent disclosure of the events by healthcare providers. The authors found that while patients regarded the disclosure process as helpful overall, many felt that the process left some of their needs and concerns unaddressed. Implications of these results and recommendations for improving disclosure practice are discussed. Three tables are included.*
- 16. Reducing Catheter-Associated Blood Stream Infections in a Pediatric Intensive Care Unit: A Collaborative Effort.**  
Sharar ZA, Northway T, Skippen P, et al.  
J Patient Saf. 2008(Dec); 4(4):221–226.  
*This article describes the implementation and impact of an initiative aimed at reducing the incidence of catheter-related blood stream infection (CA-BSI) in the pediatric ICU of a tertiary academic hospital in Vancouver, British Columbia. The intervention involved implementation of a bundle of recommended practices for catheter insertion and maintenance along with staff education. Comparison of pre- and post-intervention data showed significant reduction in rates of CA-BSI following implementation of the program. One table and two appendices are included.*

- 17. Revisiting Duty-Hour Limits — IOM Recommendations for Patient Safety and Resident Education.**  
Iglehart JK.  
N Engl J Med. 2008(Dec 18); 359(25):2633–2635.  
*This commentary addresses the recently released Institute of Medicine (IOM) report Resident Duty Hours: Enhancing Sleep, Supervision, and Safety. Iglehart summarizes the contents of report, which examines the impact of the resident duty-hour regulations instituted by the Accreditation Council for Graduate Medical Education (ACGME) in 2003 and ultimately calls for further interventions and stricter oversight than stipulated by the ACGME mandate. The author reviews the history of duty-hour legislation, discusses the rationale behind the IOM's new recommendations, and comments on the financial and staffing implications for hospitals were the recommendations to be adopted.*
- 18. Risk Management and Medicolegal Issues Related to Postpartum Haemorrhage.**  
Upadhyay K, Scholefield H.  
Best Pract Res Clin Obstet Gynaecol. 2008(Dec); 22(6):1149–1169.  
*Postpartum hemorrhage (PPH) is a serious and relatively common obstetric adverse event. In this article, the authors summarize recent UK data on the incidence and clinical circumstances of PPH; they then review current evidence concerning patient and organizational risk factors for PPH and outline a variety of risk reduction strategies and techniques. Multiple tables and figures are included.*
- 19. Safely Implementing Health Information and Converging Technologies.**  
The Joint Commission.  
Sentinel Event Alert. Issue 42, December 11, 2008.  
Available at:  
[http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea\\_42.htm](http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_42.htm)  
*The introduction of new health information technology (HIT) systems or applications may generate unanticipated patient safety hazards and opportunities for error. This Sentinel Event Alert reviews data on the incidence, nature, and causes of HIT-associated safety incidents, highlights relevant Joint Commission requirements, and outlines risk reduction strategies.*

**20. Safety of Acupuncture Practice in Japan: Patient Reactions, Therapist Negligence and Error Reduction Strategies.**

Yamashita H, Tsukayama H.

Evid Based Complement Alternat Med. 2008(Dec); 5(4):391–398.

*Safety events associated with acupuncture therapy have until recently received relatively little attention in the medical literature. In this article, the authors review current evidence concerning the safety of acupuncture practice in Japan and characterize common adverse reactions and practitioner errors; finally, they describe the implementation of a clinic-based incident reporting system intended to improve acupuncturists' awareness of and adherence to safety practices. While the authors conclude on the basis of their findings that acupuncture is by nature low-risk, they recommend the institution of required postgraduate training and a system of continuing provider education as a means of reinforcing patient safety. Multiple tables are included.*

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