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1. Disclosing Errors to Patients: Perspectives of Registered Nurses.

Shannon SE, Foglia MB, Hardy M, Gallagher TH.
Jt Comm J Qual Patient Saf. 2009(Jan); 35(1):5–12.

In this study, the authors interviewed 96 registered nurses from four Puget Sound, Wash, healthcare facilities to explore nurses' attitudes and experiences concerning disclosure of medical error to patients. The authors found that nurses customarily disclosed errors that caused negligible harm and that did not involve other care providers, but deferred disclosure to senior colleagues when the error was more serious or involved other care providers. While nurses conceptualized error disclosure as a team effort, in practice they often felt shut out of the disclosure process. Nurses reported that this lack of involvement placed them in ethically and professionally awkward situations and hindered their communication with patients who had experienced an error. Implications of these results and recommendations for the development of team disclosure processes are discussed. Two tables are included.

2. Factors Associated with Intern Fatigue.

Friesen LD, Vidyarthi AR, Baron RB, Katz PP.
J Gen Intern Med. 2008(Dec); 23(12):1981–1986.

While the Accreditation Council for Graduate Medical Education's (ACGME) duty-hour regulations aimed to improve safety by reducing provider fatigue and associated medical errors, the causes of fatigue among medical interns remain poorly understood. To explore this question, the authors conducted a survey that assessed self-reported fatigue, work hours, sleep quality, stress, and teamwork-related factors in a cross-sectional sample of interns at the University of California, San Francisco (the survey was administered eight months after the implementation of ACGME-mandated duty-hour restrictions in July, 2003). Results showed high levels of self-reported fatigue in the study sample; of the factors examined, only sleep quality and stress significantly affected fatigue, and no significant association was observed between fatigue and number of hours worked. On the basis of these results, the authors suggest that greater attention to the influence of work-related factors on fatigue may be warranted. Three tables and one figure are included.

3. HHS Action Plan to Prevent Healthcare-Associated Infections.

Washington, DC: US Department of Health and Human Services; January 2009.

Available at: <http://www.hhs.gov/ophs/initiatives/hai/index.html>

This document presents a national agenda for the reduction and prevention of healthcare-associated infections (HAIs). The first sections of the plan set forth goals and metrics for HAI prevention, along with a prioritized list of Centers for Disease Control and Prevention recommendations. The following sections propose guidelines concerning elements of the infrastructure needed to support a comprehensive HAI reduction effort, including research; information systems and technology; regulatory oversight; outreach; and administrative coordination and evaluation.

- 4. Hospital-Wide Code Rates and Mortality before and after Implementation of a Rapid Response Team.**
Chan PS, Khalid A, Longmore LS, Berg RA, Kosiborod M, Spertus JA.
JAMA. 2008(Dec 3); 300(21):2506–2513.
This study assessed the effect of rapid response team implementation on facility-wide code (i.e., cardiac or respiratory arrest) and mortality rates at a tertiary care academic hospital. The authors sought to extend existing research, which has shown that rapid response team implementation reduces code rates among non-ICU patients but has not examined this relationship on a hospital-wide level. In the present study, an analysis of prospectively collected data from comparable 20-month periods before and after rapid response team implementation showed no significant reductions in either hospital-wide code rates or mortality following the intervention. Possible explanations for this result and implications are discussed in detail. Four tables and two figures are included.
- 5. Implementing a Patient Safety and Quality Program across Two Merged Pediatric Institutions.**
Abramson E, Hyman D, Osorio SN, Kaushal R.
Jt Comm J Qual Patient Saf. 2009(Jan); 35(1):43–48.
This article describes a pediatric patient safety and quality improvement program recently implemented at New York-Presbyterian Hospital, New York City. The authors describe the structure of the program, comment on barriers and facilitators to its success, and highlight ongoing initiatives and future plans. In particular, they discuss the challenges of designing and implementing a safety program for a merged institution with two separate campuses. One figure is included.
- 6. In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008.**
Schoen C, Osborn R, How SKH, Doty MM, Peugh J.
Health Aff. 2009(Jan/Feb); 28(1):w1–w16 (published online November 13, 2008).
This study compared the healthcare-related experiences of adults with chronic medical conditions in eight industrialized countries (Australia, Canada, France, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States). A total of nearly 7,500 chronically ill adults in the eight countries were surveyed concerning their healthcare system use and their perceptions of healthcare system access, safety, efficiency, cost, and overall performance. While respondents in all countries felt that their respective systems could be improved, US patients overall had the least favorable opinion. US patients also disproportionately experienced problems with care coordination, limited access to care due to high costs, and medical errors. Further results and implications are discussed. Multiple tables are included.

- 7. Inpatient Medication History Verification by Pharmacy Students.**
Mersfelder TL, Bickel RJ.
Am J Health-Syst Pharm. 2008(Dec 1); 65(1):2273–2275.
This study investigated whether involvement of pharmacy students in the medication history taking process could improve the quality of histories obtained from patients at a community teaching hospital. Medication histories obtained upon hospital admission were compared with histories subsequently obtained by pharmacy students for a total of 326 internal medicine patients. Results showed that the students frequently identified medication or dosage information absent from the initial medication history, leading to improvements in accuracy or thoroughness in 67% of the medication histories studied. Two tables are included.
- 8. Knowledge Is Power: Averting Safety-Compromising Events in the OR.**
Catalano K.
AORN J. 2008(Dec); 88(6):987–995.
This article discusses patient safety incidents in the perioperative environment and describes resources that can help nurses be better prepared to address these issues. The author reviews resources provided by the Joint Commission and other organizations and highlights ongoing state and federal initiatives related to patient safety.
- 9. Medical Diagnoses Commonly Associated with Pediatric Malpractice Lawsuits in the United States.**
McAbee GN, Donn SM, Mendelson RA, McDonnell WM, Gonzalez JL, Ake JK.
Pediatrics. 2008(Dec); 122(6):e1282–e1286.
Available at: <http://www.pediatrics.org/cgi/content/full/122/6/e1282>
This study used closed claims analysis to examine characteristics of pediatric malpractice litigation in the United States. The authors reviewed national claims data from the Physician Insurers Association of America (PIAA) database for the years 1985 to 2006 to identify the medical conditions and circumstances of care most frequently associated with lawsuits against pediatricians. In this article, they discuss findings concerning selected conditions and outline general strategies for reducing pediatric malpractice vulnerability. Multiple tables are included.
- 10. Medication Errors Occurring with the Use of Bar-Code Administration Technology.**
Pennsylvania Patient Safety Authority.
Pa Patient Saf Advis. 2008(Dec); 5(4):122–126.
Available at:
[http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5\(4\)/Pages/122.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5(4)/Pages/122.aspx)
This article discusses medication safety incidents associated with the use of bar-code medication administration (BCMA) technology. In a review of reports from the Pennsylvania Patient Safety Reporting System (PA-PSRS) database, the authors found that BCMA-related medication errors occurred at multiple stages of the medication administration process and involved errors both directly and indirectly related to the technology itself. Several sample PA-PSRS cases are discussed as an illustration of the various error types and causes. Risk reduction strategies are outlined.

- 11. Narrative Review: Do State Laws Make It Easier to Say “I’m Sorry?”**
McDonnell WM, Guenther E.
Ann Intern Med. 2008(Dec 2); 149(11):811–815.
A number of US states have established “apology laws” designed to promote disclosure of medical error by precluding the admission of physician apologies as legal evidence. This article presents findings from a study that systematically identified and categorized existing state apology laws as of November, 2007. The authors found that 36 states had apology laws in effect, many of which had been adopted recently, and that the provisions of the laws varied significantly from state to state. The potential effects of apology legislation and its implications for policy and practice are discussed. One table and one figure are included.
- 12. Pediatric Aspects of Inpatient Health Information Technology Systems.**
Kim GR, Lehmann CU, and the Council on Clinical Information Technology.
Pediatrics. 2008(Dec); 122(6):e1287–e1296.
Available at: <http://www.pediatrics.org/cgi/content/full/122/6/e1287>
This article reviews issues and considerations relating to the adoption and use of health information technology (HIT) in pediatric inpatient care. The authors discuss the safety and quality rationale for HIT adoption in the pediatric setting; they then describe HIT applications that address two specific error-prone processes of care: medication delivery and patient care transitions.
- 13. Physician Autonomy and Informed Decision Making: Finding the Balance for Patient Safety and Quality.**
Mathews SC, Pronovost PJ.
JAMA. 2008(Dec 24/31); 300(24):2913–2915.
While the movement toward standards-based medicine is considered essential to the improvement of healthcare quality and safety, perceived challenges to physician autonomy may inhibit the adoption of standards-based practices. This commentary reflects on the tension between the goals of standardization and the preservation of appropriate physician autonomy and considers how these apparently conflicting objectives might be reconciled.
- 14. Root Cause Analysis: Are We Looking for Keys under the Lamp Post?**
Wu AW, Cuong J, Pronovost P.
Focus on Patient Saf. 2008(Winter); 11(4):3–5.
Available at: http://npsf.org/paf/npsfp/fo/pdf/Focus_Volume_11_Issue_4.pdf
This article takes a critical look at root cause analysis (or RCA), a procedure used by many healthcare organizations to investigate instances of serious patient harm. The authors identify problems that may undermine the effectiveness of RCA and outline strategies to help organizations better realize the potential of this tool.

- 15. The Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) National Prevalence Study of *Clostridium difficile* in U.S. Healthcare Facilities: Overview and Key Findings.**
Association for Professionals in Infection Control and Epidemiology; November 2008.
Available at: <http://www.apic.org/AM/CM/ContentDisplay.cfm?ContentFileID=11410>
This brief report summarizes findings from a May, 2008 survey to assess the prevalence of Clostridium difficile infection and colonization in US hospitals. A total of 648 hospitals in 47 states with a total of 110,550 inpatients participated in the survey. The study found that C. difficile infection/colonization occurred at a rate of 1.3% among inpatients in the study sample — a considerably higher rate than has been documented in previously, smaller-scale studies. Additional findings including national estimates of the cost and impact of C. difficile infection are noted.
- 16. The CLABs Collaborative: A Regionwide Effort to Improve the Quality of Care in Hospitals.**
Koll BS, Straub TA, Jalon HS, Block R, Heller KS, Ruiz RE.
Jt Comm J Qual Patient Saf. 2008(Dec); 34(12):713–723.
This article describes the design, implementation, and results of a multihospital initiative aimed at reducing the incidence of central line-associated bloodstream (CLAB) infections in the intensive care unit setting. The collaborative initiative, developed in partnership by the Greater New York Hospital Association (GNYHA) and the United Hospital Fund and carried out in 36 GNYHA hospitals, used hospital-based interdisciplinary teams to support implementation of evidence-based practices for central line insertion and maintenance. Results showed that participating hospitals achieved significant reductions in CLAB infection rates during the 33-month intervention period. The authors discuss further details of their results and comment on challenges encountered and lessons learned. Multiple tables and figures are included.
- 17. The Increasing Number of Clinical Items Addressed During the Time of Adult Primary Care Visits.**
Abbo ED, Zhang Q, Zelder M, Huang ES.
J Gen Intern Med. 2008(Dec); 23(12):2058–2065.
This study sought to assess quantitatively whether the length of adult primary care visits, the amount of care provided during these visits, and the relationship between care provided and time available have changed in recent years. The authors used data on office-based primary care visits in the US (from the National Center for Health Statistics' National Ambulatory Medical Care Survey) to calculate average visit duration, number of clinical items addressed per visit, and time available per item for visits during the years 1997 to 2005. Results indicated that while both the number of items addressed per visit and the length of visits increased over the period examined, the increase in number of clinical items was proportionately greater, resulting in a decrease in the time spent per clinical item. Possible explanations for the observed changes and the implications for quality of care and payment policy are discussed. Four tables and one figure are included.

18. Timely Follow-Up of Abnormal Outpatient Test Results: Perceived Barriers and Impact on Patient Safety.

Moore C, Saigh O, Trikha A, Lin JJ.

J Patient Saf. 2008(Dec); 4(4):241–244.

This study examined physicians' perceptions concerning timeliness of follow-up on outpatient test results and the causes and clinical impact of delayed follow-up. In a survey of nearly 200 physicians at three New York City academic medical centers, the authors asked respondents how often they experienced delays in following up on results of six common types of outpatient tests; whether they had observed instances of patient harm attributable to delayed follow-up; and the reasons for such delays. Results indicated that respondents perceived delays in follow-up as being a frequent occurrence that sometimes negatively affected treatment or caused harm to patients. The authors discuss these results and comment on the need for technological and organizational strategies to address this issue. Two tables and two figures are included.

19. Tubular Dressing Retainer: Retention without Restriction.

Pennsylvania Patient Safety Authority.

Pa Patient Saf Advis. 2008(Dec); 5(4):127–129.

Available at:

[http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5\(4\)/Pages/127.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5(4)/Pages/127.aspx)

This article discusses patient safety incidents associated with the use of tubular dressing retainers, a type of stretchy bandage applied over a wound dressing to hold the dressing in place. Several cases involving improper application of these devices are documented in state and federal incident report databases. The authors note that while such incidents appear uncommon, the clinical consequences may be serious and have involved significant patient harm. Strategies to help ensure safe practice are discussed, with an emphasis on educating staff and patients about the issue. One figure is included.

20. What Do You Do When Your Loved One Is Ill? The Line between Physician and Family Member.

Fromme EK, Farber NJ, Babbott SF, Pickett ME, Beasley BW.

Ann Intern Med. 2008(Dec 2); 149(11):825–829.

Evidence suggests that many physicians sometimes provide medical treatment for their own family members, although the practice is generally discouraged. This article explores this issue through a candid discussion of the authors' own experiences. The authors describe instances in which they treated or became involved in the care of family members and comment on the consequences—positive and negative—of this involvement. Finally, they offer suggestions as to how physicians can participate in the care of loved ones safely and appropriately. One table is included.

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