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- 1. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population.**  
Haynes AB, Weiser TG, Berry WR, et al., for the Safe Surgery Saves Lives Study Group. *N Engl J Med.* 2009(Jan 29); 360(5):491–499 (published online January 14, 2009).  
*As part of the World Health Organization (WHO) Safe Surgery Saves Lives initiative, eight hospitals in locations around the world participated in a pilot evaluation of the WHO surgical safety checklist. In this study, the authors compared pre- and post-intervention data to assess the impact of use of the checklist on rates of surgical complications at the participating hospitals. They found that overall rates of complications and mortality decreased significantly (by about one-third) following implementation of the checklist. While some hospitals experienced a more pronounced impact, all participating hospitals experienced reductions in complications, and significant reductions occurred at both high- and low-income sites. Implications of these findings and possibilities for further research are discussed. Multiple tables are included.*
- 2. A System Analysis of a Suboptimal Surgical Experience.**  
Lee RC, Cooke DL, Richards M.  
*Patient Saf Surg.* 2009(Jan 6); 3:1.  
Available at: <http://www.pssjournal.com/content/3/1/1>  
*This case study analyzes a healthcare episode in which the patient (one of the authors of the article) encountered multiple instances of suboptimal care. The authors use a system dynamics approach to model the systems involved in this case and to identify the sources of the problems that occurred. The authors comment on system changes implemented as a result of this study and discuss potential further applications of this technique. One table and four figures are included.*
- 3. Adverse Health Care Events Reporting System: What Have We Learned?**  
St. Paul, MN; Minnesota Department of Health; January 2009.  
Available at: <http://www.health.state.mn.us/patientsafety/publications/09aheeval.pdf>  
*Minnesota's Adverse Health Care Events Law, enacted in 2003, established a state adverse events reporting system to which Minnesota healthcare facilities must report occurrences of any of a set of serious adverse events. This report evaluates the impact of this legislation during the five years since its implementation, presents data on reported events, and outlines recommendations for next steps and further improvements.*

**4. Certified Nursing Assistants' Perceptions of Nursing Home Patient Safety Culture: Is There a Relationship to Clinical Outcomes?**

Bonner AF, Castle NG, Men A, Handler SM.

J Am Med Dir Assoc. 2009(Jan); 10(1):11–20.

*This study examined the relationship between patient safety culture and patient outcomes in the nursing home setting. The authors first surveyed certified nursing assistants (CNAs) at 72 US nursing homes concerning their perceptions of patient safety culture at their facilities. Survey responses were analyzed correlatively with data on facility-level rates of three safety- and quality-related outcomes: falls, pressure ulcers, and restraint use. Results showed that facilities that rated more favorably with respect to patient safety culture tended to have higher rates of reported falls (possibly reflecting a greater emphasis on event reporting) as well as lower rates of restraint use than did other facilities; no association between safety culture ratings and incidence of pressure ulcers was observed. Three tables, one figure, and an appendix are included.*

**5. Clinical Information Technologies and Inpatient Outcomes: A Multiple Hospital Study.**

Amarasingham R, Plantinga L, Diener-West M, Gaskin DJ, Powe NR.

Arch Intern Med. 2009(Jan 26); 169(2):108–114.

*This study examined the relationship between health information technology use and patient outcomes in a cross-sectional group of urban Texas hospitals. The authors used a previously developed survey tool assess the extent of clinicians' IT use at participating hospitals; survey data were analyzed correlatively with data on hospital inpatient mortality, complications, costs, and lengths of stay. Results showed that greater automation of clinical information processes was associated with lower rates of complications and mortality and lower costs for hospitals in the study sample (no clear impact on lengths of stay was discerned). Implications of these findings and questions for further research are discussed. The authors suggest that further studies should address potentially confounding circumstances not addressed in the present study, such as the likelihood that hospitals that embrace clinical IT applications have stronger organizational support for patient safety than those that do not. Five tables are included.*

**6. Community-Wide Implementation of Health Information Technology: The Massachusetts eHealth Collaborative Experience.**

Goroll AH, Simon SR, Tripathi M, Ascenzo C, Bates DW.

J Am Med Inform Assoc. 2009(Jan/Feb); 16(1):132–139.

*The Massachusetts eHealth Collaborative is a multi-stakeholder initiative that aims to promote region-wide adoption of electronic health record (EHR) systems in communities throughout the state of Massachusetts. In this article, the authors outline the design and implementation of the program, discuss important considerations and challenges encountered, and comment on policy implications and future prospects. Multiple tables and figures are included.*

**7. Developing a Radiation Error Scoring System to Monitor Quality Control Events in a Radiation Oncology Department.**

Konski A, Movsas B, Konopka M, Ma C, Price R, Pollack A.

J Am Coll Radiol. 2009(Jan); 6(1):45–50.

*This article describes the development of a system for the classification and analysis of treatment errors in the radiation oncology department of Fox Chase Cancer Center, Philadelphia, Pa. The authors looked at all quality control events reported in 2003 and used the system to classify the events by type, severity, and various patient- and treatment-related factors. They discuss their findings and comment on strategies for preventing errors in the radiation therapy setting. Four tables and two figures are included.*

**8. Factors Associated with System-Level Activities for Patient Safety and Infection Control.**

Fukuda H, Imanaka Y, Hirose M, Hayashida K.

Health Policy. 2009(Jan); 89(1):26–36.

*This study investigated the relationship between hospital characteristics and patient safety and infection control activities at teaching hospitals in Japan. The authors correlatively analyzed survey data from 418 hospitals to determine whether certain aspects of hospital infrastructure were associated with amounts of staff time devoted to patient safety-related activities. Results showed that hospitals with greater financial resources and those with dedicated patient safety and infection control personnel had significantly more person-hours devoted to patient safety and infection control activities; hospitals where staff perceived deficits in leadership support for patient safety tended to have lower levels of patient safety activity. Economic and policy implications of these findings are discussed. Three tables are included.*

**9. Healthcare Consumers: Essential Partners in Safe Medication Use.**

Cohen MR.

Focus Patient Saf. 2008(Winter); 11(4):1–3.

Available at: [http://npsf.org/paf/npsfp/fo/pdf/Focus\\_Volume\\_11\\_Issue\\_4.pdf](http://npsf.org/paf/npsfp/fo/pdf/Focus_Volume_11_Issue_4.pdf)

*The consequences of unsafe medication use by patients in the home setting are a source of increasing concern. This article emphasizes the need for consumer involvement in the safe medication use process and offers strategies for improving patient-provider communication about medication-related instructions and the risks of incorrect use. Consumer-oriented medication safety resources are highlighted, including a new online resource recently launched by the Institute for Safe Medication Practices, [www.ConsumerMedSafety.org](http://www.ConsumerMedSafety.org).*

**10. Impact of a Patient Care Pathway Protocol on Surgical Site Infection Rates in Cardiothoracic Surgery Patients.**

Trussell J, Gerkin R, Coates B, et al.

Am J Surg. 2008(Dec); 196(6):883–889.

*This study evaluated the impact of a quality improvement initiative on rates of surgical site infection (SSI) in cardiac surgical patients at Banner Good Samaritan Medical Center, Phoenix, Ariz. The intervention involved the implementation of a set of evidence-based practices for the perioperative management of patients undergoing coronary artery bypass graft surgery, including antibiotic prophylaxis, tight glucose control, and hair removal with clippers rather than shaving. Results showed that SSI rates were significantly lower among patients treated according to the protocol than in a pre-intervention control group. Three tables are included.*

**11. Improving Patient Understanding of Prescription Drug Label Instructions.**

Davis TC, Federman AD, Bass PF III, et al.

J Gen Intern Med. 2009(Jan); 24(1):57–62.

*This study investigated whether variations in the phrasing of instructions on prescription labels would influence patients' understanding of dosage instructions. The authors conducted interviews with a total of 359 adult ambulatory patients in which participants were shown ten labeled medication bottles and asked to indicate how they would take each medication. The wording of the instructions on the labels was deliberately varied to present a range of more- and less-specific phrasings. Results showed that patients were significantly more likely to interpret the instructions correctly when the instructions were more specific, although patients with low literacy more frequently misunderstood the instructions even when more precise language was used. On the basis of these findings, the authors suggest that expressing dosage information in concrete language may help improve patients' comprehension of printed medication instructions. Three tables are included.*

**12. Improving the Quality of Health Care: Who Is Responsible for What?**

Wharam JF, Sulmasy D.

JAMA. 2009(Jan 14); 301(2):215–217.

*This commentary seeks to define healthcare quality and to delineate the quality-related roles of various healthcare stakeholders. The authors propose a framework depicting the individual and overlapping responsibilities of physicians, healthcare institutions and policy makers, and patients. Finally, they apply this model in a critique of incentive-based quality improvement strategies. One table is included.*

- 13. IOM: Shorten Residents' Work Shifts to Reduce Fatigue, Improve Patient Safety.**  
Kuehn BM.  
JAMA. 2008(Jan 21); 301(3):259–261.  
*The recently released Institute of Medicine (IOM) report Resident Duty Hours: Enhancing Sleep, Supervision, and Safety evaluates the impact of resident duty-hour limits imposed by the Accreditation Council for Graduate Medical Education (ACGME) in 2003 and calls for modifications to the original ACGME guidelines as well as additional measures to improve patient safety. This article highlights the main points of the report and comments on the ongoing controversy surrounding resident work schedules and patient safety.*
- 14. Jack Barney Award: The Effect of Fatigue on Cognitive and Psychomotor Skills of Trauma Residents and Attending Surgeons.**  
Gerdes J, Kahol K, Smith M, Leyba MJ, Ferrara JJ.  
Am J Surg. 2008(Dec); 196(6):813–820.  
*This study sought to assess the impact of fatigue on surgical skill and to compare the effects of fatigue in senior clinicians versus in trainees. The authors looked at how well trauma residents and attending trauma surgeons performed several simulated surgical tasks under different levels of fatigue (to compare performance in fatigued and non-fatigued states, participants were tested before and after they had been on call). Results showed that fatigue negatively affected surgical proficiency in both residents and attending surgeons. Fatigue-related impairment affected cognitive ability more than psychomotor skill, and while both groups made more cognitive errors when fatigued, the attending surgeons made significantly fewer errors than did the residents. Five figures are included.*
- 15. Missed Nursing Care: Errors of Omission.**  
Kalisch BJ, Landstrom G, Williams RA.  
Nurs Outlook. 2009(Jan/Feb); 57(1):3–9.  
*Missed nursing care, defined as any element of nursing care that should be provided but instead is omitted, is an understudied phenomenon that may significantly affect patient safety. This study surveyed a total of 459 nurses at three Michigan hospitals to assess the prevalence, nature, and causes of missed nursing care. Results suggested that missed nursing care occurred frequently and for a variety of reasons; resource constraints, followed by faulty communication, were the most frequently cited reason for missed care. Implications of these findings and possible approaches to addressing this issue are discussed. Three tables are included.*

- 16. Proceedings of a Summit on Preventing Patient Harm and Death from I.V. Medication Errors.**  
Am J Health-Syst Pharm. 2008(Dec 15); 65(24):2367–2379.  
Available at:  
<http://www.ashp.org/DocLibrary/Policy/PatientSafety/IVSafety/IVSafetySummitProceedings.pdf>  
*This article summarizes proceedings from a July, 2008 summit conference on improving IV medication safety. The authors present consensus-derived recommendations that emerged from the meeting, including a prioritized list of medication safety best practices; strategies for overcoming implementation challenges; and short- and long-term actions required from regulatory agencies, professional organizations, and other stakeholders to enable these efforts to succeed. Two tables are included.*
- 17. State of Healthcare 2008.**  
London, England: Commission for Healthcare Audit and Inspection; December 2008.  
Available at:  
[http://www.healthcarecommission.org.uk/db/documents/State\\_of\\_Healthcare\\_2008.pdf](http://www.healthcarecommission.org.uk/db/documents/State_of_Healthcare_2008.pdf)  
*This report provides an overview of National Health Service (NHS) performance and documents the progress of numerous safety and quality improvement efforts. The report includes data on NHS hospitals' compliance with national standards, an update on the prevalence and management of healthcare-associated infections, and a discussion of consumers' experiences with the healthcare system based on national patient surveys.*
- 18. The Evolving Concept of Health Literacy.**  
Nutbeam D.  
Soc Sci Med. 2008(Dec); 67(12):2072–2078.  
*This article reviews current thinking about health literacy and compares two discrete conceptualizations of health literacy that have emerged from the fields of medicine and public health respectively. The author discusses the theoretical and practical implications of these differing approaches, comments on the strengths and limitations of each, and considers how each of these viewpoints could inform future health literacy work. Two figures are included.*
- 19. The Nomenclature of Safety and Quality of Care for Patients with Congenital Cardiac Disease: A Report of the Society of Thoracic Surgeons Congenital Database Taskforce Subcommittee on Patient Safety.**  
Jacobs JP, Benavidez OJ, Bacha EA, Walters HL III, Jacobs ML.  
Cardiol Young. 2008(Dec); 18(Suppl 2):81–91.  
*This study sought to define and classify commonly used patient safety terminology as applied in the context of treatment of patients with congenital cardiac disease. The authors present consensus-derived definitions for terms such as complication, medical error, adverse event, and near miss. From these definitions they derive a taxonomy of patient safety events depicting the relationships among the terms with respect to preventability and degree of harm. Two tables, two figures, and two appendices are included.*

**20. Using Enhanced Text to Facilitate Recognition of Drug Names: Evidence from Two Experimental Studies.**

Schell KL.

Appl Ergon. 2009(Jan); 40(1):82–90.

*The use of modified or enhanced text in printed drug information has been proposed as a means of reducing medication errors associated with misrecognition of drug names by providers. This article describes two studies that assessed the impact of textual enhancements on visual and cognitive processing of drug names in an experimental setting. The studies were designed to test whether modifications in color, case, and size of text would affect how accurately participants identified differences in pairs of drug names presented successively on a computer screen. The authors found that errors occurred most frequently with drug names that were highly similar, and that the application of text enhancements did not significantly alter this tendency. Overall, text enhancements were not associated with any significant improvement in drug name recognition, and in fact some enhancements appeared to increase certain types of errors. Three tables and two figures are included.*

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