National Patient Safety Foundation®
Current Awareness Literature Alert

March (2) 2009
Volume 13, Issue 3:2

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1. A Multidisciplinary Team Approach to Retained Foreign Objects.
Cima RR, Kollengode A, Storsveen AS, et al.
Jt Comm J Qual Patient Saf. 2009(Mar); 35(3):123–132.
This article describes an ongoing improvement initiative aimed at reducing the occurrence of surgical retained foreign objects (RFOs) at the Mayo Clinic, Rochester, Minn. The authors discuss in detail the development, implementation, and outcomes of the program and comment on facilitators and barriers to its success. They report results indicating significant and sustained improvement attributable to the program. One table and multiple figures are included.

2. Apologies and Medical Error.
Robbennolt JK.
Clin Orthop Relat Res. 2009(Feb); 467(2):376–382.
This article summarizes current knowledge concerning the role of apology as a form of response to medical error. Topics discussed include patients' and physicians' attitudes toward communication about medical errors, common obstacles to apology, and requirements for effective apologies. Finally, the authors comment on recent progress in the development of institutional and national guidelines relating to apology and offer recommendations for future research in this area.

3. Association of Communication between Hospital-Based Physicians and Primary Care Providers with Patient Outcomes.
Bell CM, Schnipper JL, Auerbach AD, et al.
J Gen Intern Med. 2009(Mar); 24(3):381–386.
This study examined whether communication between hospitalists and primary care providers (PCPs) affected post-discharge outcomes among patients at six US academic medical centers. The authors looked at data for a total of 1,078 patients admitted during a 2-year period to assess whether communication between patients' PCPs and their in-hospital physicians predicted the incidence of adverse outcomes (death, hospital readmission, or emergency department visit) within 30 days of discharge. While their analysis found no statistical association between communication and patient outcomes, the authors note that their findings emphasize the need for better communication between primary care and hospital-based physicians. For instance, nearly one-quarter of PCPs surveyed did not know their patients had been admitted to the hospital, and of those who knew their patients had been admitted, only 23% reported having had direct communication with hospital-based physicians who cared for their patients. Two tables are included.

4. Building Organizational Capacity: A Cornerstone of Health System Reform.
Corrigan J, McNeill D.
Health Aff. 2009(Mar/Apr); 28(2):w205–w215.
In this paper, Corrigan and McNeill argue that fundamental structural changes will be needed in order to realize the potential of healthcare system reforms. They discuss the challenges and opportunities associated with this process and outline a national policy agenda for the development of appropriate new organizational models. One table is included.

5. Chlorhexidine-Impregnated Sponges and Less Frequent Dressing Changes for Prevention of Catheter-Related Infections in Critically Ill Adults: A Randomized Controlled Trial.

Timsit J-F, Schwebel C, Bouadma L, et al., for the Dressing Study Group.
JAMA. 2009(Mar 25); 301(12):1231–1241.
This article reports on a multicenter randomized controlled trial that evaluated the impact of chlorhexidine-treated dressings and weekly dressing changes on rates of catheter-related infection (CRI) in patients at seven ICUs in France. The study used a 2x2 factorial design and involved a total of 1636 patients over a 30-month period. Results indicated that use of the chlorhexidine-impregnated dressings was associated with a 60% reduction in CRIs (the authors note that pre-intervention infection rates in study ICUs were already quite low). Results also established non-inferiority of performing scheduled dressing changes weekly as opposed to every three days; however, because patients in the intervention group frequently required unscheduled dressing changes, the overall number of dressing changes was reduced only slightly in this group as compared with the control. Multiple tables and figures are included.

6. Clinical Triggers: An Alternative to a Rapid Response Team.

Moldenhauer K, Sabel A, Chu ES, Mehler PS.
Jt Comm J Qual Patient Saf. 2009(Mar); 35(3):164–174.
This article describes the clinical triggers program, a type of rapid response system developed and implemented at Denver Health Medical Center (DHMC), Denver, Colo. Clinical triggers is an approach to the management of clinically unstable patients in which the primary team of clinicians caring for the patient, rather than a separately constituted rapid response team, is summoned if the patient's condition meets any of a given list of criteria for intervention. The authors discuss the design, implementation, and impact of the DHMC program and comment on its potential benefits and drawbacks as compared with conventional rapid response teams. Multiple tables and figures are included.

7. Diagnostic Errors — The Next Frontier for Patient Safety.

Newman-Toker DE, Pronovost P.
JAMA. 2009(Mar 11); 301(10):1060–1062.
This commentary draws attention to the problem of diagnostic errors, a significant patient safety issue that, the authors argue, has thus far been overlooked by most medical research and improvement efforts. The authors present definitions of diagnostic error and misdiagnosis-related harm, review data on the scope and impact of diagnostic errors, and offer practical and theoretical suggestions for advancing research and development in this area. One table is included.

8. Do European Hospitals Have Quality and Safety Governance Systems and Structures in Place?

Shaw C, Kutryba B, Crisp H, Vallejo P, Suñol R.
Qual Saf Health Care. 2009(Feb); 18(Suppl 1):i51–i56.
This study, part of the Methods of Assessing Response to Quality Improvement Strategies (MARQuIS) project, sought to systematically evaluate patient safety and quality systems in a sample of European hospitals. Researchers used a combination of surveys and on-site assessments to describe the oversight and management of safety and quality at 89 hospitals in six EU member states. The surveys and assessments considered a variety of factors, including documented statements of commitment to safety and quality, involvement of hospital leaders in safety and quality activities, the existence of staff and committees dedicated to safety and quality management, and staff development and education efforts. Results showed that while most participating hospitals had formal safety and quality systems in place, some hospitals lacked such systems altogether, and significant variation in the structure and operation of systems was evident. Implications of these findings and possibilities for further application of the assessment tools developed in this study are discussed. Multiple tables are included. [See also item 14.]

9. Engaging as Partners in Patient Safety: The Experience of Librarians.

Zipperer L, Sykes S.
Patient Saf Qual Healthcare. 2009(Mar/Apr); 6(2):28–33.
Available at: http://www.psqh.com/marapr09/librarians.html
This article explores the involvement of librarians and other information professionals in organizational patient safety improvement efforts, using as a basis for discussion a survey that examined healthcare librarians' perceptions about their participation in organizational patient safety activities and the evolution of this role in recent years. The authors discuss selected survey findings and highlight opportunities for reinforcing and expanding the role of librarians as members of the safety team. Two figures are included.

10. Errors in Administration of Parenteral Drugs in Intensive Care Units: Multinational Prospective Study.

Valentin A, Capuzzo M, Guidet B, et al., on behalf of the Research Group on Quality Improvement of the European Society of Intensive Care Medicine (ESICM) and the Sentinel Events Evaluation (SEE) Study Investigators.
BMJ. 2009(Mar 12); 338:b814. doi:10.1136/bmj.b814.
This study examined errors in parenteral medication errors in the ICUs of an international sample of hospitals. The authors analyzed self-reported data collected during a 24-hour observation period from 113 ICUs in 27 countries to assess the prevalence, nature, causes, and consequences of parenteral medication errors. Results, detailed in the article, indicated that errors in parenteral medication administration occurred frequently in the study sample and in a small number of cases (.9%) caused serious harm or death. A number of patient-, treatment-, and facility-related factors were associated with increased risk of error. Implications of these results and potential strategies for improvement are discussed. Multiple tables are included.

11. Evaluation of the Contributions of an Electronic Web-Based Reporting System: Enabling Action.

Levtzion-Korach O, Alcalai H, Orav EJ, et al.
J Patient Saf. 2009(Mar); 5(1):9–15.
This study sought to assess the use and impact of an electronic web-based event reporting system at a tertiary care academic hospital. The authors analyzed 14,179 reports submitted to the system over a 31-month period with respect to a variety of parameters, including frequency of reporting, nature and severity of reported incidents, characteristics of reporting personnel, and time required for submittal and for managerial review of a report. The authors also examined the role of the reporting system in promoting safety improvement and change; in the article, they provide examples of follow-up actions taken in response to reported events. Multiple tables and figures are included.

12. Grand Rounds — When Things Go Awry.

Levy P.
Running a Hospital [blog]. March 31, 2009.
Available at: http://runningahospital.blogspot.com/2009/03/grand-rounds-when-things-go-awry.html
This blog entry presents a collection of personal essays describing patients' and healthcare providers' experiences with medical error, with commentary by blog author Paul Levy. This item appeared as an episode of Grand Rounds, a weekly digest presenting highlights from the medical blogging community hosted by a different blogger each week.

13. How Can Primary Care Cross the Quality Chasm?

Solberg LI, Elward KS, Phillips WR, et al.
Ann Fam Med. 2009(Mar/Apr); 7(2):164–169.
The IOM report Crossing the Quality Chasm *(2001) described the gap between actual and potential healthcare system performance and focused on the need for better translation of research-derived knowledge into practice as a means of addressing this issue. This commentary seeks to qualify the Quality Chasm argument by suggesting that the performance gap emphasized in the report is just one of multiple obstacles that impede healthcare system performance. The authors identify three additional "chasms," describe the factors that contribute to them, and discuss potential solutions to these obstacles.*

14. Implementation of Patient Safety Strategies in European Hospitals.
Suñol R, Vallejo P, Groene O, et al.
Qual Saf Health Care. 2009(Feb); 18(Suppl 1):i57–i61.
This study, part of the Methods of Assessing Response to Quality Improvement Strategies (MARQuIS) project, sought to describe patient safety-related systems and structures and to identify hospital-related correlates of patient safety activities at a sample of hospitals in eight EU countries. The analysis looked at self-reported survey data from 389 hospitals as well as data from on-site audits performed at a subset of 89 hospitals. Results indicated that while most hospitals had in effect formal structures and policies relating to patient safety, implementation of patient safety mechanisms such as electronic prescribing and event reporting systems varied considerably, suggesting that significant opportunities for improvement exist. Implications of these findings for further research and improvement efforts are discussed. Four tables are included. [See also item 8.]

15. Measuring Preventable Harm: Helping Science Keep Pace with Policy.
Pronovost PJ, Colantuoni E.
JAMA. 2009(Mar 25); 301(12):1273–1275.
This commentary considers the need for an effective means of measuring patient safety and the difficulty of ascertaining whether safety actually has demonstrably improved. A major impediment to effective measurement, the authors argue, has been the lack of a consistent approach to discriminating between preventable and nonpreventable harm. They discuss potential methods for classifying medical harm and the advantages and drawbacks of each, and offer policy recommendations to promote progress in this area.

16. Medication Errors: Significance of Accurate Patient Weights.
Pennsylvania Patient Safety Authority.
Pa Patient Saf Advis. 2009(Mar); 6(1):10–15.
Available at: http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Mar6(1)/Pages/10.aspx
This article discusses medication errors associated with the use of inaccurate information about patient weights. The authors present data and an analysis of weight-related medication errors based on nearly 480 event reports submitted to the Pennsylvania Patient Safety Authority, along with risk reduction strategies. Four tables are included.

17. Patient Screening and Assessment in Ambulatory Surgical Facilities.
Pennsylvania Patient Safety Authority.
Pa Patient Saf Advis. 2009(Mar); 6(1):3–9.
Available at: http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Mar6(1)/Pages/03.aspx
This article discusses risk management and safety considerations in the ambulatory surgery setting, with an emphasis on the need for effective preoperative screening to identify patients at risk for surgical complications. The authors review data from relevant event reports submitted to Pennsylvania's reporting system and from the current literature, and offer risk reduction strategies. Links to two sample health screening forms are included.

18. Perspective: Health Information Technology and Patient Safety: Evidence from Panel Data.

Parente ST, McCullough JS.

Health Aff. 2009(Mar/Apr); 28(2):357–360.

This study sought to assess the impact of health information technology adoption on patient safety in a large national sample of Medicare patients. The authors analyzed the relationship between implementation of any of three health IT applications (electronic medical records [EMRs], computerized nurse charting systems, and picture archiving and communications systems) and selected patient safety indicators using Medicare inpatient claims data from a 4-year period. Results showed that EMRs had a slight favorable influence on patient outcomes; neither of the other technologies examined had a statistically significant impact. The authors discuss the implications of their research as well as its limitations; they note in particular the need for further data to support meaningful analysis of the impact of health IT adoption on patient safety on a broader scale.

19. Rethinking Satisfaction Surveys: Time to Next Complaint.

Alemi F, Hurd P.

Jt Comm J Qual Patient Saf. 2009(Mar); 35(3):156–161.

This article argues that while patient satisfaction surveys are a popular means of obtaining feedback about healthcare consumers' experiences with their care, these surveys can be expensive to conduct and may not be effective tools for implementing needed change. To improve upon this process, the authors propose a method for using patient complaints data as a source of information to guide hospital improvement efforts. They present a theoretical model and cost-effectiveness argument for the use of patient complaints data, including a case study illustrating how analysis of data about the frequency, patterns, and timing of complaints could be used to identify specific events as well as general areas warranting improvement. Two tables and three figures are included.

20. The Safety of Intravenous Drug Delivery Systems: Update on Current Issues since the 1999 Consensus Development Conference.

Sanborn M, Gabay M, Moody ML.

Hosp Pharm. 2009(Feb); 44(2):159–164.

Available at: http://www.factsandcomparisons.com/assets/hpdatenamed/20090201_Feb2009_peer3.pdf

This paper reports on current issues relating to the safety of intravenous medication delivery systems. The authors review recent policy developments, summarize the ongoing debate concerning standardization of parenteral nutrition formulations, and comment on the potential safety benefits of new automated compounding devices.
