



**April (1) 2009**

Volume 13, Issue 4:1

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- 1. A Comprehensive Hand Hygiene Approach to Reducing MRSA Health Care–Associated Infections.**  
Lederer JW Jr., Best D, Hendrix V.  
Jt Comm J Qual Patient Saf. 2009(Apr); 35(4):180–185.  
*This article describes an initiative designed and implemented by Novant Health System to improve compliance with hand hygiene guidelines throughout its acute care facilities. The evolution of the program and key performance measurement and improvement activities are discussed. The authors report that in addition to effecting significant and sustained improvements in hand hygiene compliance, implementation of the program was associated with a decrease of more than 50% in systemwide rates of hospital-acquired MRSA infection. Two figures and an appendix are included.*
- 2. A New Strategy to Improve Quality: Rewarding Actions Rather than Measures.**  
Werner RM, McNutt R.  
JAMA. 2009(Apr 1); 301(13):1375–1377.  
*This commentary, a companion piece to the article by Kernisan et al. in the same issue of JAMA (see item 3 below) takes a critical look at widely used strategies for healthcare quality improvement. The authors identify a number of conceptual and practical limitations of current approaches to quality improvement and propose a new model focused on tangible improvement, meaningful measurement, and the recognition of local, individualized needs and achievements.*
- 3. Association between Hospital-Reported Leapfrog Safe Practices Scores and Inpatient Mortality.**  
Kernisan LP, Lee SJ, Boscardin WJ, Landefeld CS, Dudley RA.  
JAMA. 2009(Apr 1); 301(13):1341–1348.  
*This study sought to determine whether hospitals' performance on the Leapfrog Safe Practices Survey predicted in-hospital mortality rates among a group of US urban hospitals. The Safe Practices Survey, a component of the Leapfrog Hospital Survey, measures hospitals' self-reported progress in adopting National Quality Forum–endorsed safe practices for improved care. The authors used multiple statistical analyses to assess correlations between inpatient mortality and Safe Practice Survey quartile rankings for 155 hospitals that participated in the survey in 2006. Results showed no significant association between Safe Practice Survey scores and mortality rates among the study sample. Possible explanations for these findings and the implications with respect to safety and quality improvement and assessment methodology are discussed. Four tables are included.*

- 4. Critical Communication: Using Plain Language to Reduce Medical Errors.**  
Corina I, D’Angelo L.  
Wantagh, NY: PULSE of NY; January 2009.  
Available at: [http://www.pulseofny.org/resources/PULSE\\_CCbook.pdf](http://www.pulseofny.org/resources/PULSE_CCbook.pdf)  
*This white paper provides background on the issue of health literacy and illustrates efforts by PULSE of New York and other organizations to address this concern. The authors emphasize the crucial need for clear communication between patients and healthcare providers and highlight the work of PULSE’s Critical Communication programs, which work to teach both patients and clinicians strategies for improving healthcare-related communication.*
- 5. Disrespectful and Abusive Behavior: The “Hidden Curriculum” of Medical School.**  
Isaac T.  
Focus Patient Saf. 2009(Spring); 12(1):1–3.  
Available at: [http://npsf.org/paf/npsfp/fo/pdf/Focus\\_Volume\\_12\\_%20Issue\\_1.pdf](http://npsf.org/paf/npsfp/fo/pdf/Focus_Volume_12_%20Issue_1.pdf)  
*This article discusses the problem of inappropriate and disruptive clinician behavior — a common phenomenon that can undermine healthcare workers’ morale and patient safety. The author describes ways in which this type of behavior may be perpetuated by the medical training system and outlines structural and organizational approaches to addressing this issue.*
- 6. Family-Centered Multidisciplinary Rounds Enhance the Team Approach in Pediatrics.**  
Rosen P, Stenger E, Bochkoris M, Hannon MJ, Kwoh CK.  
Pediatrics. 2009(Apr); 123(4):e603–e608.  
Available at: <http://www.pediatrics.org/cgi/content/full/123/4/e603>  
*This study sought to assess quantitatively the effects of the use of family-centered multidisciplinary rounds, an approach to clinical rounds designed in accordance with the principles and objectives of family-centered care. The authors used a quasi-experimental survey design to compare family-centered and traditional rounds at a tertiary-care academic children’s hospital with respect to patient and family experience, staff satisfaction, and staff time requirements. While there was no significant difference in patient and family satisfaction between the two types of rounds, staff satisfaction was considerably greater among those who participated in family-centered rounds. Family-centered rounds took longer on average than conventional rounds, but the difference was not large enough to be deemed significant. Three tables are included.*
- 7. Market-Based Control Mechanisms for Patient Safety.**  
Coiera E, Braithwaite J.  
Qual Saf Health Care. 2009(Apr); 18(2):99–103.  
*This article gives an introduction to the concept of market-based control (MBC) and argues that such a system could be a useful new approach to improving patient safety. Using MBC-based environmental policy such as the Kyoto protocol as an analogy, the authors construct a potential model for the application of MBC to healthcare. Finally, they discuss the possible risks and benefits associated with such a system and address several anticipated criticisms of their approach. One table and two figures are included.*

- 8. Medication Errors in Critical Care: Risk Factors, Prevention and Disclosure.**  
Camiré E, Moyen E, Stelfox HT.  
CMAJ. 2009(Apr 28); 180(9):936–943.  
*This article summarizes published evidence concerning the characteristics and prevention of medication errors in the ICU setting. The authors present findings from a review of 17 studies concerning the incidence of ICU medication errors, possible contributing factors, prevention strategies, and error disclosure. A case study illustrating an instance of ICU medication error is included.*
- 9. National Survey of Patients’ Bill of Rights Statutes.**  
Paasche-Orlow MK, Jacob DM, Hochhauser M, Parker RM.  
J Gen Intern Med. 2009(Apr); 24(4):489–494.  
*This study sought to assess the readability and thematic content of state- and hospital-generated patients’ bill of rights (PBOR) documents in the US. In their analysis of PBOR documents from 23 states and 240 US hospitals, the authors found that many PBOR texts were written at a reading level beyond the capacity of the typical US adult, and that thematic content varied considerably among the documents examined and did not necessarily include rights stipulated by state legislation or by the AHA. Implications of these findings and the role of PBORs with respect to the patients’ rights and health literacy movements are discussed. Four tables are included.*
- 10. Rating Recommendations for Consumers about Patient Safety: Sense, Common Sense, or Nonsense?**  
Weingart SN, Morway L, Brouillard D, et al.  
Jt Comm J Qual Patient Saf. 2009(Apr); 35(4):206–215.  
*This study sought to evaluate consumer patient safety recommendations from a variety of sources including government, professional, nonprofit, and commercial organizations. To assess the nature and value of recommendations available to consumers, Weingart et al. identified, classified, and rated a total of 160 recommendations from 26 organizations. The authors found that there was far less overlap than anticipated among the recommendations from different organizations and that the most widely used recommendations were not necessarily those the authors judged most valuable. Implications of these findings and suggestions for improving the utility of consumer patient safety information are discussed. Five tables and one figure are included.*
- 11. Reducing Health Care Hazards: Lessons from the Commercial Aviation Safety Team.**  
Pronovost PJ, Goeschel CA, Olsen KL, et al.  
Health Aff. 2009(May/June); 28(3):w479–w489.  
*This article describes the Commercial Aviation Safety Team (CAST), a government-industry partnership dedicated to the analysis and prevention of aviation safety threats, and discusses how principles of the CAST approach could be applied to improve the efficacy of risk mitigation efforts in the healthcare industry. One table is included.*

- 12. Reducing Surgical Site Infections at a Pediatric Academic Medical Center.**  
Ryckman FC, Schoettker PJ, Hays KR, et al.  
Jt Comm J Qual Patient Saf. 2009(Apr); 35(4):192–198.  
*This article reports on the development, implementation, and impact of a safety improvement initiative aimed at reducing the incidence of surgical site infections (SSIs) at Cincinnati Children’s Hospital Medical Center. The authors describe the program design and methods and comment on notable challenges and facilitating factors in its success. Four figures are included.*
- 13. Requirements for the Design and Implementation of Checklists for Surgical Processes.**  
Verdaasdonk EGG, Stassen LPS, Widhiasmara PP, Dankelman J.  
Surg Endosc. 2009(Apr); 23(4):715–726.  
*This article provides an overview concerning the use of checklists as a tool to improve surgical safety. The authors summarize published evidence concerning the development and use of surgical checklists and propose guidelines for checklist design and implementation based on aviation industry standards. One table and two figures are included.*
- 14. Rescue Me: Saving the Vulnerable Non-ICU Patient Population.**  
Bader MK, Neal B, Johnson L, et al.  
Jt Comm J Qual Patient Saf. 2009(Apr); 35(4):199–205.  
*This article describes the development and implementation of a rapid response system designed to improve management of clinically unstable medical-surgical inpatients at Mission Hospital, Mission Viejo, Calif. The authors describe the structure and operation of the rapid response team (RRT) and present data on usage and patient outcomes during the two years following implementation. Results showed that implementation of the RRT was associated with demonstrable improvements including a significant reduction in the rate of cardiac/respiratory arrests among non-ICU patients. Two tables and four figures are included.*
- 15. Safe Intra-hospital Transport of the Non-ICU Patient Using Standardized Handoff Communication.**  
Pennsylvania Patient Safety Authority.  
Pa Patient Saf Advis. 2009(Mar); 6(1):16–19.  
Available at: [http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Mar6\(1\)/Pages/16.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Mar6(1)/Pages/16.aspx)  
*This article discusses safety issues related to the intrafacility transport of non-ICU patients. The authors review evidence from error reports and the published literature concerning risks associated with non-ICU patient transport and offer suggestions for preventing or mitigating these problems. Risk reduction strategies such as the development of specially trained transport teams and the use of standardized communication techniques to improve information transfer during patient handoffs are discussed. One table is included.*

- 16. Safety in the MR Environment: MR Safety Screening Practices.**  
Pennsylvania Patient Safety Authority.  
Pa Patient Saf Advis. 2009(Mar); 6(1):20–26.  
Available at: [http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Mar6\(1\)/Pages/20.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Mar6(1)/Pages/20.aspx)  
*Pre-MRI assessment to identify ferromagnetic objects in or on the patient's body is an important defense against MR-related accidents and patient injury. The authors give examples of reported incidents in which ineffective screening contributed to MRI-related adverse events, provide an overview of MRI technology and published safety guidelines, and outline pre-procedure screening processes that can help to mitigate risk. One table and three figures are included.*
- 17. Serious Reportable Events in Massachusetts Acute Care Hospitals: January 1, 2008 – December 31, 2008.**  
Boston, MA: Massachusetts Executive Office of Health and Human Services, Dept of Public Health, Bureau of Health Care Quality and Safety; April 2009.  
Available at: [http://www.mass.gov/Eeohhs2/docs/dph/quality/healthcare/sre\\_acute\\_care\\_hospitals.pdf](http://www.mass.gov/Eeohhs2/docs/dph/quality/healthcare/sre_acute_care_hospitals.pdf)  
*This report presents data on adverse events in Massachusetts hospitals collected by the Massachusetts Department of Health's reporting system during 2008. Established in January 2008 and modeled on the National Quality Forum's taxonomy of adverse events, the Massachusetts system requires hospitals to report instances of any of 28 events in six categories. A total of 338 events were reported in 2008, the majority of which were falls. Summary results and hospital-specific data are included in the report, as well as a comparison of event data between Massachusetts and Minnesota, which uses a similar reporting structure.*
- 18. The Design of the SAFE or SORRY? Study: A Cluster Randomised Trial on the Development and Testing of an Evidence Based Inpatient Safety Program for the Prevention of Adverse Events.**  
Van Gaal BGI, Schoonhoven L, Hulscher MEJL, et al.  
BMC Health Serv Res. 2009(Apr 1); 9(58).  
Available at: <http://www.biomedcentral.com/1472-6963/9/58>  
*This article describes the design and implementation of an initiative aimed at preventing three types of adverse events (pressure ulcers, patient falls, and hospital-acquired urinary tract infections) in the inpatient population. The program was implemented at ten hospital and ten nursing home wards in the Netherlands and was evaluated using a cluster randomized trial design. This paper reports on the study methods and program implementation; study results are not included in this paper but are expected to be published separately later this year. Three tables and one figure are included.*

**19. The Rate and Costs Attributable to Intravenous Patient-Controlled Analgesia Errors.**

Meissner B, Nelson W, Hicks R, Sikirica V, Gagne J, Schein J.

Hosp Pharm. 2009(Apr); 44(4):312–324.

Available at: [http://www.factsandcomparisons.com/assets/hpdatanamed/20090401\\_Apr2009\\_peer1.pdf](http://www.factsandcomparisons.com/assets/hpdatanamed/20090401_Apr2009_peer1.pdf)

*This study sought to estimate the frequency and cost of errors involving intravenous patient-controlled analgesia (IV PCA) in the United States. Using data from the USP's MEDMARX and the FDA's MAUDE databases, the authors first performed error-rate and cost analyses and then extrapolated these findings to obtain national estimates for medication-related (MEDMARX) and device-related (MAUDE) errors. Results indicated that IV PCA-related errors occurred frequently and at considerable cost to the US healthcare system — an annual estimated \$338 million for medication-related errors and \$12 million for device-related errors. Implications of these findings and questions remaining for further research are discussed. Multiple tables are included.*

**20. The Sixth Annual HealthGrades Patient Safety in American Hospitals Study.**

Golden, CO: Health Grades, Inc.; April 2009.

Available at: <http://www.healthgrades.com/media/DMS/pdf/PatientSafetyInAmericanHospitalsStudy2009.pdf>

*This report presents findings from HealthGrades' sixth annual study of patient safety in US hospitals. The study looked at hospitals' performance on a subset of the Agency for Health Care Research and Quality patient safety indicators (PSIs) in order to calculate the nationwide incidence and costs of adverse events among Medicare patients between 2005 and 2007. The authors found that while safety improved in some areas, there was no appreciable reduction in the overall incidence of patient safety events, and that costs associated with the treatment of adverse events were an estimated \$6.9 billion in the period examined. In addition, hospitals were scored based on their individual performance on the PSIs; those scoring among the top 15% are acknowledged in the report as recipients of the HealthGrades 2009 Patient Safety Excellence Award.*

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