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- 1. A Comprehensive Guide to Managing Never Events and Hospital-Acquired Conditions: A Quality and Risk Management Approach to Patient Safety and Preventable Adverse Events.**  
Bunting RF Jr., Schukman J, Wong WB.  
Washington, DC; Atlantic Information Services, Inc.: 2009.  
*This book provides a thorough and practical reference on the history and current practice of patient safety and adverse event management in the US healthcare system. The guide includes up-to-date information on a wide range of strategies for addressing preventable adverse events, along with historical background, statistics on the magnitude and impact of the issue, and an extensive list of resources.*
- 2. Continuous Pulse Oximetry Monitoring in the Inpatient Population.**  
Pyke J, Christoffersen K, Avery J, Blike GT, McGrath SP, Karon N.  
Pat Saf Qual Healthcare. 2009(May/June); 6(3):32–35.  
Available at: <http://www.psqh.com/mayjun09/oximetry.html>  
*This article describes a pulse oximetry monitoring system recently implemented in an inpatient surgical ward at Dartmouth-Hitchcock Medical Center, Lebanon, NH. The authors outline the implementation process, comment on technical considerations such as management of false alarms, and present preliminary findings concerning the system's impact on patient care. Two figures are included.*
- 3. Disclosing Errors that Affect Multiple Patients.**  
Chafe R, Levinson W, Sullivan T.  
CMAJ. 2009(May 26); 180(11):1125–1127.  
*This article discusses issues in the management of healthcare errors that may involve a large number of patients, such as medical device malfunctions or diagnostic testing failures. The authors outline steps for the identification, review, and disclosure of errors affecting multiple patients, comment on the challenges and barriers to disclosure, and offer recommendations for the development of national guidelines to address these types of errors.*
- 4. Empowered to Improve: Memorial Hermann Uses Lessons from the Nuclear Energy Industry to Make Quality and Safety Strides, Help Win NQF Award.**  
Gardner E.  
Mod Healthcare. 2009(May 18); 39(20):28–31.  
*This article describes how Memorial Hermann Healthcare System, an eight-hospital system based in Houston, Texas, has used organization-wide training incorporating safety techniques used in the nuclear power industry to achieve marked progress in patient safety and quality of care in its facilities. Memorial Hermann received the National Quality Forum's 16th annual National Quality Healthcare Award in recognition of its patient safety and quality accomplishments.*

- 5. Impact of Performance Obstacles on Intensive Care Nurses' Workload, Perceived Quality and Safety of Care, and Quality of Working Life.**  
Gurses AP, Carayon P, Wall M.  
Health Serv Res. 2009(Apr); 44(2 Pt 1):422–443.  
*This study explored the effects of workplace-associated “performance obstacles” on perceived workload, quality and safety of patient care, and job-related wellbeing through a survey of 265 nurses in 17 ICUs. The authors conceptualized performance obstacles as a variety of work-related conditions that might impede nurses’ ability to carry out their jobs, including problems with equipment or design of the physical environment, faulty communication, and counterproductive organizational practices. Results of the survey, which asked nurses to assess their experiences during a single work shift, showed that performance obstacles were associated with perceived higher workload, reduced quality and safety of care, and reduced quality of working life. On the basis of these findings, the authors suggest that efforts to address such performance obstacles may be a useful approach to managing nursing workload and improving safety and quality of care. Three tables and two figures are included.*
- 6. Improving Transitions to Reduce Readmissions.**  
Bisognano M, Boutwell A.  
Front Health Serv Manage. 2009(Spring); 25(3):3–10.  
*This article summarizes current knowledge concerning the frequency, causes, and costs of hospital readmissions and discusses how improving the transitions of care associated with discharge could help to reduce rates of avoidable rehospitalization. The authors offer practical suggestions for improvement and outline several discharge-care transition models drawn from recent and ongoing research in this area.*
- 7. Leapfrog Hospital Survey Results 2008.**  
Washington, DC: The Leapfrog Group; April 2009.  
Available at: <http://www.leapfroggroup.org/media/file/leapfrogreportfinal.pdf>  
*This report presents data from the Leapfrog Group’s annual survey assessing hospitals’ self-reported performance on a set of evidence-based safety and quality measures. The authors highlight summary findings for the 1,282 hospitals that participated in the 2008 survey and comment on performance trends and implications. Results showed that while improvements have occurred in certain areas, the majority of participating hospitals did not fully meet Leapfrog’s standards for safety and efficiency of care, suggesting that overall much room for improvement remains.*

**8. Measuring Hand Hygiene Adherence: Overcoming the Challenges.**

Oakbrook Terrace, IL; The Joint Commission; 2009.

Available at: [http://www.jointcommission.org/NR/rdonlyres/68B9CB2F-789F-49DB-9E3F-2FB387666BCC/0/hh\\_monograph.pdf](http://www.jointcommission.org/NR/rdonlyres/68B9CB2F-789F-49DB-9E3F-2FB387666BCC/0/hh_monograph.pdf)

*This monograph, a collaborative effort among the Joint Commission and six other national and international health and infection control organizations, aims to provide a comprehensive resource concerning the monitoring and assessment of healthcare workers' hand hygiene compliance. Topics covered include the fundamentals of hand hygiene guidelines, rationales for measuring guideline compliance, and measurement techniques and methodology. Several chapters are devoted to detailed discussion of specific measurement methods, including direct observation, measuring product use, and conducting staff and patient surveys. Additional chapters address the importance of assessing hand hygiene thoroughness and technique (in addition to frequency), analysis and presentation of data, and overcoming common challenges. A review of national and global hand hygiene initiatives and an extensive list of additional resources and measurement tools are included.*

**9. Patient Error: A Preliminary Taxonomy.**

Buetow S, Kiata L, Liew T, Kenealy T, Dovey S, Elwyn G.

Ann Fam Med. 2009(May/June); 7(3):223–231.

*Medical errors resulting from actions of or mistakes committed by patients, as opposed to those attributable to clinicians or healthcare delivery systems, have received relatively little attention in the medical literature. As a step toward addressing this gap, this study sought to create a taxonomy of patient errors, using data from nominal group sessions involving patients and healthcare professionals. The resulting taxonomy includes 70 items in eight categories comprising two main classes of error: action errors and mental errors. Implications and next steps for further research are discussed. Two tables are included.*

**10. Pennsylvania Patient Safety Authority 2008 Annual Report.**

Harrisburg, PA; Pennsylvania Patient Safety Authority; April 2009.

Available at: [http://patientsafetyauthority.org/PatientSafetyAuthority/Documents/annual\\_report\\_2008.pdf](http://patientsafetyauthority.org/PatientSafetyAuthority/Documents/annual_report_2008.pdf)

*This report summarizes data on patient safety events reported to Pennsylvania's state reporting system during 2008; presents findings from a survey of patient safety activities in 200 Pennsylvania healthcare facilities; and provides updates on the Authority's ongoing research, education, and outreach initiatives.*

- 11. Pharmacists' Medication Reconciliation–Related Clinical Interventions in a Children's Hospital.**  
Gardner B, Graner K.  
Jt Comm J Qual Patient Saf. 2009(May); 35(5):278–282.  
*This article describes the design, implementation, and impact of an intervention to improve medication reconciliation procedures at a tertiary care pediatric teaching hospital. The process involved a combination of technical and organizational changes including the creation of new documentation tools and the involvement of pediatric pharmacists in the medication reconciliation process. Two tables and two figures are included.*
- 12. Pilot Study: The Role of the Hospitalized Patient in Medication Administration Safety.**  
Macdonald M.  
Pat Saf Qual Healthcare. 2009(May/June); 6(3):28–31.  
Available at: <http://www.psqh.com/mayjun09/study.html>  
*This qualitative study examined patients' and nurses' attitudes related to inpatient medication administration processes and the involvement of patients in ensuring medication safety. The author used grounded theory techniques to analyze data from interviews with 6 patients and 6 nurses at a tertiary care hospital in Halifax, Nova Scotia. Results suggested that while both patients and nurses supported the notion of patient involvement in medication administration safety, it was felt that changes to the current care delivery system — such as the provision of additional patient education — would be required for this type of participation to be possible.*
- 13. Quality and Safety Indicators in Anesthesia: A Systematic Review.**  
Haller G, Stoelwinder J, Myles PS, McNeil J.  
Anesthesiology. 2009(May); 110(5):1158–1175.  
*This study sought to identify and categorize existing clinical quality and safety indicators applicable to anesthesia. A total of 108 indicators were identified through a systematic literature review and were then classified with respect to area of care and dimension of quality addressed, level of validity, and other characteristics. The authors present the resulting classification as a tabulated list and comment on considerations for the current use and potential further development of clinical indicators as a tool for quality measurement in anesthesia. Three tables and two figures are included.*

- 14. Reduction in Intraoperative Bacterial Contamination of Peripheral Intravenous Tubing through the Use of a Novel Device.**  
Koff MD, Loftus RW, Burchman CC, et al.  
Anesthesiology. 2009(May); 110(5):978–985.  
*This study assessed the impact of use of a commercially available hand disinfection device on hand hygiene performance and bacterial contamination of the anesthesia environment in surgical procedures at a tertiary care academic medical center. The authors used a controlled before-and-after study to compare anesthesia providers' hand hygiene frequency and levels of microbial contamination of anesthesia equipment in procedures with and without use of the personal hand hygiene devices (providers in both groups also had access to standard hand hygiene supplies). Results indicated that use of the device was associated with both considerable improvement in hand hygiene compliance and reduction in the likelihood of bacterial contamination of anesthesia equipment during surgery. In addition, use of the device was associated with reduction in the incidence of postsurgical healthcare-associated infections in the study population. Four tables and three figures are included.*
- 15. Relationship of Safety Climate and Safety Performance in Hospitals.**  
Singer S, Lin S, Falwell A, Gaba D, Baker L.  
Health Serv Res. 2009 (Apr); 44(2 Pt 1):399–421.  
*This study sought to evaluate quantitatively the relationship between hospital safety climate and performance on a subset of the Agency for Healthcare Research and Quality patient safety indicators (PSIs) in a cross-sectional group of 91 US hospitals. Using a correlative analysis of safety climate survey data and hospital administrative data, the authors found that hospitals' scores for overall safety climate as well as for certain dimensions of safety culture were associated with better performance on the PSIs. The relationship was stronger for certain elements of safety climate than for others and varied by staff group: for instance, frontline staff's perceptions of safety climate, but not those of senior managers, were predictive of PSI performance. Implications of these findings for practice and for further research are discussed. Four tables are included.*
- 16. To Err Is Human — To Delay Is Deadly.**  
Jewell K, McGiffert L.  
Austin, TX: Consumers Union; May 2009.  
Available at: <http://www.safepatientproject.org/safepatientproject.org/pdf/safepatientproject.org-ToDelayIsDeadly.pdf>  
*This paper assesses the state of patient safety in the US healthcare system ten years after the publication of the Institute of Medicine report To Err Is Human. The authors find little conclusive evidence of any general improvement in healthcare safety and argue that, despite increased attention to the problem and countless patient safety improvement efforts undertaken during the past decade, progress toward implementing the IOM's recommendations for improvement has been limited and fragmentary. Focusing on four specific goals — preventing medication errors, fostering accountability through increased transparency, establishing effective means of tracking and measuring safety, and raising standards for patient safety competency — they comment on the progress that has been made and call for urgent action to address the challenges that remain.*

- 17. Using an Electronic Prescribing System to Ensure Accurate Medication Lists in a Large Multidisciplinary Medical Group.**  
Stock R, Scott J, Gurtel S.  
Jt Comm J Qual Patient Saf. 2009(May); 35(5):271–277.  
*This article describes an initiative undertaken by PeaceHealth Medical Group, a large multispecialty group practice based in the Pacific Northwest, to improve the accuracy of patient medication lists in the ambulatory care setting. The program involved system-wide implementation of a set of standardized procedures through which EMR-generated medication lists were reconciled with patient-provided lists at every office visit. Comparison of pre- and post-intervention data showed that use of the system was associated with significant improvement in medication-list completeness and accuracy. One table and three figures are included.*
- 18. Using Consumer-Based Kiosk Technology to Improve and Standardize Medication Reconciliation in a Specialty Care Setting.**  
Lesselroth B, Adams S, Felder R, et al.  
Jt Comm J Qual Patient Saf. 2009(May); 35(5):264–270.  
*This article describes the design and implementation of a system developed by the Portland Department of Veterans Affairs Medical Center to improve medication reconciliation in the outpatient chemotherapy setting. The system allowed patients to enter their current medication information at check-in using a software program at self-service computer kiosks installed in the clinic waiting area. Impact of the system, challenges encountered, and possibilities for further development are discussed. Although some concerns are noted, the authors feel that overall such a system represents a promising tool for improving the efficiency of medication reconciliation and promoting patients' engagement in medication safety. One table and four figures are included.*
- 19. Using Evidence-Based Environmental Design to Enhance Safety and Quality.**  
Sadler BL, Joseph A, Keller A, Rostenberg B.  
IHI Innovation Series White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2009.  
Available at: <http://www.ihl.org/IHI/Results/WhitePapers/UsingEvidenceBasedEnvironmentalDesignWhitePaper.htm> (free registration required)  
*This white paper summarizes expert opinion on the role of evidence-based design techniques as a means of improving healthcare quality and safety. Based on their review of the existing literature, the authors present recommended design-related interventions for existing facilities, newly constructed or renovated facilities, and specific areas of care. Finally, they discuss cost considerations and offer suggestions on establishing a business case for design-based improvements.*

**20. What ‘Patient-Centered’ Should Mean: Confessions of an Extremist.**

Berwick D.

Health Aff. 2009(May 19); 28(4):w555–w565.

*While the idea of patient-centered care has emerged as an important concept in the patient safety and quality improvement movements, the question of how “patient-centeredness” should be defined continues to generate debate. In this essay, Berwick traces the evolution of the notion of patient-centeredness, considers the role of patient-centered care in relation to healthcare quality objectives, and advocates the adoption of a “radical” new definition of quality in which patient-centeredness constitutes a quality goal in itself.*

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