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- 1. Are Verbal Orders a Threat to Patient Safety?**
Wakefield DS, Wakefield BJ.
Qual Saf Health Care. 2009(Jun); 18(3):165–168.
While the use of verbal orders has been identified as a quality and safety concern, thus far there has been relatively little research addressing the subject. This article reviews the existing literature concerning the safety implications of verbal orders, outlines a conceptual model illustrating the verbal order communication process and potential sources of error, and proposes questions for future research in this area. One figure is included.
- 2. Assessing Hospital Safety on Nights and Weekends: The SWAN Tool.**
Shulkin DJ.
J Patient Saf. 2009(Jun); 5(2):75–78.
This article presents the safety on weekends and nights (SWAN) tool, a self-administered survey designed to help hospitals evaluate their abilities and identify opportunities for improvement in the provision of after-hours care. The author comments on the rationale for development of the tool and summarizes current evidence concerning safety issues in after-hours care. A copy of the survey instrument is included in the article, along with guidelines for effective use of the tool.
- 3. Awareness and Reporting of Adverse Drug Reactions among Health Care Professionals in Sudan.**
Elnour AA, Ahmed AD, Abd Elrahman Yousif M, Shehab A.
Jt Comm J Qual Patient Saf. 2009(Jun); 35(6):324–329.
This study assessed knowledge, attitudes, and practices relating to adverse drug reactions (ADRs) and ADR reporting among a large group of healthcare professionals in Wad Madani, Sudan. In a survey of 475 nurses, physicians, and pharmacists at eight hospitals, the authors found that many respondents lacked awareness about ADR reporting systems at their facilities, suggesting that efforts are needed both to educate staff about existing systems and to develop and implement such systems where none currently exist. One table and one figure are included.
- 4. Catheter-Associated Urinary Tract Infection and the Medicare Rule Changes.**
Saint S, Meddings JA, Calfee D, Kowalski CP, Krein SL.
Ann Intern Med. 2009 (Jun 16); 150(12):877–884.
Catheter-associated urinary tract infections (CAUTIs) are one of the hospital-acquired conditions no longer considered reimbursable under the payment policy change implemented by the Centers for Medicare & Medicaid Services (CMS) last October. In this commentary, the authors summarize recent data and published guidelines on CAUTI management and prevention, review the details of the new CMS policy, and discuss expected benefits, potential unintended consequences, and possible further ramifications of the policy change. Three tables and one figure are included.

- 5. Color Coded Medication Safety System Reduces Community Pediatric Emergency Nursing Medication Errors.**
Feleke R, Kalynych CJ, Lundblom B, Wears R, Luten R, Kling D.
J Patient Saf. 2009(Jun); 5(2):79–85.
This study investigated whether the use of a color-coded pediatric dosage chart could help to improve medication safety in the community emergency department setting. Sixteen community ED nurses were asked to perform medication preparation tasks in a simulated emergency scenario using first a conventional dosage chart and then the color-coded system. The authors found that both speed and accuracy increased with use of the color-coded system, suggesting that such a tool can be a useful device for reducing errors and improving safety of medication administration in pediatric emergency care. Multiple tables and figures are included.
- 6. Developing and Evaluating a Trigger Response System.**
Cherry K, Martinek J, Esleck S, Ivory A, Logan R, Ward J.
Jt Comm J Qual Patient Saf. 2009(Jun); 35(6):331–338.
This article describes the implementation, evaluation, and impact of a trigger response system at a tertiary care hospital. Trigger response, a component of rapid response systems (RRS), is the process used to summon the rapid response team when a RRS call is initiated. The authors discuss the design and selection of the system, describe in detail the implementation process, and comment on preliminary results. Three tables and two figures are included.
- 7. Development and Validation of the SURgical PATient Safety System (SURPASS) Checklist.**
De Vries EN, Hollmann MW, Smorenburg SM, Gouma DJ, Boermeester MA.
Qual Saf Health Care. 2009(Apr); 18(2):121–126.
This article describes the design, validation, and testing for usability of a surgical patient safety checklist developed at Academic Medical Center, Amsterdam, The Netherlands. The resulting checklist consists of 60 items in five sections spanning the continuum of surgical care from admission to discharge (the authors note that theirs is the first such checklist to cover the entire surgical patient pathway). Ongoing research on the implementation and efficacy of the checklist and its potential future applications are discussed. Multiple tables and figures are included.
- 8. Ending Extra Payment for “Never Events” — Stronger Incentives for Patients’ Safety.**
Milstein A.
N Engl J Med. 2009(Jun 4); 360(23):2388–2390.
This article comments on the recent Medicare policy changes that terminate reimbursements to hospitals for additional costs associated with treating “never events” and certain other hospital-associated complications. The author discusses the political context of these changes and their implications as a part of a trend toward requiring healthcare providers to assume greater financial accountability for errors and defects in quality of care. One table is included.

9. Factors Influencing Incident Reporting in Surgical Care.

Kreckler S, Catchpole K, McCulloch P, Handa A.
Qual Saf Health Care. 2009(Apr); 18(2):116–120.

This study examined surgical staff's perceptions and practices concerning surgical incident reporting through a survey of 137 doctors and nurses at a UK teaching hospital. Respondents were asked about their knowledge and use of the hospital's reporting system as well as their inclination to report incidents in several hypothetical scenarios. Results showed that nurses were more familiar with the hospital's reporting system and were more likely than doctors to have reported events using the system. Regarding the hypothetical incidents, events resulting in harm were more likely to be reported than events with no harm or near misses, and certain types of events were more likely to be reported than others. Possible explanations for these findings and implications are discussed. Two tables and four figures are included.

10. Health Care–Associated Infection Prevention and Control: Pharmacists' Role in Meeting National Patient Safety Goal 7.

Tauman AV, Robicsek A, Roberson J, Boyce JM.
Hosp Pharm. 2009(May); 44(5):401–411.

Available at: http://www.factsandcomparisons.com/assets/hpdatanamed/20090501_May2009_peer3.pdf

This article summarizes presentations from a December 2008 symposium dealing with the role of pharmacists in the management and prevention of healthcare-associated infections (HAIs). Two successful hospital-based HAI prevention initiatives are highlighted: a program for universal MRSA surveillance developed at NorthShore University HealthSystem, Evanston, Ill, and an antimicrobial stewardship program established at the Hospital of Saint Raphael, New Haven, Conn. Multiple tables and figures are included.

11. How Active Resisters and Organizational Constipators Affect Health Care–Acquired Infection Prevention Efforts.

Saint S, Kowalski CP, Banaszak-Holl J, Forman J, Damschroder L, Krein SL.
Jt Comm J Qual Patient Saf. 2009(May); 35(5):239–246.

This study sought to explore the role of hospital personnel in the adoption of evidence-based practices for the prevention of healthcare-associated infection (HAI). The authors conducted interviews with 86 staff members from a purposive sample of 14 hospitals in which participants were asked about their experiences with implementation of HAI prevention practices and the factors that facilitated or obstructed implementation. Results suggested that hospital personnel's resistance was a common obstacle to implementation of best practices, and that such forms of resistance could be classified as one of two distinct types: active resisters and "organizational constipators." Examples of each type and strategies for overcoming resistance to change are discussed. Four tables are included.

- 12. Impact of a Comprehensive Patient Safety Strategy on Obstetric Adverse Events.**
Pettker CM, Thung SF, Norwitz ER, et al.
Am J Obstet Gynecol. 2009(May); 200(5):492.e1–492.e8.
Available at: <http://download.journals.elsevierhealth.com/pdfs/journals/00029378/PIIS0002937809000921.pdf>
This article describes the development, implementation, and impact of an initiative that aimed to improve obstetric safety at a large academic medical center. The multipart improvement program consisted of an array of organizational, technological, and educational interventions including standardization of protocols, introduction of an obstetric safety nurse position, and staff training in teamwork and communication. Results showed that implementation of the program was associated with significant safety improvements as measured by the Adverse Outcomes Index, a composite measure that reflects the collective incidence of 10 obstetric adverse events, as well as improvements in perceived safety culture. One table and two figures are included.
- 13. Learning Networks for Sustainable, Large-Scale Improvement.**
McCannon CJ, Perla RJ.
Jt Comm J Qual Patient Saf. 2009(May); 35(5):286–291.
This article discusses the use of “learning networks” in healthcare and argues that such entities can play an essential role in quality and safety improvement efforts. The authors highlight national healthcare improvement initiatives that have advantageously employed learning networks and describe key factors in their success. Finally, they comment on the prospects for development of a national learning network in the United States. One table and one figure are included.
- 14. Levels of Consciousness during Regional Anesthesia and Monitored Anesthesia Care: Patient Expectations and Experiences.**
Esaki RK, Mashour GA.
Anesth Analg. 2009(May); 108(5):1560–1563.
This study compared the expected and experienced levels of consciousness in 117 patients who had undergone procedures involving nongeneral anesthesia (regional anesthesia or monitored anesthesia care). The authors found that both expectations and experiences of complete unconsciousness were common, and that patients’ expectations concerning the procedure often derived from a source other than the anesthesia provider. The authors suggest that pre-procedure counseling from anesthesia providers may help to clarify patients’ expectations concerning intraoperative consciousness, and that further research concerning patients’ subjective experience of anesthesia is warranted. Three tables and two figures are included.

- 15. Medication Errors Resulting from Computer Entry by Nonprescribers.**
Santell JP, Kowiatek JG, Weber RJ, Hicks RW, Sirio CA.
Am J Health-Syst Pharm. 2009(May 1); 66(9):843–853.
This study sought to identify and classify medication errors associated with the use of computerized medication order entry systems by non-prescribing healthcare personnel. The authors examined MEDMARX data from a 4.5 year period and comparable data from a university medical center with respect to error severity, type of error, type of drug involved, and other characteristics. Detailed descriptive results are presented and the implications of these findings for safe medication practices are discussed. Results showed that while a considerable number of errors reached patients, only a small number (less than 1% of total errors) resulted in harm. Of note was the finding that, among the MEDMARX data, computer entry increased the likelihood of certain types of errors, suggesting that order-entry technology may itself contribute to error. Multiple tables are included.
- 16. Pediatric Safety Incidents from an Intensive Care Reporting System.**
Skapik JL, Pronovost PJ, Miller MR, Thompson DA, Wu AW.
J Patient Saf. 2009(Jun); 5(2):95–101.
This study sought to describe the nature, severity, and correlates of adverse events and safety incidents in the pediatric intensive care population. The authors conducted a cross-sectional analysis using two years' worth of data from a national incident reporting system, which included a total of 464 incidents reported by 23 ICUs. Results showed that incidents frequently involved physical injury or other harm to a patient. Consistent with expectations, medication errors accounted for the greatest number of incidents; however, medication errors were less likely than other types of incidents to cause harm. Most incidents were associated with multiple contributing factors; patient characteristics were the most frequently cited contributing factor and were associated with increased likelihood of harm. Further results, significance of these findings, and possible strategies for improving safety in the pediatric intensive care environment are discussed. Multiple tables are included.
- 17. Safety Outcomes in the United States: Trends and Challenges in Measurement.**
Greenberg MD, Haviland AM, Yu H, Farley DO.
Health Serv Res. 2009(Apr); 44(2 Pt 2):739–755.
The difficulty of measuring progress in patient safety and the lack of a national standardized system of measurement have been widely recognized as obstacles to the advancement of healthcare improvement efforts. This study, undertaken to support future research efforts by the Agency for Healthcare Research and Quality, sought to assess trends in selected patient safety outcomes in the US and to gauge the usefulness of available data sources and outcome measures. The authors examined published data from the Joint Commission, MEDMARX, and the Centers for Medicare and Medicaid Services (CMS) as well as measures derived by the authors from the application of selected patient safety indicators to hospital administrative data. Advantages and limitations of the methods examined and challenges and opportunities in the development of effective mechanisms for patient safety measurement are discussed. Four figures are included.

18. The Cost Conundrum.

Gawande A.

New Yorker. 2009(Jun 1):36–44.

Available at: http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande

This article takes an in-depth look at the economics of healthcare in the US and attempts to unravel some of the system's apparent paradoxes: why healthcare spending is much higher in some communities than in others, and why higher spending does not equate to better or more effective care. To illustrate his discussion, Dr. Gawande examines the case of a Texas town with some of the nation's highest per capita Medicare expenditures, as well as several communities and health systems, such as the Mayo Clinic, that have achieved exceptionally high-quality care with lower-than-average costs. Finally, he discusses possible approaches to addressing the problem of out-of-control healthcare spending and the implications for the future of healthcare in the US if the current state of disjunction between cost and quality of care continues to prevail.

19. The Growth of Partnerships to Support Patient Safety Practice Adoption.

Mendel P, Damberg CL, Sorbero MES, Varda DM, Farley DO.

Health Serv Res. 2009(Apr); 44(2 Pt 2):717–738.

Multi-organization collaborative educational networks have been recognized as an important supporting factor in many patient safety and quality improvement efforts. This paper presents a systematic analysis of patient safety partnerships in the US between 2004 and 2006. The authors interviewed representatives of national patient safety organizations and used social network analysis to describe patient safety partnerships with respect to structure, function, and changes over time. They found that patient safety partnerships increased in number and activity during the time period examined, suggesting increasing capacity for beneficial exchange of information and dissemination of practices within the healthcare system. Multiple tables and figures are included.

20. Using Quality Indicators to Improve Hospital Care: A Review of the Literature.

De Vos M, Graafmans W, Kooistra M, Meijboom B, Van der Voort P, Westert G.

Int J Qual Health Care. 2009(Apr); 21(2):119–129.

This article presents findings of a systematic review concerning the implementation and impact of quality indicators as a means of improving hospital performance. A total of 21 eligible studies were identified and analyzed with respect to study design, implementation method, and effects on care processes and on patient outcomes. The authors found that most studies employed multiple implementation methods; use of feedback reports was common and appeared to promote effectiveness of the intervention. Most studies measured the effect of the intervention on care processes and found that use of indicators was associated with process improvements; only 6 of the 21 studies looked at patient outcomes, and of these, only 2 reported improvement in outcomes associated with the use of quality indicators. Four tables and one figure are included.

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