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1. **A 62-Year-Old Woman with Skin Cancer Who Experienced Wrong-Site Surgery: Review of Medical Error.**
Gallagher TH.
JAMA. 2009(Aug 12); 302(6):669–677.
This article presents a case study and discussion of an instance of medical error involving wrong-site surgery. After giving accounts of the incident from the perspectives of the patient and of the physician involved, the author reflects on the questions raised by this case in relation to current research, policy, and practice concerning disclosure of and response to medical error. Two tables are included.

2. **A Comparison of Hospital Adverse Events Identified by Three Widely Used Detection Methods.**
Naessens JM, Campbell CR, Huddleston JM, et al.
Int J Qual Health Care. 2009(Aug); 21(4):301–307.
This study looked at three common methods for the detection of adverse events: the Agency for Healthcare Research and Quality patient safety indicators, self-report by providers, and the Institute for Healthcare Improvement Global Trigger Tool. The authors compared adverse events identified by each method among all patients discharged from Mayo Clinic Rochester hospitals in 2005. They found that approximately 4% of discharges had an adverse event detected by one or more methods with relatively little overlap between methods. The authors conclude, in agreement with other studies, that the use of multiple event detection methods provides an effective approach for internal assessment, but they caution that a combined approach may be less appropriate for public reporting or comparison between organizations. Three tables and one figure are included.

3. **A Systematic Review of Health Care Efficiency Measures.**
Hussey PS, De Vries H, Romley J, et al.
Health Serv Res. 2009(Jun); 44(3):784–805.
This study sought to identify and describe existing measures of healthcare efficiency. The authors identified 265 efficiency measures in the published literature, as well as eight proprietary measures developed by vendors or organizations. The measures were classified with respect to denominator of measurement (e.g., efficiency can be measured at the hospital, physician, or health-plan level), inputs, outputs, methods, and evidence of scientific robustness. The authors conclude that while numerous efficiency measures exist, most have not been validated scientifically, and most focus on costs without incorporating information about quality of care. Further details of these findings and issues to be addressed for the field of efficiency measurement are discussed. Two tables and two figures are included.

4. Application of Patient Safety Indicators Internationally: A Pilot Study among Seven Countries.

Drösler SE, Klazinga NS, Romano PS, et al.

Int J Qual Health Care. 2009(Aug); 21(4):272–278.

This study examined the feasibility of using the Agency for Healthcare Research and Quality patient safety indicators (PSIs) as a basis for international comparison of patient safety and quality performance. Hospital- and national-level PSI data from seven countries (USA, UK, Sweden, Spain, Germany, Canada, and Australia) were analyzed statistically to assess indicator rates and between-country variation (country-specific data are presented anonymously in the article). Results suggested that the PSIs could conceivably be used as a foundation for international patient safety comparisons, but that a number of methodological considerations would need to be addressed to ensure validity of this approach. Three tables and two figures are included.

5. Are Patients in Part to Blame when Doctors Miss the Diagnosis?

Chen PW.

New York Times. August 7, 2009.

Available at: http://www.nytimes.com/2009/08/07/health/07chen.html

This article comments on a recent study that showed that failures or delays in diagnosis often involved deficits in processes of care, and that the actions of physicians and of patients contributed about equally to these deficits. The author discusses patient circumstances that may play a role in erroneous or missed diagnoses and what doctors can do to help eliminate obstacles that prevent patients from seeking timely care.

6. Effects of the Premier Hospital Quality Incentive Demonstration on Medicare Patient Mortality and Cost.

Ryan AM.

Health Serv Res. 2009(Jun); 44(3):821–842.

The Premier Hospital Quality Incentive Demonstration (PHQID) project is an incentive-based improvement initiative that rewards hospitals financially for high performance on certain measures of quality of care. This study sought to assess the impact of the PHQID by evaluating its effects on mortality and Medicare costs in Medicare patients treated between 2000 and 2006. In an econometric analysis of data on more than 6.7 million patients treated during this period, the authors found that PHQID did not significantly affect patient mortality or Medicare cost. Possible explanations for these findings and implications are discussed. Four tables and one figure are included.

7. Global Priorities for Patient Safety Research.
Bates DW, Larizgoitia I, Prasopa-Plaizier N, Jha AK.
BMJ. 2009(May 23); 338:b1775.
This article describes the development by the WHO World Alliance for Patient Safety of a priority-ranked list of topics for research in developing, transitional, and developed countries. The authors list the top priorities identified for countries at each level of development and comment on the similarities and differences among the lists. Communication and coordination, organizational or system failures, and safety culture were identified as areas of priority for research in developed countries, while development and evaluation of locally effective solutions and cost effectiveness of risk reduction strategies were considered priorities for developing and transitional countries. Two tables are included.

8. High Quality Care and Ethical Pay-for-Performance: A Society of General Internal Medicine Policy Analysis.
Wharam JF, Paasche-Orlow MK, Farber NJ, et al.
J Gen Intern Med. 2009(Jul); 24(7):854–859.
This position paper argues that while the premise of pay for performance is ethically sound, its implementation in practice entails risks that could pose serious ethical concerns. The authors delineate these issues, which include uncertainty about the benefit of pay for performance for patients, insufficient understanding and measurement of quality, the potential for adverse unintended consequences, and lack of oversight. Finally, they propose policy recommendations for corrective strategies to address these concerns.

9. Implementing Standardized Operating Room Briefings and Debriefings at a Large Regional Medical Center.
Berenholtz SM, Schumacher K, Hayanga AJ, et al.
Jt Comm J Qual Patient Saf. 2009(Aug); 35(8):391–397.
This article describes the implementation and impact of a briefing and debriefing procedure designed to improve teamwork among surgical staff at a tertiary-care teaching hospital. The briefing and debriefing tool used structured communication techniques to promote safety-enhancing behaviors such as team awareness and coordination. The authors found that use of the tool consistently improved self-perceived teamwork and communication among surgical team members representing a range of surgical specialties. Two tables and one figure are included.

10. Improving Measurement in Clinical Handover.
Jeffcott SA, Evans SM, Cameron PA, Chin GSM, Ibrahim JE.
Qual Saf Health Care. 2009(Aug); 18(4):272–276.
This article emphasizes the need for more rigorous methods for assessing clinical handover and discusses how such methods might be devised. The authors present a conceptual model for patient handover and describe how application of such a model could facilitate the development of standardized measurements. This, in turn, the authors argue, could help to guide research and improvement efforts to eliminate handover-related errors and enhance patient safety. Multiple figures are included.

11. Pseudoinnovation: The Development and Spread of Healthcare Quality Improvement Methodologies.
Walshe K.
Int J Qual Health Care. 2009(Jun); 21(3):153–159.
This article examines trends in the diffusion of healthcare quality improvement techniques over the past 20 years and takes a critical look at the possible effects of this process on organizational quality improvement practices. The author argues that the development and adoption of new QI techniques that are essentially similar to existing methods represents a form of "pseudoinnovation" that may ultimately hamper, rather than benefit, quality improvement efforts. Two tables and two figures are included.

12. Resilience in Healthcare and Clinical Handover.
Jeffcott SA, Ibrahim JE, Cameron PA.
Qual Saf Health Care. 2009(Aug); 18(4):256–260.
Resilience, an important concept in human factors science, describes the ability of people or systems to maintain safety by effectively anticipating and managing risk in hazardous environments. This article explains the concept of resilience and discusses how it might be applied in healthcare, using the area of clinical handover as an example. Multiple tables are included.

13. The Assessment of Adverse Events in Hospitals in Brazil.
Mendes W, Martins M, Rozenfeld S, Travassos C.
Int J Qual Health Care. 2009(Aug); 21(4):279–284.
This study sought to describe the incidence and preventability of adverse events in three Rio de Janeiro teaching hospitals. The authors retrospectively reviewed records of 1,100 randomly selected patients admitted during 2003. They found that adverse events occurred in 7.6% of hospitalizations and that two-thirds of these events were preventable. The authors note that while the overall incidence of adverse events is comparable to rates observed in developed nations, the relative percentage of preventable adverse events appears to be significantly higher among Brazilian hospitals. Two tables are included.

14. The New Sentinel Network — Improving the Evidence of Medical-Product Safety.
Platt R, Wilson M, Chan KA, Benner JS, Marchibroda J, McClellan M.
N Engl J Med. 2009(Aug 13); 361(7):645–647.
This article comments on the FDA's recently launched Sentinel Initiative, a national network for the collection and analysis of data on the safety of drugs and medical devices. The authors describe the structure and objectives of the initiative and discuss its potential for success, including a consideration of methodological strengths and limitations, as well as technical challenges that may arise.

15. The Risks of Rewards in Health Care: How Pay-for-Performance Could Threaten, or Bolster, Medical Professionalism.
Wynia MK.
J Gen Intern Med. 2009(Jul); 24(7):884–887.
In this commentary, the author looks at pay for performance in relation to medical professionalism and challenges assumptions that he sees as implicit in the design of physician-targeted pay-for-performance systems. He argues that, while it is assumed that rewarding excellent performance will encourage more of the same, application of incentives could paradoxically compromise performance by weakening physicians' intrinsic motivation. He concludes that physicians must play a formative role in the development of quality measurement definitions and processes to ensure that pay for performance reinforces medical professionalism rather than undermining it.

16. The Shifting Mission of Health Care Delivery Organizations.
Bohmer RMJ, Lee TH.
N Engl J Med. 2009(Aug 6); 361(6):551–553.
This commentary describes how healthcare payment reform could lead to fundamental changes in the structure and objectives of the healthcare delivery system in the US. The authors discuss how the transformation from a service-focused to an outcomes-focused model of care delivery might take place and comment on the implications of such a change for healthcare organizations, physicians, and executives.

17. Thinking Outside the Pillbox: A System-Wide Approach to Improving Patient Medication Adherence for Chronic Disease.
Cambridge, MA: New England Healthcare Institute; August 2009.
Available at: http://www.nehi.net/publications/
Poor medication adherence is common in patients with chronic conditions and can lead to poor outcomes and increased healthcare costs. This report summarizes published data on the prevalence, costs, and clinical consequences of poor medication adherence, reviews research on the efficacy of various interventions, and discusses other potential strategies for addressing this issue.

18. Use of Strategies from High-Reliability Organisations to the Patient Hand-Off by Resident Physicians: Practical Implications.
Philibert I.
Qual Saf Health Care. 2009(Aug); 18(4):261–266.
This study explored multiple factors influencing the safety of patient hand-offs in a group of medical residents. The authors conducted interviews and surveys with medical residents in three specialties to assess methods and mediums of handoff communication, the impact of work-hour restrictions on handoffs, and use of techniques from high-reliability organizations as a means of improving handoff communication and patient safety. The authors present descriptive findings and comment on possibilities for further research in this area. Four tables are included.

19. What Are the Critical Success Factors for Team Training in Health Care?
Salas E, Almeida SA, Salisbury M, et al.
Jt Comm J Qual Patient Saf. 2009(Aug); 35(8):398–405.
This article comments on the increasing use of team training as a tool for quality and safety improvement in healthcare and offers practical guidelines on developing and implementing a team training program. On the basis of a review of the published literature, the authors identify seven key requirements for effective team training, each of which is discussed with an example and tips for successful implementation. One table is included.

20. WHO Guidelines on Hand Hygiene in Health Care.
Geneva, Switzerland: World Health Organization; 2009.
Available at: http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf
This publication provides a comprehensive review of scientific evidence related to hand hygiene in the healthcare environment along with practice recommendations and implementation guidelines developed by the WHO.

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Anita Spielman, Editor
aspielman@npsf.org