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1. 10 Steps to Better Health Care.

Gawande A, Berwick D, Fisher E, McClellan M.
New York Times. August 13, 2009:A27.

Available at: <http://www.nytimes.com/2009/08/13/opinion/13gawande.html>

This op-ed piece argues that there are viable solutions to the US healthcare payment crisis that would avoid the need for undesirable measures such as increased taxes or rationing of care. The authors compared healthcare communities throughout the US and identified those that were distinguished by cost and quality profiles notably better than the national averages. They highlight the approaches of ten of these communities as an illustration of how alternatives to the current systems might work, and suggest that the nation as a whole should try to emulate these “positive outliers.”

2. Adverse Events and Potentially Preventable Deaths in Dutch Hospitals: Results of a Retrospective Patient Record Review Study.

Zegers M, De Bruijne MC, Wagner C, et al.
Qual Saf Health Care. 2009(Aug); 18(4):297–302.

This study sought to quantify and characterize adverse events (AEs) among inpatients at 21 hospitals in the Netherlands during 2004. The authors retrospectively reviewed records from 3,943 discharged patients and 3,983 deceased patients to assess the frequency, nature, preventability, and clinical consequences of adverse events. They found that AEs occurred in 5.7% of all admissions (some admissions had multiple AEs) and that nearly two-fifths of AEs were considered preventable. While the majority of AEs resulted in no permanent harm, a significant number (12.8%) were associated with permanent harm or death. Surgery-related AEs were the most common type, accounting for more than half of all events. Further results are presented and implications of these findings discussed in the article. The authors note that theirs is the largest study to date examining the incidence of AEs in a European patient population. One figure and multiple tables are included.

3. Back to Basics: Ten Steps to Save 85,000 Lives and \$35 Billion a Year in Health Care Delivery.

Gima Z, Gosselar P, Levine A, Lincoln T, Ramirez A.
Washington, DC: Public Citizen; 2009.

Available at: <http://www.citizen.org/documents/BackToBasics.pdf>

This report identifies ten potential interventions to improve the delivery of healthcare that available evidence suggests hold promise as straightforward, highly effective means of improving safety and reducing costs. The first part of the report presents each reform along with estimates of potential savings in healthcare costs and preventable deaths that could accrue from its implementation. The second part of the report outlines steps that the federal government could take to support implementation of such reforms.

- 4. Copy and Paste: A Remediable Hazard of Electronic Health Records.**
Siegler EL, Adelman R.
Am J Med. 2009(Jun); 122(6):495–496.
This editorial discusses problems that can occur when clinicians copy and paste information between entries in electronic patient records — a charting expedient enabled by computerized health record technology. They argue strongly against this practice, citing its potential to diminish the quality of clinical narrative, impede communication between providers, and contribute to the propagation of errors. They discuss possible remedies to the problem and how the adoption of alternative approaches to charting might help.
- 5. Data-Based Risk Calculators Becoming More Sophisticated — and More Popular.**
Mitka M.
JAMA. 2009(Aug 19); 302(7):730–731.
This article comments on recent developments and growing interest in the use of risk calculators — tools that use aggregated patient data to assess the risks and benefits of a specific procedure for a given patient. The author highlights several risk calculators currently in development and discusses how the application of such tools could help to improve quality and patient safety.
- 6. Elements of Danger — The Case of Medical Imaging.**
Lauer MS.
N Engl J Med. 2009(Aug 27); 361(9):841–843.
This editorial comments on the article by Fazel et al. in the same issue of New England Journal of Medicine, which reports research results suggesting that radiation exposure from routine medical imaging procedures in the general population occurs at levels that pose significant concern (see item 7). The author argues that these findings highlight the need for a fundamental reconsideration of the use of medical imaging, and discusses what would be required for such a shift to occur. One figure is included.
- 7. Exposure to Low-Dose Ionizing Radiation from Medical Imaging Procedures.**
Fazel R, Krumholz HM, Wang Y, et al.
N Engl J Med. 2009(Aug 27); 361(9):849–857.
This study sought to quantify cumulative annual radiation exposure associated with medical imaging procedures in the general population of US adults. The authors analyzed insurance claims data on more than 950,000 patients from five regions of the country over a two-year period to estimate annual effective radiation doses experienced as a result of diagnostic or therapeutic imaging procedures. They calculated the distribution of radiation doses among four categories (low, moderate, high, or very high) and assessed the relationship between several patient and procedure variables and level of exposure. Results showed that while most patients received low cumulative doses, significant numbers received doses that were moderate, high, or very high; annual effective doses increased as a function of patient age and were higher overall among women than among men. While acknowledging several limitations, the authors argue that their findings warrant concern and emphasize the need for strategies to ensure appropriate use of imaging procedures. Three tables and one figure are included.

- 8. Hospital-Acquired Infections — New York State 2008.**
Albany, NY: New York State Department of Health; May 1, 2009.
Available at: http://www.health.state.ny.us/statistics/facilities/hospital/hospital_acquired_infections/2008/docs/hospital-acquired_infection.pdf
This report presents data on rates of hospital-acquired infections (HAIs) at New York hospitals during 2008. Hospital-specific rate comparisons, regional comparisons, and comparisons of New York State and national rates are provided. Also included in the report are discussions of findings, lessons learned, and next steps for the reporting system, as well as descriptions of ongoing HAI prevention initiatives sponsored by the NY State Department of Health.
- 9. Hospital Mortality among Major Trauma Victims Admitted on Weekends and Evenings: A Cohort Study.**
Laupland KB, Ball CG, Kirkpatrick AW.
J Trauma Manag Outcomes. 2009(Jul 27); 3(8).
Available at: <http://www.traumamanagement.org/content/3/1/8>
Some evidence suggests that hospital patients admitted during evenings or weekends may experience poorer outcomes than those admitted during regular business hours. This study assessed the impact of day and time of admission on in-hospital mortality among 4,000 patients with major trauma admitted to four hospitals in the Calgary Health Region, Alberta, Canada, during a four-year period. In a statistical analysis, the authors found no association between day or time of admission and likelihood of in-hospital mortality in the study sample. Possible explanations for these findings and their implications are discussed. Two tables and two figures are included.
- 10. Hospital Quality and Intensity of Spending: Is There an Association?**
Yasaitis L, Fisher ES, Skinner JS, Chandra A.
Health Aff. 2009(Jul/Aug); 28(4):w566–w572.
This study examined the relationship between cost and quality of care at the individual facility level in a large group of US hospitals. Using data from the CMS Hospital Compare project, the authors compared hospitals' performance on process-of-care quality measures for three conditions with Medicare spending on end-of-life care in 2,712 hospitals during the period 2004–2007. They found that hospital-level spending and quality performance either were not correlated or were negatively correlated for each of the quality indices examined. The authors discuss these findings in the context of previous related studies, which primarily have examined cost-quality relationships at the regional level, and comment on the implications for quality reporting. Multiple tables and figures are included.

- 11. Implementing a Pediatric Rapid Response System to Improve Quality and Patient Safety.**
Van Voorhis KT, Willis TS.
Pediatr Clin N Am. 2009(Aug); 56(4):919–933.
This article reviews recent published data on the development, implementation, evaluation, and impact of rapid response systems and presents case examples describing the implementation of successful pediatric rapid response systems at two North Carolina children’s hospitals. Three tables are included.
- 12. Leadership Committed to Safety.**
The Joint Commission.
Sentinel Event Alert. Issue 43, August 27, 2009.
Available at: http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_43.htm
Citing evidence that lapses in leadership may contribute to a substantial number of sentinel events, this alert addresses the crucial need for healthcare organizational leaders to demonstrate commitment to and play a major role in patient safety. The authors discuss the role of leaders in cultivating institutional practices and attitudes that promote patient safety, as well as in responding to unsafe behavior with appropriate disciplinary action. Finally, they review the relevant existing Joint Commission standards and offer recommendations for senior leaders on meeting these requirements.
- 13. Meeting the Challenge of Patient Safety in the Ambulatory Care Setting.**
Turney S, Evans EW, Callaway E, et al.
Englewood, CO: Medical Group Management Association; 2009.
Available at: <http://blog.mgma.com/free-patient-safety-in-ambulatory-care-setting-white-paper>
This white paper outlines the history of the patient safety movement and its spread from the inpatient to the ambulatory care setting. The authors review important patient safety considerations in ambulatory surgery, office-based surgery, and primary care. Finally, they discuss the need for policies and procedures that underpin safe practice and the roles of administrators and clinical leaders in promoting safety practices.
- 14. Nursing: A Key to Patient Satisfaction.**
Kutney-Lee A, McHugh MD, Sloane DM, et al.
Health Aff. 2009(Jul/Aug); 28(4):w669–w677.
This study examined the relationship between nurses’ work environments and patient satisfaction with care at 430 hospitals in four US states. The authors analyzed data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in conjunction with nurse survey data on work environment, staffing levels, and other factors to assess potential correlations. They found significant positive associations between quality of nurses’ work environment and all dimensions of patient satisfaction as measured by the HCAHPS instrument; they found in addition that nurse-patient ratios influenced several measures of patient satisfaction. The authors conclude that these findings reinforce evidence of a link between nursing factors and patient-perceived quality of care. Three tables are included.

- 15. Physician Practice Patterns Resemble ACGME Duty Hours.**
Anim M, Markert RJ, Wood VC, Schuster BL.
Am J Med. 2009(Jun); 122(6):587–593.
This study surveyed 570 practicing physicians in the Dayton, Ohio, area to assess their knowledge of resident duty hour regulations enacted in 2003 by the Accreditation Council for Graduate Medical Education (ACGME) and the correspondence between their actual work hours and the standards imposed for residents. They found that a majority of practicing physicians were aware of the regulations but that their work hours often exceeded the ACGME limits: for instance, approximately 42% reported working more than the mandated limit of 80 hours per week for residents. Respondents were less aware of ACGME rules requiring residents to take 10-hour rest periods between shifts and 4 days off per month, but their work hours were more likely to follow these standards. Accordance between actual work hours and ACGME standards was closer among physicians in practice for fewer than five years than among those in practice longer. Further findings and implications are discussed. Multiple tables are included.
- 16. Setting Priorities for Patient Safety: Ethics, Accountability, and Public Engagement.**
Pronovost PJ, Faden RR.
JAMA. 2009(Aug 26); 302(8):890–891.
Allocation of resources to support patient safety research and improvement efforts is complicated by the difficulty of determining which areas should be given priority. This commentary examines ethical considerations involved in setting such priorities and suggests guidelines for further discussion of this issue.
- 17. The Incidence of Adverse Events in Swedish Hospitals: A Retrospective Medical Record Review Study.**
Soop M, Fryksmark U, Köster M, Haglund B.
Int J Qual Health Care. 2009(Aug); 21(4):285–291.
This study sought to describe the frequency, nature, preventability, and clinical consequences of adverse events in Swedish hospitals. In an analysis of data on 1,967 admissions at 28 Swedish hospitals over a one-year period, the authors identified a total of 241 adverse events, of which 169 were considered preventable. Extrapolating from these findings to a total of 1.2 million annual admissions yielded an estimate of 105,000 preventable adverse events and 630,000 excess days of hospitalization per year. Multiple tables are included.
- 18. “There Is A Chain of Chinese Whispers...”: Empirical Data Support the Call to Formally Teach Handover to Prequalification Doctors.**
Cleland JA, Ross S, Miller SC, Patey R.
Qual Saf Health Care. 2009(Aug); 18(4):267–271.
This article presents findings from a focus-group study that explored attitudes and experiences concerning patient handover among junior doctors at a large teaching hospital in Aberdeen, UK. The authors found that many participants understood the process of handover intellectually but struggled with it in practice. They discuss ways in which medical curricula could better prepare new doctors to deal with the handover process and how insights from this study might inform such efforts.

19. Using Medical Emergency Teams to Detect Preventable Adverse Events.

Iyengar A, Baxter A, Forster AJ.

Crit Care. 2009(Jul 30); 13(4):R126.

Available at: <http://ccforum.com/content/13/4/R126>

This study investigated whether data from medical emergency team (MET) calls could be used as a means of identifying preventable adverse events at an academic tertiary care hospital. The authors examined prospectively collected data on 65 MET calls that occurred during a 4-week period to assess clinical and organizational characteristics and to determine how frequently the precipitating circumstances involved a preventable adverse event. They found that nearly 25% of the cases examined involved a preventable adverse event, most of which stemmed from therapeutic errors. (The possibility of bias due to small sample size and facility-specific factors are discussed in the article.) On the basis of their findings, the authors suggest that analysis of MET calls represents a useful, low-cost, and easily implementable method of surveillance for preventable adverse events. One table is included.

20. What Are Covering Doctors Told about Their Patients? Analysis of Sign-Out among Internal Medicine House Staff.

Horwitz LI, Moin T, Krumholz HM, Wang L, Bradley EH.

Qual Saf Health Care. 2009(Aug); 18(4):248–255.

This study sought to evaluate the content and quality of communication during sign-outs, (i.e., handoffs of care), and to assess factors influencing quality of such communication among house staff at an urban university hospital. The authors analyzed oral and written exchanges between outgoing and incoming teams in a total of 88 sign-out sessions involving 503 patient sign-outs. Descriptive and quantitative analyses, detailed in the article, showed that sign-out interactions tended to use imprecise language and unstructured communication styles, and that important elements of patient information were frequently omitted; system and organizational factors played a considerable role in sign-out quality. Implications of these findings for further research and improvement efforts are discussed. Multiple tables and figures are included.

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