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1. **Adequacy of Consent Documentation in a Specialty Surgical Unit: Time for Community Debate?**
Siddins MT, Klinken EM, Vocale LR.
Med J Aust. 2009(Sep 7); 191(5):259–262.
This study assessed the quality of information provided on procedural consent forms for urological surgery patients at a teaching hospital in Adelaide, South Australia. The analysis, which involved review of a total of 1,280 consent forms from three discrete time periods, found many deficiencies in comprehensibility and completeness of information. Fewer than 20% of forms described the procedure using nontechnical terms, and only a small percentage provided information about procedure-related risks. The authors discuss improvement efforts undertaken in response to these findings at their facility, as well as the need for the establishment of profession-wide standards in this area. Three figures are included.

2. **After a Diagnosis, Someone to Help Point the Way.**
Alderman L.
New York Times. September 12, 2009:B6.
Available at: http://www.nytimes.com/2009/09/12/health/12patient.html
This article highlights the growing market for the services of patient advocates, professionals who specialize in helping patients more effectively negotiate the healthcare system. The author describes different types of advocacy services that have become available in recent years and offers practical advice on how to find the best advocate for a variety of needs.

3. **Application of AHRQ Patient Safety Indicators to English Hospital Data.**
Bottle A, Aylin P.
Qual Saf Health Care. 2009(Aug); 18(4):303–308.
This study investigated the feasibility and validity of using AHRQ patient safety indicators to identify adverse events in English hospitals. The authors analyzed data on all National Health Service hospital admissions from a one-year period to assess rates of selected indicators and their potential correlation with several independent safety-related variables. They found that in most cases the occurrence of any of the examined indicators predicted higher rates of in-hospital mortality and unplanned readmission and longer lengths of stay. The authors conclude that the patient safety indicators could provide a useful and theoretically valid means of incident surveillance in UK hospitals, but that a number of methodological and technical considerations, notably the translation between US and UK medical coding systems, would first need to be addressed. Three tables and one figure are included.

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4. **Applying Toyota Production System Principles to a Psychiatric Hospital: Making Transfers Safer and More Timely.**
Young JQ, Wachter RM.
Jt Comm J Qual Patient Saf. 2009(Sep); 35(9):439–448.
This article describes how a psychiatric hospital redesigned its processes to improve safety and quality of care associated with transfer of patients between the hospital and its outpatient clinics. The intervention used quality improvement techniques from the manufacturing industry to standardize and simplify the transfer process, resulting in substantial and sustained improvements in timeliness and consistency. Three tables and one figure are included.

5. **Comparing Costs and Quality of Care at Retail Clinics with That of Other Medical Settings for 3 Common Illnesses.**
Mehrotra A, Liu H, Adams JL, et al.
Ann Intern Med. 2009(Sep 1); 151(5):321–328.
This study assessed costs and quality of treatment provided at retail health clinics as compared with other available options for patients belonging to a large Minnesota health plan. The authors used claims data to match episodes of care provided at retail clinics with similar cases treated at physicians' offices, urgent care clinics, or emergency departments for three common acute conditions. They found that retail clinics provided care of comparable quality to that provided in other healthcare venues and at considerably lower cost. Four tables are included.

6. **Eight Rights of Safe Electronic Health Record Use.**
Sittig DF, Singh H.
JAMA. 2009(Sep 9); 302(10):1111–1113.
While electronic health records (EHRs) have been hailed by political leaders as a panacea to the problem of medical errors, much uncertainty remains about the efficacy and safety of their use. In this commentary, the authors draw upon a human factors framework to define eight fundamental requirements for safe and effective use of EHRs and comment on what it will take to realize these objectives in practice.

7. **Electronic Medical Records at a Crossroads: Impetus for Change or Missed Opportunity?**
D'Avolio LW.
JAMA. 2009(Sep 9); 302(10):1109–1111.
The recent promulgation of incentives for electronic health record (EHR) adoption reflects the assumption that widespread adoption will lead to system-wide quality improvements. In this commentary, the author examines this assumption and suggests that simply implementing currently available EHR technology may not be enough to achieve this goal. In order to realize these potential benefits, he argues, significant changes in the design and focus of EHR systems are needed, including a greater emphasis on data standards and capabilities that will support their use within larger data networks.

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8. **Errors in Radiation Therapy.**
Pennsylvania Patient Safety Authority.
Pa Patient Saf Advis. 2009(Sep); 6(3):87–92.
Available at: http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Sep6(3)/Pages/87.aspx
This article discusses errors associated with radiation oncology procedures and approaches to preventing such errors. The authors review data from Pennsylvania hospital incident reports and the published literature concerning the incidence, causes, and consequences of radiation therapy events. They discuss technological and informatics developments that may help to reduce risk, as well as the need to apply existing safety strategies, such as patient and procedure verification, in the radiation treatment context. Four tables are included.

9. **E-Surveys as a Practical Enhancement to Tracer Methodology for Continuous Joint Commission Accreditation Readiness.**
North F, Hunt VL, Chaudhry R, Richards DD, McGee JV, Stroebel RJ.
Jt Comm J Qual Patient Saf. 2009(Aug); 35(8):430–434.
This article highlights e-surveys, an email-based tool designed to help hospitals prepare for accreditation evaluations by administering ongoing staff assessment and education. The authors describe the design, implementation, and impact of such a tool developed in the internal medicine division at the Mayo Clinic, Rochester, Minn. Two figures are included.

10. **Evaluation of Preoperative and Perioperative Operating Room Briefings at the Hospital for Sick Children.**
Khoshbin A, Lingard L, Wright JG.
Can J Surg. 2009(Aug); 52(4):309–315.
This study involved the implementation and evaluation of communication techniques designed to improve teamwork and safety awareness among OR staff at a children's hospital in Toronto, Ont. Two types of structured briefings were instituted during the study: an early morning "huddle" among OR team members to review the plan for the day, and "time-outs" before each surgical procedure to verify correctness of the patient, procedure, and surgical site. The authors found that use of the briefings significantly improved perceived safety and teamwork, but mostly among nurses; physicians were less likely to regard the briefings as useful or beneficial. Four tables and three appendices are included.

11. **How Can We Make More Progress in Measuring Physicians' Performance to Improve the Value of Care?**
Miller TP, Brennan TA, Milstein A.
Health Aff. 2009(Sep/Oct); 28(5):1429–1437.
Approaches to performance measurement in healthcare have thus far mainly addressed the performance of organizations and not that of individual practitioners. This article discusses the argument for measuring physician performance and the challenges involved, and comments on recent developments and possible future direction in this area. Two tables are included.

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12. **How Does the Quality of U.S. Health Care Compare Internationally?**
Docteur E, Berenson RA.
Urban Institute, Robert Wood Johnson Foundation. August 2009.
Available at: http://www.rwjf.org/files/research/qualityquickstrikeaug2009.pdf
This paper offers an evidence-based examination of how healthcare quality in the US compares with that in other countries — a point of political contention and popular concern in ongoing debates over healthcare reform. The authors review findings from recent studies that have compared aspects of healthcare system performance between the US and one or more other countries. Such studies have used a variety of indicators to measure relative quality of care among nations, including healthcare-amenable mortality, processes and outcomes of care for specific conditions, utilization and appropriateness, access to care, and patient safety. On the basis of their analysis, the authors conclude that US healthcare is a "mixed bag" of strengths and weaknesses, but that the available evidence supports neither claims of the current system's exceptional quality nor fears that proposed reforms will diminish quality of care for individuals.

13. **Multinational Medicines — Ensuring Drug Quality in an Era of Global Manufacturing.**
Okie S.
N Engl J Med. 2009(Aug 20); 361(8):737–740.
This article discusses how the increasing globalization of drug manufacturing has posed challenges for drug quality surveillance and regulation. Using several recent cases as illustrations, the author comments on the types of problems that can occur, describes current FDA procedures for monitoring drug quality, and highlights opportunities for improvement in these processes. Two figures are included.

14. **On-Call Supervision and Resident Autonomy: From Micromanager to Absentee Attending.**
Farnan JM, Johnson JK, Meltzer DO, Humphrey HJ, Arora VM.
Am J Med. 2009(Aug); 122(8):784–788.
This study explored attitudes and current practices concerning the supervision of resident physicians, using interviews and surveys of resident and attending physicians at a university hospital. They found that while residents and attending physicians agreed about the appropriate degree of supervision needed in hypothetical scenarios, reconciling the need for supervision with the objective of resident autonomy often proved challenging in practice. Implications of these findings for medical education and for patient safety and suggestions for improvement are discussed. One table is included.

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15. **Residents' Perceptions of a Night Float System.**
Jasti H, Hanusa BH, Switzer GE, Granieri R, Elnicki M.
BMC Med Educ. 2009(Aug 3); 9(52).
Available at: http://www.biomedcentral.com/1472-6920/9/52
Night float systems have developed in response to the need to modify traditional call schedules to comply with mandatory resident duty-hour restrictions. This study examined attitudes toward and experiences with a night float system using a survey of 149 internal medicine interns and residents at a university medical center. While respondents believed overall that the night float system benefited patient care, reduced medical errors, and improved residents' well-being, many felt that such a system could undermine continuity of care. Many respondents also expressed concern that the night float system offered fewer educational opportunities than did a traditional on-call system. Four tables are included.

16. **Safe Patient Outcomes Occur with Timely, Standardized Communication of Critical Values.**
Pennsylvania Patient Safety Authority.
Pa Patient Saf Advis. 2009(Sep); 6(3):93–97.
Available at: http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Sep6(3)/Pages/93.aspx
Errors or delays in the communication of critical laboratory results between the laboratory and care providers can compromise patient safety and quality of care. This article reviews data from Pennsylvania's reporting system on safety incidents involving communication of critical values and discusses strategies for improvement. The authors emphasize the need for standardization of definitions and procedures related to critical values and for facilities to develop effective processes to ensure that critical test results are systematically identified and promptly reported.

17. **Safety in Doses: Improving the Use of Medicines in the NHS.**
London, UK: National Patient Safety Agency; 2009.
Available at: http://www.nrls.npsa.nhs.uk/resources/?entryid45=61625
This report presents a review of data on 72,482 medication safety incidents reported by UK National Health Service facilities during 2007. The report addresses safety issues for a variety of settings of care and specific patient populations, and offers recommendations and resources for improvement.

18. **Shingles Does It.**
Coulehan J.
Health Aff. 2009(Sep/Oct); 28(5):1509–1514.
In this essay, the author, a physician and professor of medicine, recounts a firsthand experience with inefficient and poorly coordinated healthcare that began when he sought emergency treatment for a case of shingles. Reflecting on lessons that could be learned from his experiences, he discusses possible reasons for the systemic dysfunction that he encountered, the difficulty that patients face in trying to resist excessive or unnecessary treatment, and what can be done to improve the system.

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19. **The Negative Impact of Nurse-Physician Disruptive Behavior on Patient Safety: A Review of the Literature.**
Saxton R, Hines T, Enriquez M.
J Patient Saf. 2009(Sep); 5(3):180–183.
This article presents results from a review of recent literature concerning the effects of disruptive behavior between nurses and physicians on patient safety in a variety of healthcare settings. Ten published studies, all of which were descriptive and non-interventional, were identified as eligible for inclusion. Analysis suggested that disruptive behavior, including verbal abuse, intimidation, and other forms of problematic interpersonal behavior, occurred frequently and had significant detrimental effects on patient safety and nurses' well-being. The authors discuss their findings as well as the need for methodological improvements, such as the development of standardized definitions and measures of disruptive behavior, to support further research and to enable interventions to counteract this problem. Four tables are included.

20. **Using In Situ Simulation to Identify and Resolve Latent Environmental Threats to Patient Safety: Case Study Involving a Labor and Delivery Ward.**
Hamman WR, Beaudin-Seiler BM, Beaubien JM, et al.
J Patient Saf. 2009(Sep); 5(3):184–187.
This article reports on the implementation and impact of a series of in situ simulations used to help improve patient safety at a Midwestern community hospital. Analysis of team performance in simulated scenarios enabled the researchers and the hospital staff to identify system-related safety hazards and to take steps to address these issues.

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