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**1. A Review of Significant Events Analysed in General Practice: Implications for the Quality and Safety of Patient Care.**

McKay J, Bradley N, Lough M, Bowie P.

BMC Fam Pract. 2009(Sep 1); 10(61).

Available at: <http://www.biomedcentral.com/1471-2296/10/61>

*Significant event analysis (SEA) is an approach to reporting and analysis of patient safety incidents used mainly in UK physician practices. This article presents findings from a study that examined 191 SEA reports submitted by general practitioners in Scotland during an 18-month period. The authors present descriptive findings concerning the nature, severity, and causes of events, individual and system issues identified, and corrective actions taken as a result. They comment on the implications of these findings for understanding safe practice and for establishing the utility and potential further applications of SEA as a tool for team education and performance improvement. Multiple tables are included.*

**2. Academic Year-End Transfers of Outpatients from Outgoing to Incoming Residents: An Unaddressed Patient Safety Issue.**

Young JQ, Wachter RM.

JAMA. 2009(Sep 23/30); 302(12):1327–1329.

*This commentary highlights potential patient safety risks associated with the transfers of patient responsibility that occur with the yearly changeover of medical residents in ambulatory care settings. The authors describe characteristics of year-end transfers of care and propose strategies to address the safety issues that may arise during these transitions.*

**3. An Empirical Model to Estimate the Potential Impact of Medication Safety Alerts on Patient Safety, Health Care Utilization, and Cost in Ambulatory Care.**

Weingart SN, Simchowitz B, Padolsky H, et al.

Arch Intern Med. 2009(Sep 14); 169(16):1465–1473.

*This study sought to quantify the cost and patient safety benefit associated with medication alerts generated by a commercial electronic prescribing system used by 2,321 ambulatory care physicians in Massachusetts. The authors examined drug-interaction alerts triggered by the system over a 6-month period to estimate how many adverse events the system intercepted and the cost incurred had these events actually happened. Results indicated that the alerts potentially prevented numerous adverse events, with considerable associated healthcare cost savings. However, given that a small number of the total alerts were responsible for most of the impact, the authors suggest that refining the alert-generating algorithms to focus on high-impact alerts could improve the utility of such systems. Multiple tables and figures are included.*

- 4. Association of Resident Fatigue and Distress with Perceived Medical Errors.**  
West CP, Tan AD, Habermann TM, Sloan JA, Shanafelt TD.  
JAMA. 2009(Sep 23/30); 302(12):1294–1300.  
*This study analyzed longitudinally collected survey data from 380 medical residents at the Mayo Clinic, Rochester, Minn, to assess the relationship between occurrence of self-reported major medical errors and factors reflective of residents' physical and mental well-being, including fatigue, quality of life, burnout, and symptoms of depression. Specifically, the authors sought to determine the independent effects of fatigue and of distress, considered as distinct variables, upon frequency of medical error. They found that higher levels of fatigue and of distress as defined in the study independently predicted a greater likelihood of subsequent self-reported medical error, suggesting that these two factors may need to be addressed separately in efforts to improve residents' well-being and patients' safety. Four tables are included.*
- 5. Chemical Dependency and the Physician.**  
Berge KH, Seppala MD, Schipper AM.  
Mayo Clin Proc. 2009(Jul); 84(7):625–631.  
*Substance abuse and addiction among physicians is a relatively common but little recognized issue with significant implications for patient safety. This article discusses the epidemiology of physician addiction; approaches to identification of the problem, intervention, and treatment; and legal and ethical considerations. Three tables and one figure are included.*
- 6. Connecting Remote Cardiac Monitoring Issues with Care Areas.**  
Pennsylvania Patient Safety Authority.  
Pa Patient Saf Advis. 2009(Sep); 6(3):79–83.  
Available at: [http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Sep6\(3\)/Pages/79.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Sep6(3)/Pages/79.aspx)  
*This article discusses safety issues associated with remote cardiac monitoring, which is used to monitor patients outside the critical care area and to alert providers rapidly in the event that such a patient's condition deteriorates. The authors review data from Pennsylvania hospital incident reports and from the clinical literature and discuss risk reduction strategies.*
- 7. Development and Initial Validation of the Bedside Paediatric Early Warning System Score.**  
Parshuram CS, Hutchison J, Middaugh K.  
Crit Care. 2009(Aug 12); 13(4):R135.  
Available at: <http://ccforum.com/content/13/4/R135>  
*This article describes the development and preliminary validation of the Bedside Paediatric Warning System (PEWS) Score, a system designed to promote timely response to critically ill patients. Developed at the Hospital for Sick Children, Toronto, Ont, the system assigns a severity score based on patient physiological variables to help identify patients at risk for clinical deterioration while there is still time to intervene. Multiple tables and figures are included.*

- 8. Dropping the Baton during the Handoff from Emergency Department to Primary Care: Pediatric Asthma Continuity Errors.**  
Hsiao AL, Shiffman RN.  
Jt Comm J Qual Patient Saf. 2009(Sep); 35(9):467–474.  
*This study evaluated communication of information and continuity of care between emergency and primary care providers (PCPs) for pediatric asthma patients at two New Haven, Conn, community health centers. The authors analyzed chart documentation for 350 asthma-related ED visits to assess how frequently the recommended notification of and follow-up with patients' primary care providers occurred. They found that lapses in continuity were common: the majority of patients had no documented contact with their PCP in follow-up to the ED visit, and PCPs appeared not to have been notified about their patients' ED visits in more than a third of the cases examined. Further findings, implications, and possibilities for improving continuity of care are discussed. Three tables and four figures are included.*
- 9. Early In-Hospital Mortality Following Trainee Doctors' First Day at Work.**  
Jen MH, Bottle A, Majeed A, Bell D, Aylin P.  
PLoS One. 2009(Sep 23); 4(9):e71103.  
*This study examined whether hospitalization at National Health Service facilities is measurably less safe during the period when new junior doctors begin work each year. The authors compared in-hospital mortality between two groups of non-elective patients admitted to NHS hospitals in England during the years 2000 to 2008: all such patients admitted on the day that trainee doctors began duty, and all those admitted one week earlier. Results showed that, after accounting for various potentially confounding factors, in-hospital mortality during the week following admission was 6% higher among patients in the first group than among those in the second. The discrepancy in mortality risk was more pronounced among medical admissions than among other types (surgical or oncologic). Implications of these findings and possibilities for further research are discussed. Two tables are included.*
- 10. Effects on Management and Outcome of Severe Sepsis and Septic Shock Patients Admitted to the Intensive Care Unit after Implementation of a Sepsis Program: A Pilot Study.**  
Girardis M, Rinaldi L, Donno L, et al., and the 'Sopravvivere alla Sepsis' group of the Modena-University Hospital.  
Crit Care. 2009(Sep 3); 13(5):R143.  
Available at: <http://ccforum.com/content/13/5/R143>  
*This study assessed the impact of an intervention designed to improve adherence to sepsis treatment guidelines and clinical outcomes of patients with severe sepsis and/or septic shock in the ICU of the University Hospital of Modena, Modena, Italy. Results showed that the program, which involved staff education and the implementation of evidence-based protocols for sepsis management, was associated with increased compliance with guidelines and reduced in-hospital mortality among ICU sepsis patients. Three tables and two figures are included.*

- 11. Good Law from Tragic Facts — Congress, the FDA, and Preemption.**  
Annas GJ.  
N Engl J Med. 2009(Sep 17); 361(12):1206–1211.  
*This article comments on current issues in drug regulatory policy apropos of the recent case of Wyeth v. Levine, in which the plaintiff sued the drug company after intravenous administration of the Wyeth-manufactured drug Phenergan caused her to develop gangrene, necessitating amputation of part of her right arm. The author reviews the facts and arguments in the case and discusses the questions about drug-safety legislation and policy it has brought to light.*
- 12. How Improving Practice Relationships among Clinicians and Nonclinicians Can Improve Quality in Primary Care.**  
Lanham HJ, McDaniel RR Jr., Crabtree BF, et al.  
Jt Comm J Qual Patient Saf. 2009(Sep); 35(9):457–466.  
*This article describes research that investigated how relationships among providers in a healthcare organization can influence organizational performance and quality of care. The authors applied principles from systems theory to an analysis of data from four federally funded studies that examined processes of change and quality improvement in the primary care setting. They present a conceptual model of practice relationships developed as a result of this analysis and discuss how such a framework could be applied to quality improvement efforts in primary care as well as in other healthcare settings. Multiple tables and figures are included.*
- 13. Improving Safety and Eliminating Redundant Tests: Cutting Costs in U.S. Hospitals.**  
Jha AK, Chan DC, Ridgway AB, Franz C, Bates DW.  
Health Aff. 2009(Sep/Oct); 28(5):1475–1484.  
*This study sought to calculate the healthcare costs attributable to preventable adverse events and to redundant or duplicative medical tests during a one-year period in the US. Using a literature-derived conceptual model and data from the National Inpatient Sample, the authors estimated that preventable adverse events cost hospitals more than \$16.6 billion and redundant tests more than \$8 billion in 2004. They conclude that by eliminating such events the healthcare system could realize substantial cost savings as well as improved safety and quality of care. Three tables and one figure are included.*

**14. Medicare's Policy Not to Pay for Treating Hospital-Acquired Conditions: The Impact.**

McNair PD, Luft HS, Bindman AB.

Health Aff. 2009(Sep/Oct); 28(5):1485–1493.

*This study sought to calculate the potential financial impact of Medicare's recently implemented policy eliminating reimbursement to hospitals for costs associated with the treatment of eight preventable hospital-acquired conditions. The authors used data on Medicare patients discharged from California hospitals in 2006 to estimate how the policy would affect Medicare payments for six of the eight conditions. They found that cost savings attributable to implementation of the policy would be relatively small — an estimated \$92,000–\$227,000 in California, or \$1.1–\$2.7 million nationwide. Implications of these findings and possible changes that could increase the policy's impact are discussed. Two tables are included.*

**15. Medication Safety in Community Pharmacy: A Qualitative Study of the Sociotechnical Context.**

Phipps DL, Noyce PR, Parker D, Ashcroft DM.

BMC Health Serv Res.

Available at: <http://www.biomedcentral.com/1472-6963/9/158>

*This study explored organizational, ergonomic, and socio-psychological factors influencing medication safety in the community pharmacy setting. Using data from a series of focus group sessions with pharmacy practitioners in North West England, the authors identified multiple factors perceived as affecting patient safety, which they classify according to three major themes: relationships between pharmacists and their colleagues or customers; demands on pharmacists, including commercial pressures as well as legal and regulatory requirements; and management and governance, including organizational safety culture, use of protocols, and physical work environment. Two tables are included.*

**16. Professional Commitment, Patient Safety, and Patient-Perceived Care Quality.**

Teng C-I, Dai Y-T, Shyu Y-I, Wong M-K, Chu T-L, Tsai Y-H.

J Nurs Scholarsh. 2009(Sep); 41(3):301–309.

*This study examined how nurses' professional commitment affected patient safety and patient-perceived quality of care at two northern Taiwan medical centers. The authors analyzed data from surveys of 284 nurse-patient pairs to assess the influence of professional commitment on frequency of six types of safety events and on 20 items of patient-reported quality of care. They found that professional commitment had significant positive associations with both patient safety and patient-perceived quality of care. Three tables are included.*

**17. Silence, Power and Communication in the Operating Room.**

Gardezi F, Lingard L, Espin S, Whyte S, Orser B, Baker GR.  
J Adv Nurs. 2009(Jul); 65(7):1390–1399.

*This article describes a study that used an ethnographic approach to examine patterns of nurse-physician communication among operating room personnel. The authors examined observational data from more than 700 surgical procedures at three teaching hospitals in Toronto, Ont. Although not the initial subject of study, the occurrence of various types of “silence” as a feature of OR communication emerged as a focus in their analysis. The authors identify three types of silence and describe the roles that they play within the power relationships that may govern interprofessional communication. Finally, they comment on how such insights might be applied to efforts to improve interprofessional communication and teamwork.*

**18. Strategies for Safe Medication Use in Ambulatory Care Settings in the United States.**

Sorenson AV, Bernard SL.  
J Patient Saf. 2009(Sep); 5(3):160–167.

*This article reports on a study that sought to identify useful approaches to medication safety at ambulatory care facilities in the US. The authors conducted case studies of medication safety systems and practices in use at 34 selected ambulatory care facilities in 6 geographic regions, with particular attention to the role of clinical pharmacy services in medication safety. They present descriptive findings and discuss themes that emerged in their analysis, including the importance of successful incorporation of clinical pharmacy services, reinforcement of safe practices by organizational leaders, and the use of strategies to promote patient-centered and culturally sensitive care. Four figures are included.*

**19. The Role of Advice in Medication Administration Errors in the Pediatric Ambulatory Setting.**

Lemer C, Bates DW, Yoon C, Keohane C, Fitzmaurice G, Kaushal R.  
J Patient Saf. 2009(Sep); 5(3):168–175.

*This study investigated whether provision of medication information by providers influenced the frequency of self-reported medication administration errors among parents of pediatric ambulatory patients. The authors analyzed data from parent interviews and medical record review for 1,685 pediatric patients from six Boston-area physician offices to identify the incidence of medication events and the nature of medication information provided. They found that the parents surveyed frequently reported not having received information about their children’s medications from care providers; neither provision of information nor type of information provided appeared to affect the frequency of reported medication errors. Implications of these findings and suggestions for improving the communication of medication information are discussed. Five tables and one figure are included.*

**20. Why Don't Doctors Wash Their Hands More?**

Chen PW.

New York Times. September 17, 2009.

Available at: <http://www.nytimes.com/2009/09/17/health/17chen.html>

*This article comments on the persistent problem of poor hand hygiene in the healthcare setting and highlights the recent launch of the Joint Commission's Center for Transforming Healthcare, which is conducting a collaborative initiative among eight US healthcare systems to identify and implement techniques to improve hand hygiene compliance.*

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