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1. A Pilot Study Examining Undesirable Events among Emergency Department–Boarded Patients Awaiting Inpatient Beds.

Liu SW, Thomas SH, Gordon JA, Hamedani AG, Weissman JS.

Ann Emerg Med. 2009(Sep); 54(3):381–385.

This study sought to assess the frequency and nature of adverse events among patients “boarded” in the emergency department of an urban teaching hospital. Using data from a chart review of 151 patients admitted through ED, the authors found that nearly 28% of patients experienced at least one undesirable event. Undesirable events were defined to include clinical adverse events as well as omissions in care, such as failure to administer an indicated test or a prescribed medication. Such events occurred more frequently among older patients and among those with significant comorbid conditions. Two tables and one figure are included.

2. A Practical Tool to Identify and Eliminate Barriers to Compliance with Evidence-Based Guidelines.

Gurses AP, Murphy DJ, Martinez EA, Berenholtz SM, Pronovost PJ.

Jt Comm J Qual Patient Saf. 2009(Oct); 35(10):526–532.

This article presents the barrier identification and mitigation (BIM) tool, designed to promote patient safety and quality of care by improving providers’ adherence to evidence-based guidelines. The tool provides a structured method to help identify and eliminate various types of obstacles to compliance, including factors related to providers, systems, and the guidelines themselves. The authors outline the steps for using the tool and discuss results of its application in practice thus far. Among other applications, the BIM tool played a role in the Keystone ICU Project, which dramatically reduced central line-associated bloodstream infections in a collaborative group of Michigan ICUs. Multiple tables are included.

3. Active Learning: When Is More Better? The Case of Resident Physicians’ Medical Errors.

Katz-Navon T, Naveh E, Stern Z.

J Appl Psychol. 2009(Sep); 94(5):1200–1209.

This study explored the relationships among characteristics of the learning environment, organizational attitudes toward safety, and frequency of residents’ self-reported medical errors in a survey of 123 medical residents at two teaching hospitals. The authors found that a climate of active learning, which emphasizes participatory and experimental as opposed to didactic learning techniques, was associated with higher rates of error. However, the degree of organizational and managerial emphasis on safe practice also influenced this relationship, suggesting that under the right conditions organizations can reap the educational benefits of an active learning environment without compromising patient safety. Two tables and three figures are included.

4. Adequacy of Hospital Discharge Summaries in Documenting Tests with Pending Results and Outpatient Follow-up Providers.

Were MC, Li X, Kesterson J, et al.

J Gen Intern Med. 2009(Sep); 24(9):1002–1006.

This study assessed how well hospital discharge summaries recorded information about patients' pending test results and the primary care providers to whom results should be communicated, using data from a large sample of patients at two academic medical centers. In their analysis of data on 668 patients discharged with pending test results, the authors found that only 25% of discharge summaries contained information about the tests, and two-thirds of the summaries identified the follow-up provider to whom results could be sent. Implications of these findings and suggestions for improving inter-provider communication during the discharge process are discussed. Two tables and one figure are included.

5. Application of Lean Thinking to Health Care: Issues and Observations.

Joosten T, Bongers I, Janssen R.

Int J Qual Health Care. 2009(Oct); 21(5):341–347.

This article provides background on the development of lean thinking and discusses its applications in healthcare. The authors describe the evolution of lean philosophy, from its origins in the manufacturing industry to its current use as an organizational management technique, and comment on its potential benefits and limitations as a tool for healthcare quality improvement. Three tables and one figure are included.

6. Associations between Structural Capabilities of Primary Care Practices and Performance on Selected Quality Measures.

Friedberg MW, Coltin KL, Safran DG, Dresser M, Zaslavsky AM, Schneider EC.

Ann Intern Med. 2009(Oct 6); 151(7):456–463.

This study sought to determine whether physician practices with certain operational features thought to promote quality improvement provided higher quality care than did those without such enhancements. Using data from the Healthcare Effectiveness Data and Information Set (HEDIS) and from provider surveys, the authors analyzed the relationship between the presence of these features and performance on selected HEDIS quality of care measures in 412 Massachusetts primary care practices. Results showed that in general structural capabilities did not strongly influence quality performance. However, use of electronic health records was associated with significantly higher performance on several quality measures related to preventive screening and diabetes care. Three tables are included.

- 7. Beyond Literacy and Numeracy in Patient Provider Communication: Focus Groups Suggest Roles for Empowerment, Provider Attitude and Language.**
Brugge D, Edgar T, George K, Heung J, Laws MB.
BMC Public Health. 2009(Sep 21); 9(354).
Available at: <http://www.biomedcentral.com/1471-2458/9/354>
This study explored patients' experiences and perceptions concerning healthcare-related communication through a series of focus groups in English, Spanish, and Cantonese, and including patients with lower and higher education levels. While language and health literacy issues figured as expected themes of discussion, the authors found that several unexpected themes emerged as well. In particular, social and interpersonal aspects of the patient-provider relationship, including providers' attitudes and patients' sense of their own empowerment or disempowerment, appeared to be as important as linguistic issues in shaping participants' experiences with the healthcare system. Two tables and three appendices are included.
- 8. Bridging the Care Continuum: Patient Information Needs for Specialist Referrals.**
Ireson CL, Slavova S, Steltenkamp CL, Scutchfield FD.
BMC Health Serv Res. 2009(Sep 15); 9(163).
Available at: <http://www.biomedcentral.com/1472-6963/9/163>
This study sought to assess the quality of information provided to patients during the specialist referral process. As part of a larger study on communication and coordination of care related to referrals, the authors surveyed 250 patients regarding their experiences with the initial visit to a specialist for treatment of a chronic condition. They found respondents were satisfied with some but not all aspects of the information they received, and that perceived quality of information received was positively associated with patients' satisfaction with coordination of care and trust in their physicians. Multiple tables are included.
- 9. Care Homes' Use of Medicines Study: Prevalence, Causes and Potential Harm of Medication Errors in Care Homes for Older People.**
Barber ND, Alldred DP, Raynor DK, et al.
Qual Saf Health Care. 2009(Oct); 18(5):341–346.
This study sought to describe the incidence and nature of medication-related errors at care homes in the UK. The authors used a combination of methods, including staff and patient interviews, chart review, and direct observation, to collect information about errors in a randomly selected group of 256 residents at 55 facilities. They found that nearly 70% of the patients examined experienced one or more medication errors during the study period. Errors occurred at various phases of the medication use process and involved a variety of contributing factors, many related to communication and teamwork. Further details of the findings, implications, and suggestions for improvement are discussed. Two tables and two appendices are included.

- 10. Disclosing Medical Errors to Patients: A Challenge for Health Care Professionals and Institutions.**
Levinson W.
Patient Educ Couns. 2009(Sep); 76(3):296–299.
This article provides a summary of the history and current thinking concerning the disclosure of medical error to patients. Topics discussed include patient expectations of disclosure, provider performance, barriers to disclosure, policy and legal considerations, and the role of education and training.
- 11. Disclosing Medical Errors to Patients: It’s Not What You Say, It’s What They Hear.**
Wu AW, Huang I-C, Stokes S, Pronovost PJ.
J Gen Intern Med. 2009(Sep); 24(9):1012–1017.
This study examined patients’ attitudes and preferences concerning disclosure of medical error by providers. Study volunteers were asked to view and respond to three videotaped scenarios in which a physician disclosed an adverse event to a patient or family member. Multiple versions of each vignette were created to depict differing degrees of physician apology and acceptance of responsibility for the error. The authors found that participants responded more positively to scenarios where they perceived that the physician most fully apologized and acknowledged responsibility for the error. Notably, volunteers’ perceptions did not always match the researchers’ labels regarding the extent of apology provided, suggesting that subjective perceptions may be more influential than actual content in determining patients’ response to disclosure. Five tables are included.
- 12. Dual Processing and Diagnostic Errors.**
Norman G.
Adv Health Sci Educ Theor Pract. 2009(Sep); 14(Suppl 1):37–49.
The “dual process” model of cognition posits that thinking can be classified as one of two types: System 1, characterized by intuition and unconscious reasoning, or System 2, relying on logic, analysis, and abstract reasoning. In this article, the author reviews data from a variety of literature on dual process theory and from research that has applied this model to the study of clinical thinking and diagnostic error. On the basis of this evidence, he argues that approaches to reducing diagnostic error must acknowledge the importance of both types of thinking in the diagnostic process, and that the most effective educational strategies may involve teaching practitioners to be more aware of the strengths and limitations of their own reflective processes.
- 13. Effectiveness of the Medical Emergency Team: The Importance of Dose.**
Jones D, Bellomo R, DeVita MA.
Crit Care. 2009(Oct 6); 13(313).
This article summarizes data from multiple studies on the use of rapid response teams (RRTs) and their impact on patient outcomes in the hospital setting. The authors introduce the concept of RRT “dose,” which expresses the facility-level rate of RRT utilization as the number of activations per 1,000 admissions at a given facility, and discuss findings suggesting that both dose and composition of the team play an important role in its success. One table and one figure are included.

- 14. Medication Overdoses Leading to Emergency Department Visits among Children.**
Schillie SF, Shehab N, Thomas KE, Budnitz DS.
Am J Prev Med. 2009(Sep); 37(3):181–187.
This study sought to characterize emergency department visits associated with accidental pediatric medication overdoses in the US. Extrapolating from a sample of drug incident data from a 2-year period collected by the National Electronic Injury Surveillance System, the authors estimated that 71,224 ED visits for pediatric medication overdoses occurred annually in the US. While most overdoses resulted from unsupervised ingestion, a smaller but significant number involved errors in medication administration. Implications of these findings and potential strategies for improving pediatric medication safety in the home are discussed. Three tables and two figures are included.
- 15. Patient-Centered Care and Preference-Sensitive Decision Making.**
Keirns CC, Goold SD.
JAMA. 2009(Oct 28); 302(16):1805–1806.
Evidence-based medicine offers treatment principles designed to maximize the benefit of medical care at the population level, but such guidelines do not necessarily reflect the preferences of individual patients. This commentary discusses situations in which evidence-based treatment may conflict with patient-centered care, and what physicians should do when faced with this dilemma.
- 16. Ratings Game: Lists of “Top” Physicians, Hospitals Has Unclear Impact on Public.**
Mitka M.
JAMA. 2009(Oct 21); 302(15):1636–1639.
Consumers increasingly have access to rankings of hospitals and healthcare providers from a variety of sources, but whether such reports provide meaningful information and influence patient treatment decisions is uncertain. This article comments on this phenomenon and discusses questions that have arisen about the validity of such rankings, their impact on patients and on providers, and the increasingly consumer-oriented role of patients in relation to the healthcare system.
- 17. Social Aspects of Clinical Errors.**
Richman J, Mason T, Mason-Whitehead E, McIntosh A, Mercer D.
Int J Nurs Stud. 2009(Aug); 46(8):1148–1155.
This article seeks to shed light on the issue of medical errors through an examination of the social, cultural, legal, and political contexts in which they occur. The authors provide historical perspective on the conceptualization of errors in relation to medical professionalism and legal responsibility, along with a review of recent and current thinking concerning how error is defined and addressed within the culture of healthcare organizations and the medical profession.

- 18. Clean Hands Save Lives.**
Clinical Excellence Commission, NSW Health.
Med J Aust. 2009(Sep); 191(8 Suppl):S1–S32.
This publication presents a collection of articles reporting on a statewide campaign to improve hand hygiene at healthcare facilities in New South Wales, Australia. Modeled after the World Health Organization’s Clean Hands Save Lives campaign, the initiative was implemented at 208 public hospitals over a one-year period (2006–2007). These articles describe the program’s design and objectives and discuss its impact with respect to staff and patients’ hand hygiene awareness, healthcare workers’ hand hygiene compliance, and incidence of hospital-acquired methicillin-resistant Staphylococcus aureus (MRSA) infection in participating hospitals.
- 19. The “July Phenomenon”: Is Trauma the Exception?**
Schroepel TJ, Fischer PE, Magnotti LJ, Croce MA, Fabian TC.
J Am Coll Surg. 2009(Sep); 209(3):378–384.
The “July Phenomenon” is the notion that hospital care provided during the month of July, when new medical residents start work, is less safe than at other times of year. To test the validity of this assumption, this study investigated whether month or quarter of admission was associated with variation in patient outcomes among patients admitted to an academic Level I trauma center. In an analysis of a large cohort of patients admitted during a 5-year period, the authors found that neither month nor quarter of admission was associated with significant differences in inpatient mortality or in any of several other outcomes examined. They discuss potential explanations for the observed lack of a July phenomenon in this study, but conclude that it is equally possible the phenomenon itself does not exist. Multiple tables and figures are included.
- 20. The Natural History of Recovery for the Healthcare Provider “Second Victim” after Adverse Patient Events.**
Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW.
Qual Safe Health Care. 2009(Oct); 18(5):325–330.
This study sought insight into the impact of medical errors and adverse events on the healthcare providers involved — the so-called “second victims” of such events. The authors interviewed 31 care providers who had been involved in a patient adverse event to explore how the experience affected them emotionally, psychosocially, and professionally. They found that providers’ processes for coping in the aftermath of an event tended to follow a similar pattern consisting of six distinct phases. Further details of these findings, and how these results might inform efforts to develop institutional support for providers involved in adverse events, are discussed. Multiple tables are included.

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Anita Spielman, Editor

aspelman@npsf.org