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1. A Classification of Hospital-Acquired Diagnoses for Use with Routine Hospital Data.

Jackson TJ, Michel JL, Roberts RF, Jorm CM, Wakefield JG.
Med J Aust. 2009(Nov 16); 191(10):544–548.

This article describes the development of a method for analysis of hospital-acquired complications using hospital administrative data. The system was derived from an analysis of diagnostic coding data on all inpatients treated during a one-year period at acute care hospitals in Victoria, Australia. The authors describe the methodological basis of the resulting tool, which uses a taxonomy of 4,345 codes in 17 major diagnosis groups, and discuss its potential applications to quality and patient safety improvement efforts. Four figures are included.

2. A Difficult Balance — Pain Management, Drug Safety, and the FDA.

Woodcock J.

N Engl J Med. 2009(Nov 26); 361(22):2105–2107.

This article discusses risks associated with various widely used analgesics, including acetaminophen, opioid-based analgesics, and nonsteroidal anti-inflammatory drugs (NSAIDs), and describes steps the FDA is taking in response to increasing concern over such risks.

3. A Qualitative Study of Consumers' Views on Public Reporting of Health Care Associated Infections.

Mazor KM, Dodd KS.

Am J Med Qual. 2009(Sep/Oct); 24(5):412–418.

This study examined consumers' attitudes and preferences concerning public reporting of hospital data on healthcare-associated infections (HAIs). The authors conducted in-depth interviews with 59 consumers to explore their perceptions about HAI reporting and to assess their responses to various combinations of report content and format. Based on this analysis, the authors offer recommendations for the design and content of reports in order to maximize their utility to consumers. Two tables are included.

4. Assessing Surgical Quality Using Administrative and Clinical Data Sets: A Direct Comparison of the University HealthSystem Consortium Clinical Database and the National Surgical Quality Improvement Program Data Set.

Davenport DL, Holsapple CW, Conigliaro J.

Am J Med Qual. 2009(Sep/Oct); 24(5):395–402.

This study compared two data-based systems used for measuring surgical quality and safety that were used concurrently at the study hospital: the University HealthSystem Consortium Clinical Database and the National Surgical Quality Improvement Program (NSQIP). The authors performed a qualitative comparison of the systems' structures and processes, as well as a quantitative analysis that compared their performance in identifying surgical complications and mortality in a given group of patients. They found that while both systems generated useful information, the NSQIP provided more accurate and clinically relevant data, particularly with respect to surgical complications, suggesting that the NSQIP may be the more useful tool for certain quality improvement applications. Two figures and two tables are included.

- 5. Checking the Right Boxes, but Failing the Patient.**
Rifkin D.
New York Times. November 17, 2009:D5.
Available at: <http://www.nytimes.com/2009/11/17/health/17case.html>
In this brief article, the author expresses concern that the healthcare system's increasing emphasis on compliance with measurable performance standards — such as mandatory use of clinical checklists — has the risk of shifting providers' attention away from the needs of individual patients, possibly undermining the quality and safety benefits that such measures are intended to provide.
- 6. Design of a Continuous Quality Improvement Program to Prevent Falls among Community-Dwelling Older Adults in an Integrated Healthcare System.**
Ganz DA, Yano EM, Saliba D, Shekelle PG.
BMC Health Serv Res. 2009(Nov 16); 9(206).
Available at: <http://www.biomedcentral.com/1472-6963/9/206>
This article describes how the Veterans Affairs Greater Los Angeles Healthcare System developed an initiative to reduce the risk of falls and related injuries among outpatients ages 75 and over served by the organization. The program uses an existing telephone advice line to identify patients at risk for falls and to provide appropriate interventions. The authors discuss the conceptual design and implementation of the program, lessons learned thus far, and anticipated next steps. One table and two figures are included.
- 7. Diagnostic Error in Medicine: Analysis of 583 Physician-Reported Errors.**
Schiff GD, Hasan O, Kim S, et al.
Arch Intern Med. 2009(Nov 9); 169(20):1881–1887.
This study sought insight into the frequency and characteristics of diagnostic errors through an analysis of errors self-reported by clinicians. The authors examined data on 583 errors from a survey of 310 clinicians at 22 institutions that asked physicians to describe diagnostic errors they had committed or observed. Errors were classified with respect to severity, diagnosis, error type, and stage of the diagnostic process. Further analysis of the resulting categories revealed several patterns in the occurrence of errors, suggesting potential targets for further research and improvement efforts. Two tables and three figures are included.
- 8. Disclosure and Apology: What's Missing? Advancing Programs That Support Clinicians.**
Carr S.
Chestnut Hill, MA: Medically Induced Trauma Support Services, Inc.; 2009.
Available at: http://www.mitss.org/MITSS_WhatsMissing.pdf
This report summarizes proceedings from a March 2009 forum that explored strategies for providing support to clinicians involved in adverse medical events. Participants discussed their experiences and identified successes, challenges, and opportunities for improvement. Insights and recommendations that emerged from the discussion are presented, and two organizations' existing clinician support programs are described as examples.

- 9. Effect of a Weight-Based Prescribing Method within an Electronic Health Record on Prescribing Errors.**
Ginzburg R, Barr WB, Harris M, Munshi S.
Am J Health-Syst Pharm. 2009(Nov 15); 66(22):2037–2041.
This study investigated whether a weight-based dose calculator used as part of a computerized prescribing system affected the frequency of prescribing errors in the pediatric outpatient setting. The authors examined data on pediatric outpatient prescriptions for acetaminophen or ibuprofen from before and after introduction of the dose calculator into their organization’s existing electronic health record system. They found that prescribing errors decreased significantly following the intervention, with the greatest reduction occurring in the category of overdose errors. Two tables are included.
- 10. Effectiveness of a Pharmacist–Nurse Intervention on Resolving Medication Discrepancies for Patients Transitioning from Hospital to Home Health Care.**
Setter SM, Corbett CF, Neumiller JJ, Gates BJ, Sclar DA, Sonnett TE.
Am J Health-Syst Pharm. 2009(Nov 15); 66(22):2027–2031.
This study assessed the impact of an intervention designed to improve medication management associated with the transition of care for patients discharged from a university hospital to a home health care agency. The authors found that resolution of medication discrepancies was significantly better for patients in the intervention group, for whom a study pharmacist worked with patients’ home-care nurse case managers to facilitate medication management, than for those in the control group. One table is included.
- 11. How a Captive Insurer Uses Data and Incentives to Advance Patient Safety.**
Shannon DW.
Patient Saf Qual Healthcare. 2009(Nov/Dec); 6(6):18–26.
Available at: <http://www.psqh.com/novemberdecember-2009/307-how-a-captive-insurer-uses-data-and-incentives-to-advance-patient-safety.html>
This article describes how CRICO/RMF, the medical malpractice insurance provider for Harvard-affiliated healthcare organizations, has developed and implemented strategies to promote patient safety at its insured facilities. The author describes the key components of CRICO/RMF’s approach, which focuses on establishing meaningful engagement with hospital leadership and using data and financial incentives to stimulate improvement efforts, and discusses how these techniques might be applied in other organizations. Two figures are included.

- 12. How Do Healthcare Consumers Process and Evaluate Comparative Healthcare Information? A Qualitative Study Using Cognitive Interviews.**
Damman OC, Hendriks M, Rademakers J, Delnoij DMJ, Groenewegen PP.
BMC Public Health. 2009(Nov 20); 9(423).
Available at: <http://www.biomedcentral.com/1471-2458/9/423>
This study explored how healthcare consumers in the Netherlands interpreted and made use of online healthcare ratings. The authors examined data from interviews in which participants were asked to view and respond to three web pages that ranked hospitals or health plans according to quality performance, consumer rating, and other factors. Participants' responses suggested that, while some aspects of the sites were judged helpful, a number of factors related to both presentation of information and ranking methodology might inhibit consumers' comprehension and effective use of the information. Three figures and three tables are included.
- 13. Improving Operating Room Safety.**
Hurlbert SN, Garrett J.
Patient Saf Surg. 2009(Nov 20); 3(25).
Available at: <http://www.pssjournal.com/content/3/1/25>
This article describes the development, implementation, and impact of an initiative designed to improve operating room safety at a Colorado healthcare system. The program involved training based on crew resource management techniques to promote teamwork and communication among OR staff, principally through the implementation of preoperative briefings. Results, challenges encountered, and lessons learned are discussed. Two figures are included.
- 14. Increasing Efficiency and Enhancing Value in Health Care: Ways to Achieve Savings in Operating Costs per Year.**
Martin LA, Neumann CW, Mountford J, Bisognano M, Nolan TW.
IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2009.
Available at: www.ihf.org
This white paper presents a new approach to the business case for healthcare quality and safety improvement, focusing on how healthcare organizations can simultaneously reduce costs and improve quality by identifying and eliminating sources of inefficiency in the system. The paper provides detailed guidelines on implementing such an approach, including a number of tools and sample calculations.

- 15. Injury and Death Associated with Incidents Reported to the Patient Safety Net.**
Reid M, Estacio R, Albert R.
Am J Med Qual. 2009(Nov/Dec); 24(6):520–524.
This study analyzed incidents reported to the University HealthSystem Consortium Patient Safety Net (PSN), a voluntary error reporting system used by multiple hospitals, in order to identify those types of incidents most likely to be associated with patient harm. The authors examined data on the 25,300 incidents reported by eight participating organizations during a one-year period. They found that 13.3% of these incidents were associated with adverse events (AEs) and 0.4% with death. While several categories of incidents were identified as more likely to be associated with AEs, the authors note that constraints of the PSN classification system, as well as the exclusion of portions of the error reports to preserve anonymity, limited their ability to identify specific errors as targets for patient safety interventions. Three tables are included.
- 16. Managing Patients’ Medicines after Discharge from Hospital.**
London, UK: Care Quality Commission; October 2009.
Available at: http://www.cqc.org.uk/db/documents/Managing_patients_medicines_after_discharge_from_hospital.pdf
This study assessed medication management associated with the discharge process at 12 UK primary care trusts. Researchers looked at multiple aspects of the medication management process, including the communication of patients’ medication information between hospitals and primary care providers, communication between providers and patients, and reporting and analysis of medication-related adverse incidents. They found that while the study organizations performed well in certain areas of the medication management process, overall there was considerable room for improvement. A variety of possible strategies for improvement are discussed, including recommendations for organizations, practitioners, and national agencies.
- 17. Mandatory Vaccination of Health Care Workers.**
Stewart AM.
N Engl J Med. 2009(Nov 19); 361(21):2015–2017.
State and institutional policies requiring healthcare workers to undergo flu vaccination have provoked considerable debate, with some opponents arguing that such regulations violate employees’ constitutional rights. Focusing on the controversy over New York State’s policy as an example, this article discusses the objections that have been raised and argues, on the basis of legal precedent, that the requirement is likely to be upheld even in the face of such protests.
- 18. Medical Simulation Gets Real.**
Voelker R.
JAMA. 2009(Nov 25); 302(20):2190–2192.
This article comments on the burgeoning use of and interest in medical simulation, highlights some of the diverse and increasingly sophisticated technologies being used, and reviews existing research on its impact.

19. “Miracle on the Hudson” — Key Safety Lessons for the Healthcare Industry.

Porto G.

Focus Patient Saf. 2009(Fall); 12(3):1–3.

Available at: http://npsf.org/paf/npsfp/fo/pdf/Focus_Volume_12_Issue_3.pdf

This article, the second in a two-part series, continues the discussion of safety lessons to be drawn from the aviation incident involving US Airways Flight 1549, which successfully negotiated an emergency landing in the Hudson River after a bird collision disabled its engines. Part 1 discussed the behavior of the airline passengers as a model for how consumers can contribute to safer healthcare. Part 2 focuses on the safety principles illustrated by the actions of the plane’s pilot and crew, including the importance of ongoing training and competency assessment for practitioners and the need for teamwork and structured communication to ensure effective response to emergencies.

20. Timely Follow-up of Abnormal Diagnostic Imaging Test Results in an Outpatient Setting: Are Electronic Medical Records Achieving Their Potential?

Singh H, Thomas EJ, Mani S, et al.

Arch Intern Med. 2009(Sep 28); 169(17):1578–1586.

This study investigated healthcare providers’ communication about diagnostic imaging test results in the outpatient setting. The authors examined 1,196 critical test result notifications generated during an 8-month period by the electronic medical record system at a tertiary care Veterans Affairs medical center. For each notification, they determined whether the recipient acknowledged the alert and whether timely follow-up occurred. Results indicated that no follow-up had occurred within four weeks of transmission for 7.7% of the alerts examined. Several factors appeared to influence the likelihood of response; surprisingly, alerts sent to more than one recipient were significantly less likely to receive acknowledgment and follow-up than were those sent to a single recipient. Multiple tables and figures are included.

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