



December (1) 2009
Volume 13, Issue 12:1

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- 1. A 37-Year-Old Man Trying to Choose a High-Quality Hospital: Review of Hospital Quality Indicators.**
Howell MD.
JAMA. 2009(Dec 2); 302(21):2353–2360.
This article, based on a grand rounds presentation, uses the example of an actual patient to discuss how consumers can use published healthcare performance data in the process of evaluating and selecting a care provider or hospital. The author discusses the strengths and limitations of a variety of sources of quality information and offers practical advice on how patients can best use this complex and sometimes conflicting information to make educated decisions about their care.
- 2. Afraid in the Hospital: Parental Concern for Errors during a Child’s Hospitalization.**
Tarini BA, Lozano P, Christakis DA.
J Hosp Med. 2009(Nov/Dec); 4(9):521–527.
This study explored parents’ perceptions about the safety of care provided to their hospitalized children and examined factors that might influence these perceptions. In a survey of 130 parents of children hospitalized at the study facility, 63% of respondents indicated a perceived need to monitor their child’s care to protect against errors. Higher self-efficacy in interacting with physicians was associated with decreased concern about errors, while limited English proficiency appeared to be linked to increased concern. On the basis of these findings, the authors conclude that parents’ confidence in their ability to communicate with medical providers may significantly influence their perceptions about the safety of care, suggesting that interventions designed to facilitate parent-provider communication could help to allay such concerns. Two tables and one figure are included.
- 3. Contraindicated Medication Use in Dialysis Patients Undergoing Percutaneous Coronary Intervention.**
Tsai TT, Maddox TM, Roe MT, et al., for the National Cardiovascular Data Registry.
JAMA. 2009(Dec 9); 302(22):2458–2464.
This study examined the use of two contraindicated antithrombotic medications (enoxaparin and eptifibatide) in a large sample of dialysis patients who underwent percutaneous coronary intervention procedures during a 4.5-year period. The study sought to address a lack of knowledge about whether patients receive these drugs despite the FDA’s designation of them as contraindicated, and whether such use was associated with increased risk of adverse outcomes. In an analysis of data on 22,778 patients from 829 hospitals, the authors found that 22% received one or both of the medications, and that the risk of in-hospital bleeding, and possibly the risk of in-hospital death, were significantly higher among patients who received a contraindicated drug than among those who did not. Implications of these findings and the need for swift action to address this safety issue are discussed. Three tables and two figures are included.

- 4. Development and Implementation of a Pharmacy Fall Prevention Program.**
Beasley B, Patatanian E.
Hosp Pharm. 2009(Dec); 44(12):1095–1102.
Available at: http://www.factsandcomparisons.com/assets/hpdatanamed/20091201_Dec2009_peer2.pdf
This article reports on the development, implementation, and impact of a pharmacy-based program designed to reduce medication-related falls in patients at a tertiary community hospital. The intervention involved the use of a scoring and assessment system that identified patients whose medications placed them at elevated risk for falling. Results showed that the program was associated with a 30% reduction in falls, representing cost savings of over \$200,000 per year. Multiple tables and figures are included.
- 5. Empowering Frontline Nurses: A Structured Intervention Enables Nurses to Improve Medication Administration Accuracy.**
Kliger J, Blegen MA, Gootee D, O’Neil E.
Jt Comm J Qual Patient Saf. 2009(Dec); 35(12):604–612.
This article describes the development, implementation, and impact of the Integrated Nurse Leadership Program, a collaborative program that worked with nurses at seven San Francisco Bay area hospitals to improve medication safety on medical/surgical units. The project focused on developing nurse-led teams to support and sustain implementation of evidence-based practices to ensure safe medication administration at the participating hospitals. Multiple tables are included.
- 6. Impact and Preventability of Adverse Events in Spanish Public Hospitals: Results of the Spanish National Study of Adverse Events (ENEAS).**
Aranaz-Andrés JM, Aibar-Remón C, Vitaller-Burillo J, et al., and the ENEAS Work Group.
Int J Qual Health Care. 2009(Dec); 21(6):408–414.
This study sought to characterize adverse events among inpatients at 24 Spanish public hospitals. In an analysis of data on 5,624 patients discharged from these hospitals during a one-week period, the authors identified 655 adverse events, of which 43% were considered preventable. More than 30% of the events identified were associated with increased length of stay and more than 20% were associated with hospital readmission. Additional results, their relationship to findings of other published studies, and implications are discussed. Four tables and one figure are included.

- 7. Improving Healthcare Worker Hand Hygiene Adherence before Patient Contact: A Before-and-After Five-Unit Multimodal Intervention in Tuscany.**
Saint S, Conti A, Bartoloni A, et al.
Qual Saf Health Care. 2009(Dec); 18(6):429–433.
This study assessed the impact of a program designed to improve hand hygiene compliance among clinicians in five units of two hospitals in Florence, Italy. Building on a previous observational study performed at the same hospital units, the researchers used direct observation of nearly 4,000 patient–provider encounters to measure the effects of a multi-part educational and behavioral intervention on clinicians’ performance of hand hygiene before touching patients. They found that the overall rate of hand hygiene improved significantly but was still less than 50% following the intervention, with significant variations between nurses and doctors and among units. Possible explanations for these outcomes and potential next steps for further research and improvement efforts are discussed. One table is included.
- 8. Neuromuscular Blocking Agents: Reducing Associated Wrong-Drug Errors.**
Pennsylvania Patient Safety Authority.
Pa Patient Saf Advis. 2009(Dec); 4(4):109–114.
Available at: [http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Dec6\(4\)/Pages/109.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Dec6(4)/Pages/109.aspx)
This article presents data on errors associated with the use of neuromuscular blocking agents, based on an analysis of 154 error reports submitted by Pennsylvania healthcare facilities over a 5-year period. Descriptive findings are presented along with a discussion of contributing factors and suggested risk reduction strategies. Multiple tables are included.
- 9. Nurse and Nurse Assistant Perceptions of Missed Nursing Care: What Does It Tell Us about Teamwork?**
Kalisch BJ.
J Nurs Adm. 2009(Nov); 39(11):485–493.
Missed nursing care, defined as the omission of any of various types of required patient care provided by nurses, has been shown to be a common occurrence and may affect patient safety and quality of care. This study used data from surveys and focus groups to compare perceptions about missed nursing care between RNs and nurse attendants (NAs) at the same institution. Survey findings suggested that RNs and NAs differed significantly in their perceptions of the frequency, nature, and causes of missed nursing care. Subsequent focus group discussions explored how underlying issues of teamwork and communication might account for these discrepancies in perception. Three tables are included.

- 10. Patient Safety at Ten: Unmistakable Progress, Troubling Gaps.**
Wachter RM.
Health Aff. 2010(Jan); 29(1). (Published online December 1, 2009)
This article assesses progress that has been made in patient safety during the decade since publication of the Institute of Medicine’s report To Err Is Human. The author finds some notable improvements, including the development of more effective error reporting and increased engagement of organizational leadership in safety. However, he notes that progress has lagged in certain other areas, including safety-related health IT adoption and efforts at malpractice system reform. He gives progress in patient safety an overall grade of B–, slightly better than the C+ he assigned in a similar assessment in 2004. Two tables are included.
- 11. Perspective: Physician Leadership in Quality.**
Pronovost PJ, Miller MR, Wachter RM, Meyer GS.
Acad Med. 2009(Dec); 84(12):1651–1656.
This commentary argues that a lack of leadership roles for physicians in academic disciplines related to healthcare quality has contributed to the slow progress of patient safety and quality improvement efforts in the US. The authors discuss organizational factors that limit the development and impact of such roles and offer recommendations for change.
- 12. Preventing Central Line–Associated Bloodstream Infections and Improving Safety Culture: A Statewide Experience.**
Watson SR, George C, Martin M, Bogan B, Goeschel C, Pronovost PJ.
Jt Comm J Qual Patient Saf. 2009(Dec); 35(12):593–597.
This article highlights the work of the MHA Keystone: ICU program, a collaborative initiative led by the Michigan Health & Hospital Association and researchers at Johns Hopkins University that has used evidence-based methods to improve patient safety and quality of care in ICUs across the state of Michigan. The authors describe initiatives that focused on improving unit-level safety culture and eliminating central line–associated bloodstream infections—two of the four interventions carried out thus far—and discuss possible next steps for the program. Three tables and one figure are included.
- 13. Redesign of the Health Care Delivery System: A Bauhaus “Form Follows Function” Approach.**
Grumbach K.
JAMA. 2009(Dec 2); 302(21):2363–2364.
This commentary considers how the famous tenet of the Bauhaus design school might be applied to the process of healthcare reform, resulting in care that is more accessible, efficient, and patient centered. The author outlines a set of “form follows function” principles for delivery of care and describes ways in which some providers and practices are embarking on such an approach.

- 14. Safe Surgery Implementation in Thailand.**
Kasatpibal N.
AORN J. 2009(Nov); 90(5):743–749.
This article describes the recent implementation of several national initiatives designed to improve safety of surgical patients in Thailand and highlights the role of the Thai Perioperative Nursing Association in supporting these efforts.
- 15. The Human Factors of Home Health Care: A Conceptual Model for Examining Safety and Quality Concerns.**
Henriksen K, Joseph A, Zayas-Cabán T.
J Patient Saf. 2009(Dec); 5(4):229–236.
This article uses human factors theory as a framework to discuss potential safety issues associated with home health care. The author reviews the available literature and presents a conceptual model illustrating how the interaction of patient and provider factors, technology, and characteristics of the physical environment may create error-conducive conditions in the home healthcare setting. One figure is included.
- 16. The Impact of Patients’ Participation on Physicians’ Patient-Centered Communication.**
Cegala DJ, Post DM.
Patient Educ Couns. 2009(Nov); 77(2):202–208.
This study investigated the dynamics of patient–physician communication in an analysis of interactions involving 25 physicians and 150 patients. In particular, the authors sought to determine the influence of patients’ participation on the degree to which physicians engaged in patient-centered communication, by comparing how the same physicians interacted with patients who participated with different levels of engagement or reticence. They found that, consistent with their hypothesis, physicians were significantly more likely to exhibit patient-centered communication with patients who participated more actively than with those who participated less actively in the conversation. Multiple tables are included.
- 17. The Role of the “Champion” in Infection Prevention: Results from a Multisite Qualitative Study.**
Damschroder LJ, Banaszak-Holl J, Kowalski CP, Forman J, Saint S, Krein SL.
Qual Saf Health Care. 2009(Dec); 18(6):434–440.
This research, part of a larger study of infection prevention practices at Veterans Affairs hospitals, sought insight into the role of organizational “champions” in implementing infection control practices. The authors analyzed data from telephone interviews and hospital site visits to learn about successes and challenges in implementation and to identify factors that hindered or facilitated champions’ efforts. They found that both the nature of the change and of the people involved were important factors in the champions’ success. Strictly technological changes were easier to implement and could sometimes be accomplished by a single individual, whereas behavioral changes often required the concerted efforts of a team, particularly in organizations that lacked strong interpersonal networks. Four tables are included.

- 18. ‘They Wouldn’t Know How It Feels...’: Characteristics of Quality Care from Young People’s Perspectives: A Participatory Research Project.**
Moules T.
J Child Health Care. 2009(Dec); 13(4):322–332.
This study used participatory research techniques to explore how young people experience and conceptualize healthcare quality. Nine teenaged participants were engaged to help carry out the research, in which an additional 129 participants ages 9 to 14 were asked to view and respond to a vignette depicting a young patient’s experience of hospitalization. Five attributes—technical expertise, explanations, choice, friendly staff, and respect—were identified as prerequisites for high quality care. Implications for improving quality of care for young patients and for their potential involvement in the quality evaluation process are discussed.
- 19. Transforming Healthcare: A Safety Imperative.**
Leape L, Berwick D, Clancy C, et al., for the Lucian Leape Institute at the National Patient Safety Foundation.
Qual Saf Health Care. 2009(Dec); 18(6):424–428.
Available at: <http://qshc.bmj.com/content/18/6/424.full>
The Lucian Leape Institute was established by the National Patient Safety Foundation with the goal of providing strategic guidance for healthcare safety improvement. This article, emerging from the Institute’s initial roundtable sessions, presents a vision for transformation of the healthcare delivery system based on five essential concepts: transparency, care integration, consumer engagement, restoration of joy and meaning in work, and medical education reform.
- 20. Use of the Modified Early Warning Score Decreases Code Blue Events.**
Maupin JM, Roth DJ, Krapes JM.
Jt Comm J Qual Patient Saf. 2009(Dec); 35(12):598–603.
This article reports on how an Ohio hospital adopted an early warning system as a means of improving patient monitoring and reducing the risk of failure to rescue. The authors describe the implementation process and present results, which show that use of the system has been associated with an increase in rapid response system calls and with decreases in code and mortality rates during the three years since its introduction. Multiple tables and figures are included.

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