

December (2) 2009
Volume 13, Issue 12:2

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1. Admission Handoff Communications: Clinician’s Shared Understanding of Patient Severity of Illness and Problems.

Brannen ML, Cameron KA, Adler M, Goodman D, Holl JL.

J Patient Saf. 2009(Dec); 5(4):237–242.

This study examined the communication of information during patient handoffs between residents at a tertiary care children’s hospital. To evaluate how successfully information was transferred between the handoff participants, the authors analyzed audio recordings of 36 handoffs and compared independent assessments of the patient’s condition from the two clinicians involved. They found that these assessments often disagreed significantly even when the relevant information appeared to have been available during the handoff, suggesting that the handoff interaction may not in itself guarantee shared understanding. The authors conclude that greater efforts may be needed to ensure that residents acquire the requisite skills to perform effective handoff communication. Multiple tables are included.

2. Affect Is Central to Patient Safety: The Horror Stories of Young Anaesthetists.

Iedema R, Jorm C, Lum M.

Soc Sci Med. 2009(Dec); 69(12):1750–1756.

This study used an analysis of focus-group dialogues with young clinicians to explore their approaches to coping with the emotional impact of medical errors. The authors present a thematic analysis of these discussions, focusing on how the recounting of narratives of “horror” may function as a means for doctors to come to terms with and learn from these experiences. One table is included.

3. Constructing and Re-constructing Narratives of Patient Safety.

Waring JJ.

Soc Sci Med. 2009(Dec); 69(12):1722–1731.

This article presents a sociological examination of the ways in which care providers and healthcare organizations formulate “narratives” about patient safety. Drawing on data from an ethnographic study at a large teaching hospital in England, the author illustrates how the same event might be described in three different contexts (informal conversation among clinicians, a clinician’s formal incident report, and a risk management report) and discusses the insights that this type of analysis may provide into organizational culture and learning about patient safety. One table is included.

- 4. Evidence of an Emerging Digital Divide among Hospitals That Care for the Poor.**
Jha AK, DesRoches CM, Shields AE, et al.
Health Aff. 2009(Nov/Dec); 28(6):w1160–w1170.
This article reports findings from a study that assessed electronic health record (EHR) system adoption and its relationship to quality of care in hospitals that care for large numbers of poor patients. Using data from a national survey of 2,368 hospitals, the authors found that hospitals with larger proportions of poor patients overall did slightly worse on both IT adoption and quality performance than did other hospitals. However, hospitals caring for poor that had adopted EHR systems did not differ significantly from other facilities in quality performance, suggesting that EHR adoption might help to ameliorate disparities in quality related to patient demographics. Two tables and one figure are included.
- 5. Holding Doctors Accountable for Medical Errors.**
Chen PW.
New York Times. December 17, 2009.
Available at: <http://www.nytimes.com/2009/12/17/health/17chen.html>
In this Doctor and Patient column, the author talks with Robert Wachter, MD, about the progress of patient safety improvements during the past decade, the increasing focus on individual accountability, and how heightened awareness about safety issues has affected the patient–physician relationship.
- 6. Impact of a Standard Medication Chart on Prescribing Errors: A Before-and-After Audit.**
Coombes ID, Stowasser DA, Reid C, Mitchell CA.
Qual Saf Health Care. 2009(Dec); 18(6):478–485.
This study involved the development, implementation, and evaluation of a standardized medication chart designed to improve prescribing-related safety at five public hospitals in Queensland, Australia. Comparison of pre- and post-intervention data showed that use of the chart was associated with significant reductions in prescribing errors and improvements in multiple aspects of prescribing safety. The authors note that the chart developed in this study has since been adopted by all Queensland public hospitals and served as the foundation for Australia’s National Inpatient Medication Chart. Four tables, two figures, and an appendix are included.
- 7. Integration of Prospective and Retrospective Methods for Risk Analysis in Hospitals.**
Kessels-Habraken M, Van der Schaaf T, De Jonge J, Rutte C, Kerkvliet K.
Int J Qual Health Care. 2009(Dec); 21(6):427–432.
This study evaluated the usefulness of an approach to risk analysis implemented in two units of a Dutch general hospital. The authors describe the method, which was designed to combine data from prospective and retrospective analyses in a complementary fashion, and discuss the possible advantages of such an integrated approach for understanding and addressing risks to patient safety. Three tables are included.

- 8. Involvement of Parents in Critical Incidents in a Neonatal–Paediatric Intensive Care Unit.**
Frey B, Ersch J, Baenziger O, Enderli L, Doell C.
Qual Saf Health Care. 2009(Dec); 18(6):446–449.
This study sought to characterize adverse incidents in pediatric ICU patients that in some way involved the patients’ parents, using data on 2,494 incidents reported over a 6-year period at a university children’s hospital. Of these incidents, the authors identified 101 in which patients’ parents were involved. Such involvement took various forms including contributing to, discovering, or being affected by an event. Further details of the findings and implications concerning the role of parents in their children’s care and safety are discussed. Two tables are included.
- 9. Key Performance Indicators in Intensive Care Medicine. A Retrospective Matched Cohort Study.**
Kastrup M, Von Dossow V, Seeling M, et al.
J Int Med Res. 2009(Sep/Oct); 37(5):1267–1284.
This study investigated the relationship between performance on selected process-of-care indicators and patient outcomes for surgical ICU patients at a university hospital in Berlin, Germany. In a retrospective analysis of data on 634 patients, the authors found that several of the indicators examined, including anesthesia and sedation monitoring and blood glucose control, were associated with significant reductions in mortality and/or length of ICU stay. One figure and multiple tables are included.
- 10. Measures of Health Literacy: Workshop Summary.**
Institute of Medicine.
Washington, DC: The National Academies Press; 2009.
Available at: <http://www.nap.edu/catalog/12690.html>
This publication summarizes proceedings of an Institute of Medicine Roundtable workshop that explored a variety of issues related to health literacy assessment, including discussion of the strengths and limitations of existing measurement tools, possible new approaches to assessment, and the role of health literacy assessment as a component of efforts to ensure patient-centered care.
- 11. Measuring Physicians’ Quality and Performance: Adrift on Lake Wobegon.**
Berwick DM.
JAMA. 2009(Dec 9); 302(22):2485–2486.
This editorial argues that effective measurement of physicians’ quality performance may be hindered by insufficient sample size, giving rise to the impression that all physicians are “above average.” The author explains why this situation occurs and offers several possible solutions, including increased emphasis on the use of patient evaluations to assess quality of care.

- 12. Medication Errors in Labor and Delivery: Reducing Maternal and Fetal Harm.**
Pennsylvania Patient Safety Authority.
Pa Patient Saf Advis. 2009(Dec); 6(Suppl 1):1–6.
Available at: [http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/dec16_6\(suppl1\)/Pages/01.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/dec16_6(suppl1)/Pages/01.aspx)
This article discusses medication errors associated with drugs administered during the labor and delivery process. Such errors often involve medications classified as “high-alert” and may pose danger to both the mother and the fetus. The authors present data from an analysis of 2,611 errors reported by Pennsylvania hospitals along with risk reduction strategies. Two tables are included.
- 13. Postdischarge Adverse Events in the Elderly.**
Tsilimingras D, Brummel-Smith K, Brooks RG.
J Patient Saf. 2009(Dec); 5(4):201–204.
This editorial argues that adverse events that occur after patients have been discharged from the hospital are an important and understudied safety issue. The authors review existing data on the incidence, nature, and causes of postdischarge adverse events, including evidence suggesting that elderly patients may be particularly vulnerable to such occurrences, and emphasize the need for further research and appropriate interventions to address this issue.
- 14. Primary Care and Accountable Care — Two Essential Elements of Delivery-System Reform.**
Rittenhouse DR, Shortell SM, Fisher ES.
N Engl J Med. 2009(Dec 10); 361(24):2301–2303.
This commentary describes two models for healthcare delivery system reform that have figured prominently in recent discussions: the “patient-centered medical home” and the “accountable care organization.” The authors highlight the essential features of each model and describe how the two could be used together to improve quality and coordination of care.
- 15. Projected Cancer Risks from Computed Tomographic Scans Performed in the United States in 2007.**
Berrington de González A, Mahesh M, Kim K-P, et al.
Arch Intern Med. 2009(Dec 14/28); 169(22):2071–2077.
This study sought to estimate the population-level cancer risks associated with radiation exposure from computed tomographic (CT) scans in the US. Using data-based models, the authors calculated that an estimated 29,000 future cancers would be attributable to CT scans conducted in 2007. The study also identified several types of scans and patient age groups associated with disproportionate risk. Three tables and two figures are included. [See also item 16.]

- 16. Radiation Dose Associated with Common Computed Tomography Examinations and the Associated Lifetime Attributable Risk of Cancer.**
Smith-Bindman R, Lipson J, Marcus R, et al.
Arch Intern Med. 2009(Dec 14/28); 169(22):2078–2086.
This study sought to calculate the radiation exposure and related cancer risk associated with eleven types of computed tomography (CT) procedures. The authors used data on 1,119 CT scans performed at four San Francisco Bay Area facilities during a 5-month period to calculate the effective dose and associated cancer risk for each type of scan. They found that median doses in the study sample were higher than published benchmarks, with significant variation within and between institutions and procedure types. The projected risk of cancer associated with CT-related radiation exposure varied considerably by procedure type and by patient’s age and sex. Implications of these findings and possible approaches to reducing patients’ exposure to medical radiation are discussed. Four tables and two figures are included. [See also item 15.]
- 17. Reconsidering the Team Concept: Educational Implications for Patient-Centered Cancer Care.**
Haidet P, Fecile ML, West HF, Teal CR.
Patient Educ Couns. 2009(Dec); 77(3):450–455.
This article examines the concept of teamwork in relation to the delivery of oncologic care and considers how issues of inter-provider teamwork and communication might be addressed as part of educational efforts to promote patient-centered care. The authors suggest that replacing the notion of “care teams” with that of “care communities” could be helpful in this endeavor, and they discuss how such a shift in thinking might translate into practice. Finally, they identify three essential skills providers will need in order to function as type of community. Two figures are included.
- 18. Safety and Risk Management Interventions in Hospitals: A Systematic Review of the Literature.**
Dückers M, Faber M, Cruijsberg J, Grol R, Schoonhoven L, Wensing M.
Med Care Res Rev. 2009(Dec); 66(6 Suppl):90S–119S.
This study sought to synthesize published evidence about the nature and effectiveness of hospitals’ activities for identifying, analyzing, and reducing risk and promoting safety. The authors present findings from an analysis of 38 studies identified through systematic review of the literature. While most of the interventions described in the included studies appeared to be beneficial, the authors note that methodological shortcomings of a number of the studies, as well as the difficulty of isolating information about specific elements of multipart interventions, limited their ability to draw conclusions from this data. Four tables and one figure are included.

19. Strengthening Institutional Review Board Review of Highly Innovative Interventions in Clinical Trials.

Lo B, Grady D.

JAMA. 2009(Dec 23/30); 302(24):2697–2698.

Adverse events occurring during trials of new and innovative therapies must be reported to the appropriate institutional review boards (IRBs), but such information may not be available to other IRBs and investigators whom it could benefit. This commentary argues that IRBs should publicly report such data in order to protect the safety of research participants and offers recommendations as to how this could be accomplished.

20. The Challenges to Transparency in Reporting Medical Errors.

Paterick ZP, Paterick BB, Waterhouse BE, Paterick TE.

J Patient Saf. 2009(Dec); 5(4):205–209.

Disclosure of medical errors to the patients involved continues to pose difficulties for providers and healthcare organizations, despite unequivocal calls for transparent reporting from regulatory and professional entities. This article discusses obstacles to transparency and argues that reform of the medical malpractice system and improved mechanisms for error reporting are needed in order for the ideal of complete transparency to be realized. Three tables are included.

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