

# IMPROVING HEALTHCARE FOR OLDER ADULTS

## Bibliography Series



Center for Health Financing, Policy and Management  
Sol Price School of Public Policy

### Adverse Events in Hospitals – Prevention

This bibliography provides published studies on research done on preventing adverse events in hospitals and the costs associated with these events on the healthcare system.

#### **2013**

Haines TP, Hill AM, Brauer SG, Hoffmann T, Etherton-Ber C, McPhail SM. Cost Effectiveness of Patient Education for the Prevention of Falls in Hospital: Economic Evaluation from a Randomized Controlled Trial. *Boston Medical Center Medicine*. 2013;22(11):135.

McDonald KM, Matesic B, Contopoulos-Ioannidis DG, Lonhart J, Schmidt E, Pineda N, Ioannidis JPA. Patient Safety Strategies Targeted at Diagnostic Errors: A Systematic Review. *Annals of Internal Medicine*. 2013;158:381-389.

Miake-Lye IM, Hempel S, Ganz DA, Shekelle PG. Inpatient Fall Prevention Programs as a Patient Safety Strategy: A Systematic Review. *Annals of Internal Medicine*. 2013;158:390-396.

Rennke S, Nguyen OK, Shoeb MH, Magan Y, Wachter RM, Ranji SR. Hospital-Initiated Transitional Care Interventions as a Patient Safety Strategy: A Systematic Review. *Annals of Internal Medicine*. 2013;158:433-440.

Reston JT, Schoelles KM. In-Facility Delirium Prevention Programs as a Patient Safety Strategy: A Systematic Review. *Annals of Internal Medicine*. 2013;158:375-380.

Schmidt E, Goldhaber-Fiebert SN, Ho LA, McDonald KM. Simulation Exercises as a Patient Safety Strategy: A Systematic Review. *Annals of Internal Medicine*. 2013;158:426-432.

Shekelle PG. Nurse – Patient Ratios as a Patient Safety Strategy: A Systematic Review. *Annals of Internal Medicine*. 2013;158:404-409.

Shekelle PG, Pronovost PJ, Wachter RM, et al. The Top Patient Safety Strategies Can Be Encouraged for Adoption Now. *Annals of Internal Medicine*. 2013;158:365-368.

Sullivan N, Schoelles KM. Preventing In-Facility Pressure Ulcers as a Patient Safety Strategy: A Systematic Review. *Annals of Internal Medicine*. 2013;158:410-416.

Weaver SJ, Lubomksi LH, Wilson RF, Pfoh ER, Martinez KA, Dy SM. Promoting a Culture of Safety as a Patient Safety Strategy: A Systematic Review. *Annals of Internal Medicine*. 2013;158:369-374.

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## **2012**

Garrouste-Orgeas M, Soufir L, Tabah A, Schwebel C, Vesin A, Adrie C, Thuong M, Timsit JF; Outcomerea Study Group. A Multifaceted Program for Improving Quality of Care in Intensive Care Units: IATROREF Study. *Critical Care Medicine*. 2012;40(2):468-476.

Leach LS, Kagawa F, Mayo A, Pugh C. Improving Patient Safety to Reduce Preventable Deaths: The Case of a California Safety Net Hospital. *Journal for Healthcare Quality*. 2012;34(2):64-76.

Prabhaker H, Cooper JB, Sabel A, Weckbach S, Mehler PS, Stahel PF. Introducing Standardized “Readbacks” to Improve Patient Safety in Surgery: A Prospective Survey in 92 Providers at a Public Safety-Net Hospital. *Boston Medical Center Surgery*. 2012;19(12):8.

## **2010**

Abdel-Qader DH, Harper L, Cantrill JA, Tully MP. Pharmacists’ Interventions in Prescribing Errors at Hospital Discharge: An Observational Study in the Context of an Electronic Prescribing System in a UK Teaching Hospital. *Drug Safety*. 2010;33(11):1027-1044.

Donaldson N, Shapiro S. Impact of California Mandated Acute Care Hospital Nurse Staffing Ratios: A Literature Synthesis. *Policy, Politics, & Nursing Practice*. 2010;11(3):184-201.

Kolin MM, Minnier T, Hale KM, Martin SC, Thompson LE. Fall Initiatives: Redesigning Best Practice. *Journal of Nursing Administration*. 2010;40(9):384-391.

Massó GP, Aranaz A JM, Mira JJ, Perdiguero E, Aibar C. Adverse Events in Hospitals: The Patient’s Point of View. *Quality & Safety in Health Care*. 2010;19(2):144-147.

Novis SJ, Havelka GE, Ostrowski D, Levin B, Blum-Eisa L, Prystowsky JB, Kibbe MR. Prevention of Thromboembolic Events in Surgical Patients Through the Creation and Implementation of a Computerized Risk Assessment Program. *Journal of Vascular Surgery*. 2010;51(3):648-654.

Wachter RM. Why Diagnostic Errors Don’t Get Any Respect – And What Can Be Done About Them? *Health Affairs*. 2010;29(9):384-391.

## **2010**

Kamon J, Campbell F, Czoski-Murray C. Model-Based Cost-Effectiveness Analysis of Interventions Aimed at Preventing Medication Error at Hospital Admission (Medicines Reconciliation). *Journal of Evaluation in Clinical Practice*.

Neily J, Mills PD, Eldridge N, Dunn EJ, Samples C, Turner JR, Revere A, DePalma RG, Bagian JP. Incorrect Surgical Procedures Within and Outside of the Operating Room. *Archives of Surgery*. 2009;144(11):1028-1034.

## **2008**

Haines TP, Cornwell P, Fleming J, Verghese P, Gray L. Documentation of In-Hospital Falls on Incident Reports: Qualitative Investigation of an Imperfect Process. *BMC Health Services Research*. 2008;11(8):254.

Leendertse AJ, Egberts AC, Stoker LJ, van den Bernt PM; HARM Study Group. Frequency of and Risk Factors for Preventable Medication-Related Hospital Admissions in the Netherlands. *Archives of Internal Medicine*. 2008;168(17):1890-1896.

**2007**

Institute of Medicine. Identifying and Preventing Medication Errors. Washington, DC: *National Academies Press*; 2007.

Thomsen LA, Winterstein AG, Sondergaard B, Haugbolle LS, Melander A. Systematic review of the incidence and characteristics of Preventable Adverse Drug Events in Ambulatory Care. *The Annals of Pharmacotherapy*. 2007;41:1411–1426.

**2006**

Schnipper JL, Kirwin JL, Cotugno MC, et al. Role of Pharmacist Counseling in Preventing Adverse Drug Events After Hospitalization. *Archives of Internal Medicine*. 2006;166:565–571.

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