



Patient Safety November, 2003

1: Acad Med. 2003 Nov;78(11):1085-9.

The imperative for quality: a call for action to medical schools and teaching hospitals.

The Academic Medical Center Working Group of the Institute for Healthcare Improvement.

Patient safety and quality improvement are critical clinical and research endeavors supported by the federal government, accrediting bodies, regulatory agencies, and patient-advocacy groups. The Boston-based Institute for Healthcare Improvement has led in educating physicians, nurses, and other health professionals to improve the effectiveness and efficiency of their delivery systems. Recently, academic medical institutions have come together to improve patient outcomes by participating in the institute's IMPACT network. Each participating institution works in one or more of five improvement domains: patient safety, intensive care, patient flow, office practice, and workforce development. In addition, the chief executive officer of each participating organization focuses on leadership. The infrastructure for raising the bar of performance is improving at medical schools and teaching hospitals in this country. Important trends include interdisciplinary centers of excellence, improved faculty practice plan governance and management, leadership recruitment and development, and a commitment to quality as a high educational priority at a number of medical schools. Quality improvement efforts are intellectual activities that are consistent with the values of academic medicine and discovery. Academic medical centers are well positioned to lead the way in the improvement of quality of care. As institutions entrusted with the education of future health professionals and charged with developing new knowledge, the authors call for a complete commitment to the highest level of quality in patient care.

PMID: 14604865 [PubMed - in process]

2: Ann Pharmacother. 2003 Nov;37(11):1716-22.

Voluntary medication error reporting program in a Japanese national university hospital.

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BACKGROUND: In Japan, as in other countries, medical accidents arising from human error can seriously damage public confidence in medical services, as well as being intrinsically undesirable. **OBJECTIVE:** Errors voluntarily reported by the healthcare practitioners in our institution (Kanazawa University Hospital) were

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considered to assess the contributory factors by using the accumulated error database in the hospital information system. METHODS: Medical errors in our institution during the period from July 1, 2000, to June 30, 2002, were counted using the error reporting system database and were classified. RESULTS: The number of errors reported during the investigation period was 1378, of which 78% were reported by nursing staff. Medication errors involving administration of injectable or oral drugs to inpatients, dispensing, and prescription accounted for about 50% of that number. Among dispensing errors, 53% were detected by patients or their families and 36% by nurses. CONCLUSIONS: The best method of error prevention is to learn from previous errors. For this purpose, the error reporting program is effective. In patient safety management, it is important to take into account the potential risks of future errors, as well as to capture information about errors that have already happened. For safety management, adoption of appropriate information technology (e.g., implementation of a prescription order entry system) is effective in reducing medication errors. However, it is important to note that serious errors can also arise in computer-based systems.
PMID: 14565814 [PubMed - in process]

3: Crit Care Med. 2003 Nov;31(11):2665-76.

Clinical practice guidelines for the maintenance of patient physical safety in the intensive care unit: Use of restraining therapies-American College of Critical Care Medicine Task Force 2001-2002.

Maccioli GA, Dorman T, Brown BR, Mazuski JE, McLean BA, Kuszaj JM, Rosenbaum SH,

Frankel LR, Devlin JW, Govert JA, Smith B, Peruzzi WT.

SUMMARY: OBJECTIVE To develop clinical practice guidelines for the use of restraining therapies to maintain physical and psychological safety of adult and pediatric patients in the intensive care unit. PARTICIPANTS A multidisciplinary, multispecialty task force of experts in critical care practice was convened from the membership of the American College of Critical Care Medicine (ACCM), the Society of Critical Care Medicine (SCCM), and the American Association of Critical Care Nurses (AACN). EVIDENCE The task force members reviewed the published literature (MEDLINE articles, textbooks, etc.) and provided expert opinion from which consensus was derived. Relevant published articles were reviewed individually for validity using the Cochrane methodology

(<http://hiru.mcmaster.ca/cochrane/> or www.cochrane.org). CONSENSUS PROCESS The task force met as a group and by teleconference to identify the pertinent literature and derive consensus recommendations. Consideration was given to both the weight of scientific information within the literature and expert opinion. Draft documents were composed by a task force steering committee and debated by the task force members until consensus was reached by nominal group process. The task force draft then was reviewed, assessed, and edited by the Board of Regents of the ACCM. After steering committee approval, the draft document was reviewed and approved by the SCCM Council. CONCLUSIONS The task force developed nine recommendations with regard to the use of physical restraints and pharmacologic therapies to maintain patient safety in the intensive care unit.
PMID: 14605540 [PubMed - in process]

4: Curr Womens Health Rep. 2003 Dec;3(6):487-491.

The Impact of Residents' Work-hour Restrictions.

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Graduate medical education continues to deal with multiple stressors. The new work-hour regulations only add to the program directors' and department chairs' difficulty of ensuring adequate educational, didactic, and clinical training for the residents. Appropriately, patient safety has been a concern in the discussion pertaining to resident work hours. Ensuring that the training of our residents is adequate prior to their entering practice will also have a direct impact on patient safety. In this article, areas of concern are identified, and ways of continuing to evaluate and document the adequacy of resident training are proposed.

PMID: 14613670 [PubMed - as supplied by publisher]

5: Drug Saf. 2003;26(13):937-50.

Reducing medication errors: a regional approach for hospitals.

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Since the Institute of Medicine's report, To Err Is Human, and the subsequent publication, Crossing the Quality Chasm, the subject of reducing medical errors has gained considerable attention from patients, healthcare providers, employers and government organisations in the US. Most nonoperative errors are related to medications. Medication errors lead not only to negative repercussions subjectively experienced by both the patient and the healthcare staff, but also to additional expenditures due to complications. Education, adapting new safety systems and technology, and having clinical pharmacists play a larger role in the medication process can all help in solving the problem of medication errors. Designing and executing a rational system to reduce medication errors is particularly germane in the current era of increased demands for quality healthcare in the setting of cost-containment pressures. In the Delaware Valley (Philadelphia and surrounding area) of Pennsylvania, USA, a consortium of healthcare providers in cooperation with the Health Care Improvement Foundation (HCIF), and two non-profit organisations--the ECRI (formerly the Emergency Care Research Institute) and the Institute for Safe Medication Practices (ISMP)--have combined to establish and promote safe medication practices under a programme known as the Regional Medication Safety Program for Hospitals. At the core of the programme are 16 medication safety goals, which centre on establishing an institutional culture of safety, modifying infrastructure and clinical practice to reflect this culture, and using technology to facilitate these changes. It is believed that this rational campaign to improve patient safety may serve as a paradigm for other regions around the world.

PMID: 14583069 [PubMed - in process]

6: Healthcare Benchmarks Qual Improv. 2003 Nov;10(11):130-2.

Collaborative patient safety program launched.

[No authors listed]

Root-cause analysis of adverse events and near misses are emphasized.

Participant make-up offers opportunity to hear differing viewpoints. VA Center for Patient Safety considered a leader in safety movement.

PMID: 14598769 [PubMed - in process]

7: Int J Pediatr Otorhinolaryngol. 2003 Nov;67(11):1159-68.

Outpatient treatment suite: a safe and cost-effective venue to perform myringotomy and tubes placement in children.

Compliment JM, Gendelman MS, Allera JF, Matisz M, Horvath J, Hores KM, Sperring K, Herbert C, Smith JM, Kurpakus BJ, Borgman KM, Christopher Post J.

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CONTEXT: Otitis media (OM) is the most common reason that a child undergoes a

general anesthetic, with the total costs of treating this disease exceeding five billion dollars annually. Concerns regarding the development of antibiotic-resistant organisms in response to medical treatment for OM have fueled the demand for surgical intervention. However, reimbursements are decreasing. Non-traditional settings for children requiring bilateral myringotomy and tube (BMT) placement for ear disease have the potential to offer the same degree of patient safety and improved efficiency but at lower cost. OBJECTIVE: To develop a non-traditional setting for BMT surgery that is safe, cost effective, and well received by patients, families and staff. DESIGN: Prospective design of an outpatient treatment suite (OTS) for BMT placement; prospective evaluation of safety and family satisfaction; analysis of costs. SETTING: A 778 bed US urban area level one trauma center and teaching hospital, with a 2160ft(2) electro-convulsive therapy suite that was underutilized and non-revenue generating on Tuesdays and Thursdays. PARTICIPANTS: A design task force of health care providers, administrators and operations personnel; 794 healthy children between the ages of 6 months to 16 years requiring BMT surgery; 100 families of patients. MAIN OUTCOME MEASURES: Financial comparison was made between the traditional operating room (OR) setting, the outpatient surgery center (SC) and the OTS comparing overhead and indirect costs to run each site. A prospective survey was conducted of 100 consecutive patients undergoing surgery between November 2000 and June 2001. The survey was conducted at the 2weeks postoperative check and was composed of 18 questions divided into five sections, with a 5-point rating scheme, with one being very poor, and five being very good. RESULTS: Designing a new treatment venue was successful because of teamwork and a willingness to think creatively. The OTS was found to be far more cost-effective than both the main OR and SC for BMTs. The contribution to margin for the SC was US\$ 280 per case and for the main OR was US\$ 2130 per case. By operating on 794 patients in OTS, the hospital was able to generate additional contribution to margin of US\$ 197,100 when compared to the cost of performing these cases in the SC and US\$ 1,499,500 when compared to performing all cases in the main OR. No adverse consequences were noted. Patient/Family satisfaction was also rated very high, with an overall rating of 4.85 and markedly reduced time in hospital. CONCLUSION: Operating rooms (ORs) today are busier than in years past, but revenues barely meet or in some cases fall below expenses due to insurers' decreased reimbursement. This innovative approach to BMT placement has been shown to be safe and results in excellent family satisfaction, with a substantial contribution to margin. As over one million BMT cases are performed annually in the US, adoption of this approach nationally has the potential to markedly reduce the treatment costs of this common disease. PMID: 14597365 [PubMed - in process]

8: J Healthc Inf Manag. 2003 Fall;17(4):36-41.

Clinical ROI: not just costs versus benefits.

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Although sophisticated economic modeling can be used to quantify intangible benefits, ROI calculations for clinical information systems are driven more by the values and strategic direction of an organization than by any other considerations. But investing in clinical information tools to ensure quality and patient safety is, in reality, required as a cost of doing business and functioning as a safe hospital.

PMID: 14558370 [PubMed - in process]

9: J Healthc Inf Manag. 2003 Fall;17(4):29-35.

Who's counting now? ROI for patient safety IT initiatives.

Newell LM, Christensen D.

The impact and expectation of cost-justifying patient safety IT initiatives using a traditional ROI must evolve to focus beyond the financial benefit. It must encompass overall patient safety, patient satisfaction, and employee and physician satisfaction benefit categories. Computerized physician order entry (CPOE) and bar code medication administration (BCMA) systems are two particular clinical point-of-care products that will play a key role in addressing patient safety objectives. Integrating the two technologies can bring both financial and clinical benefits.

PMID: 14558369 [PubMed - in process]

10: J Pediatr Hematol Oncol. 2003 Oct;25(10):757-8.

The challenge and cost of patient safety.

Arceci RJ.

PMID: 14528095 [PubMed - in process]

11: JAMA. 2003 Oct 8;290(14):1868-74.

Comment in:

JAMA. 2003 Oct 8;290(14):1917-9.

Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization.

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CONTEXT: Although medical injuries are recognized as a major hazard in the health care system, little is known about their impact. OBJECTIVE: To assess excess length of stay, charges, and deaths attributable to medical injuries during hospitalization. DESIGN, SETTING, AND PATIENTS: The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs) were used to identify medical injuries in 7.45 million hospital discharge abstracts from 994 acute-care hospitals across 28 states in 2000 in the AHRQ Healthcare Cost and Utilization Project Nationwide Inpatient Sample database. MAIN OUTCOME MEASURES:

Length of stay, charges, and mortality that were recorded in hospital discharge abstracts and were attributable to medical injuries according to 18 PSIs.

RESULTS: Excess length of stay attributable to medical injuries ranged from 0 days for injury to a neonate to 10.89 days for postoperative sepsis, excess charges ranged from 0 dollar for obstetric trauma (without vaginal instrumentation) to 57 727 dollars for postoperative sepsis, and excess mortality ranged from 0% for obstetric trauma to 21.96% for postoperative sepsis (P<.001). Following postoperative sepsis, the second most serious event was postoperative wound dehiscence, with 9.42 extra days in the hospital, 40 323 dollars in excess charges, and 9.63% attributable mortality. Infection due to medical care was associated with 9.58 extra days, 38 656 dollars in excess charges, and 4.31% attributable mortality. CONCLUSION: Some injuries incurred during hospitalization pose a significant threat to patients and costs to society, but the impact of such injury is highly variable.

Publication Types:

Evaluation Studies

PMID: 14532315 [PubMed - indexed for MEDLINE]

12: Jt Comm J Qual Saf. 2003 Oct;29(10):503-11.

Does full disclosure of medical errors affect malpractice liability? The jury is

still out.

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BACKGROUND: Mandatory disclosure of medical errors has been advocated to improve

patient safety. Many resist mandatory disclosure policies because of concerns about increasing malpractice exposure. It has been countered that malpractice liability actually decreases when there is full disclosure of medical errors. A comprehensive literature search was conducted to determine what is known about the impact of full disclosure on malpractice liability. METHODS: Electronic searches of multiple databases were supplemented with hand searches of bibliographies and communication with recognized experts in the field. RESULTS: Screening the titles, abstracts, and, in many cases, the full articles from more than an estimated 5,200 citations resulted in identification of one published study directly examining malpractice liability when a policy of full disclosure was implemented. DISCUSSION: Despite extensive literature on the impact of disclosure on malpractice liability, few well-designed studies have focused on the real-world impact on the volume and cost of suits following implementation of a full disclosure policy. Many articles examine why patients sue their doctors, suggesting that some lawsuits may be averted by disclosure, but the articles do not allow us to estimate the additional suits that would be created by disclosure. Additional studies addressing the effect of disclosure on malpractice liability are needed.

Publication Types:

Review

Review, Tutorial

PMID: 14567259 [PubMed - indexed for MEDLINE]

13: Jt Comm J Qual Saf. 2003 Oct;29(10):551-5.

Unanticipated harm to patients: deciding when to disclose outcomes.

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BACKGROUND: Patient safety standards of the Joint Commission on Accreditation of Healthcare Organizations require that "patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes." WHAT OUTCOMES SHOULD TRIGGER DISCLOSURE: Given that all medical

treatments have an array of possible outcomes, how do we confidently say that an outcome is unanticipated? It is proposed that an adverse outcome meet one of two criteria to be considered unanticipated: (1) It would not be included in a reasonable informed consent process for treatment of the patient's condition(s) and/or would not be expected during the usual course of treatment; and (2) it may have been caused by human or systemic error--that is, it is not immediately possible to clearly and decisively rule out error. This definition requires less judgment because it represents an extension of the existing norms of communication that are expressed through the process of informed consent. The norms of the informed consent process require that the patient be given all pertinent information needed to participate in future treatment decision making.

CONCLUSIONS AND RECOMMENDATIONS FOR ORGANIZATIONAL POLICIES:

Institutional

policies and procedures should provide a clear approach to the identification, reporting, and discussion of unanticipated adverse outcomes, whether or not they are associated with error, as well as guidance and an educational program to

help physicians, staff, and students disclose unanticipated adverse events and error in the most appropriate manner.

PMID: 14567264 [PubMed - indexed for MEDLINE]

14: Obstet Gynecol. 2003 Oct;102(4):883-5.

ACOG committee opinion number 286, October 2003: patient safety in obstetrics and gynecology.

American College of Obstetricians and Gynecologists.

Emphasis on patient safety has increased in the past few years mostly in response to the Institute of Medicine report "To Err Is Human: Building a Safer Health System." Obstetrician*gynecologists should incorporate elements of patient safety into their practices and also encourage others to use these practices. The American College of Obstetricians and Gynecologists (ACOG) is committed to improving quality and safety in women's health care. The Institute of Medicine report, "To Err Is Human: Building a Safer Health System," notes that errors in health care are a significant cause of death and injury. Despite disagreements over the actual numbers cited, all health care professionals agree that patient safety is extremely important and should be addressed by the overall health care system. The American College of Obstetricians and Gynecologists continues to emphasize its long-standing commitment to quality and patient safety by codifying a set of objectives that should be adopted by obstetrician*gynecologists in their practices. Obstetrician*gynecologists are encouraged to promulgate these principles in the hospitals and other settings where they practice.

PMID: 14551024 [PubMed - indexed for MEDLINE]

15: Ophthalmology. 2003 Oct;110(10):2054-61.

Orbital implants in enucleation surgery: a report by the American Academy of Ophthalmology.

Custer PL, Kennedy RH, Woog JJ, Kaltreider SA, Meyer DR.

OBJECTIVE: To compare prosthetic and implant motility and the incidence of complications associated with porous and nonporous enucleation implants. **METHODS:** Literature searches conducted in January 2002 for 1985 to 2001 and May 2002 for October 2001 to 2002 retrieved relevant citations. The searches were conducted in MEDLINE and limited to articles published in English with abstracts. Panel members reviewed the articles for relevance to the assessment questions, and those considered relevant were rated according to the strength of the evidence. **RESULTS:** A randomized clinical trial and a longitudinal cohort study detected no difference in implant or prosthetic movement between nonpegged hydroxyapatite porous and spherical alloplastic nonporous implants. No controlled studies were retrieved that investigated whether pegging porous implants improves prosthetic movement. Several case series indicate that patients with pegged hydroxyapatite implants have some degree of improved prosthetic motility. Longitudinal cohort studies show that sclera-covered hydroxyapatite implants have higher exposure rates than sclera-covered silicone implants, and unwrapped porous polyethylene implants have higher exposure rates than unwrapped acrylic implants. There are numerous case series that document a wide range of implant exposure rates in patients with various enucleation implants. It is difficult to compare complication rates among implant types because patient populations vary, surgical techniques differ, and follow-up periods are often limited. **CONCLUSIONS:** Based on one randomized clinical trial, spherical alloplastic nonporous and nonpegged porous enucleation implants provide similar implant and prosthetic motility when they are implanted using similar surgical techniques. Coupling the prosthesis to a porous implant with a motility peg or post appears to improve prosthetic motility, but there are few

available data in the literature that document the degree of the improvement. There is a widely variable incidence of porous implant exposure, but certain surgical techniques and the type of wrapping material seem to reduce the exposure rate. Additional research is needed to document the long-term incidence of complications related to porous enucleation implants and associated surgical techniques. This includes the use of wrapping materials and what procedural modifications, both surgical and prosthetic, are most effective in reducing these complications.

Publication Types:

Evaluation Studies

PMID: 14522788 [PubMed - indexed for MEDLINE]

16: Patient Care Manag. 2003 Oct;19(10):1-2.

"Time out" for patient safety no joke to JCAHO.

[No authors listed]

PMID: 14593845 [PubMed - in process]

17: Physician Exec. 2003 Sep-Oct;29(5):39-42.

A business case for patient safety.

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PMID: 14531184 [PubMed - indexed for MEDLINE]

18: Plast Reconstr Surg. 2003 Nov;112(6):1683-9; discussion 1690-1.

An outcome study comparing intravenous sedation with midazolam/fentanyl (conscious sedation) versus propofol infusion (deep sedation) for aesthetic surgery.

Hasen KV, Samartzis D, Casas LA, Mustoe TA.

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The purpose of this study was to determine the differences in measurable outcomes following aesthetic procedures performed under intravenous sedation with incremental doses of midazolam and fentanyl and those performed under propofol infusion. The authors' hypothesis was that the differences in these outcome parameters are not significant between these intravenous sedation protocols. All intraoperative and perioperative records of 84 consecutive patients having aesthetic surgery under a conscious sedation protocol using incremental doses of intravenous midazolam and fentanyl were retrospectively reviewed and compared with the records of a second group of 85 patients having aesthetic surgery under a deep sedation regimen based primarily on propofol infusion. All procedures were hospital based and performed by two surgeons. Twenty-eight different parameters were examined by chart review. In addition, a patient questionnaire was used to assess patient satisfaction and patient recall of operative and perioperative pain, anxiety, nausea, and vomiting. Multivariate statistical analysis was conducted. The two sedation groups were similar with regard to aesthetic procedures performed and patient demographics. The mean duration of operative time was statistically equivalent (152 minutes and 153 minutes). In both groups, there were minor adverse intraoperative events reported but no significant complications. Transient hypotension was more common in the propofol infusion group (12.9 percent versus 2.4 percent, $p = 0.018$), but no patient required intervention beyond reducing the sedative agent or increasing intravenous fluids. The amount of supplemental fentanyl given intraoperatively was significantly higher in the group whose primary agent for sedation was propofol infusion than the group who received midazolam/fentanyl (209 mug and 143 mug, respectively). The overall questionnaire response rate was

80 percent for both groups. The midazolam/fentanyl sedation group had more recall of "unpleasant intraoperative events" (17 percent versus 3 percent, $p = 0.007$). However, both groups had low recall of intraoperative pain, anxiety, and nausea. The propofol infusion group experienced significantly more nausea in the recovery room ($p = 0.002$), nausea at the time of discharge ($p = 0.009$), and nausea the evening after the operation ($p = 0.013$). Greater than 90 percent of the patients in both groups would have the same anesthetic in the future rather than undergo general anesthesia. Patient safety, outcomes, and satisfaction are similar in plastic surgery procedures performed under sedation protocols using either incremental doses of midazolam and fentanyl or propofol infusion. All operative and postoperative outcomes for pain, anxiety, and vomiting were similar in the two groups except for immediate postoperative nausea, which was higher in the propofol infusion group. The overall satisfaction of patients undergoing plastic surgery procedures under these intravenous sedation protocols appears very high.

PMID: 14578803 [PubMed - in process]

19: Postgrad Med. 2003 Sep;114(3):15-6, 18.

Medical errors and patient safety. Despite widespread attention to the issue, mistakes continue to occur.

Jacott W.

Publication Types:

Editorial

PMID: 14503397 [PubMed - indexed for MEDLINE]

20: Prof Nurse. 2003 Oct;19(2):79-83.

Infusion devices: understanding the patient perspective to avoid errors.

Quinn C.

The National Patient Safety Agency (NPSA) has sponsored a project to detect the root causes of problems with infusion devices and to identify ways of preventing errors. It is piloting a number of solutions in six trusts after a project that included a survey of patient views discovered the need for better communication and information for patients about this treatment method.

PMID: 14593780 [PubMed - in process]

21: Qual Manag Health Care. 2003 Oct-Dec;12(4):232-9.

Do health care managers know the comparative quality of their care?

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Compared with other industries, health care is a high-risk industry. In this study, two national data sets on patient claims and a survey of improvement efforts in Swedish health care were used to investigate the linkage between how health care managers perceive their performance regarding adverse medical events and their performance as reflected in patient malpractice claims rates. The departments' focus on patient safety issues in their improvement efforts was also evaluated. Our results show that Swedish health care department managers underestimate their departments' frequency of adverse medical events relative to that of similar units. Also, there is no correlation between the managers' perception of adverse medical events and their actual frequency of patient malpractice claims. More research is needed on the use of patient-generated malpractice claims and claims rates to promote a higher awareness of the magnitude of the safety problems in health care.

PMID: 14603785 [PubMed - in process]

21: Science. 2003 Oct 3;302(5642):31.

Infectious diseases. SARS experts want labs to improve safety practices.

Normile D.

Publication Types:

News

PMID: 14526044 [PubMed - indexed for MEDLINE]

22: Stroke. 2003 Oct;34(10):e184. Epub 2003 Sep 18.

Comment on:

Stroke. 2003 Jun;34(6):e46-7.

ESPRIT: safety and efficacy of oral anticoagulation--a rebuttal.

ESPRIT.

Publication Types:

Comment

Letter

PMID: 14500928 [PubMed - indexed for MEDLINE]

23: Technol Health Care. 2003;11(4):275-81.

Quality analysis of medical device vigilance reports.

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The quality of the notifications issued within the European Medical Device Vigilance system were retrospectively reviewed and the adequacy of the recommended guidelines evaluated. The study material comprised all 589 vigilance notifications the Finnish competent authority received from manufacturers and other national competent authorities during 1997, 1999, and 2001. The number of vigilance reports, particularly the reports issued by national competent authorities, has increased from 82 in 1997 up 166 in 2001 while the proportion of reports with demonstrated bearing on health risk has decreased from about 40% down to 20% during the last five years. The number of manufacturers' reports has also increased from 28 in 1997 up to 98 in 2001 while the information given in the reports have become somewhat more incoherent. The time needed to close a device-related incident has increased, too. It is obvious that the present vigilance guidelines provide adequate guidance for both the manufacturers and competent authorities to manage vigilance cases efficiently and appropriately. It is crucial that all pertinent parties should adopt the recommended procedures and act accordingly. The vigilance system underpinned with high quality notifications only assures the continuous enhancement of patient safety, the bottom line.

PMID: 14600338 [PubMed - in process]

