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USP Patient Safety CAPSLink™

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This message has been sent to you as a service of the U.S. Pharmacopeia, Center for the Advancement of Patient Safety (CAPS). USP is a not-for-profit, non-governmental organization that promotes the public health by establishing state-of-the-art standards to ensure the quality of medicines and other health care technologies. CAPS is a component of USP's Patient Safety public health program. USP's Center for the Advancement of Patient Safety was created to encourage medication error reporting, conduct data analysis and research, develop educational programs, and propose standards, recommendations, and guidelines that ultimately improve the safety and quality of patient care.

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1. USP Issues Recommendations for Preventing Medication Errors in Children

To help improve the safety of young patients, the United States Pharmacopeia (USP) recently published recommendations for preventing medication errors in children. While medication errors can happen to any patient at any age, the consequences can be far more devastating when children are involved. USP's Center for the Advancement of Patient Safety (CAPS) created the recommendations after analyzing medication error data from its databases. Health care practitioners must consider a child's age, weight, medication dosing frequencies, and a number of other factors to help ensure the safety of young patients. For a comprehensive list of recommendations to help prevent medication errors in pediatric populations, send an e-mail request to <http://www.usp.org/prnrecomm>

2. Study Examines Risk Factors for Objects Left in Patients After Surgery

A new study in the New England Journal of Medicine estimates that a surgical instrument or sponge is left inside a patient in more than 1,500 surgical cases each year. The risk of a patient retaining a foreign body after surgery increases in emergencies, unplanned changes in procedure, and in those patients with higher body-mass index. The article outlines a number of techniques that can reduce these incidences including counting instruments and sponges before and after procedures and x-raying patients for instruments that may have inadvertently been left behind. <http://www.nejm.org> (Subscription Required)

3. Errors Made by Interpreters a Growing Problem

A recently published study in Pediatrics examined the growing problem of medical errors made by interpreters. Although some of the mistakes were small, 63% were considered serious enough to have medical consequences, because the incorrect translation altered the description of illness to the doctor, misstated diagnostic or treatment options, or affected a parent's understanding of a child's condition or the need for follow-up visits or referrals.

<http://www.jsonline.com/alive/news/jan03/108507.asp>

4. Use of Oncology “Dashboards” to Monitor Performance

Quick snapshots of service-line indicators (i.e., “dashboards”) are providing oncology administrators the ability to distill large data sets into a manageable number of metrics to monitor. The dashboards provide a simple coding system to guide appropriate levels of response to potential problems and allow for a more accurate assessment of performance against budgetary concerns and strategic goals while identifying trends in critical performance areas.

<http://www.advisory.com/members/basecontent.asp?contentid=32789&collectionid=148&program=8&contentarea=186320&eprefid=8>

5. Pharmaceutical Companies Begin to Adopt Bar Codes

The use of bar code technology has been touted as a tool that can improve patient safety, but requires products to carry such a code on the label. A protracted debate over whether drug makers should be required to place bar codes on individualized dosage packages (“unit-dose” packages) has, in part, delayed the widespread adoption of bar code technology within the hospital setting. Recently, Pfizer, Inc. has signaled a new willingness on the part of some manufacturers to imprint bar codes on their products in an effort to reduce medication errors in hospitals. Pfizer's code identifies the product and dosage (i.e., NDC code) as well as lot number and expiration date. Other companies' codes only identify the NDC. The FDA is expected to release its ruling on bar-coding standards Feb. 15 <http://www.healthleaders.com/news/newspage1.php?contentid=41528>

6. ER Visits Due to Drug Misuse Soars

Emergency room visits related to the abuse of painkillers more than doubled from 1994 to 2001, from 41,687 to 90,232, according to a separate survey by the Drug Abuse Warning Network, a public health system within HHS that monitors drug-related medical emergencies. Teenagers' use of painkillers contributes a significant portion of prescription misuse. The painkillers most commonly cited for abuse were hydrocodone, oxycodone and methadone. <http://www.latimes.com/news/printedition/asection/la-na-drugs17jan17.0,5866335.story?coll=la%2Dnews%2Da%5Fsection>

7. Errors Associated with Medical Devices Under Surveillance

Over 1,000 devices are recalled each year by the FDA according to a “Perspective” article in the January 16 issue of the New England Journal of Medicine. The Medical Device Surveillance Network is a new FDA program designed to promote early reporting of problems and patient injuries associated with medical devices. The surveillance program is intended to capture serious, low-frequency events that were not reported before marketing, detect unintended changes in risk due to design or manufacturing modifications, and assess risks and benefits over longer follow-up periods or in high-risk populations. <http://content.nejm.org/>

8. Autopsies Uncover Diagnostic Discrepancies

A new report released by the Agency for Healthcare Research and Quality provides further evidence that autopsies can detect clinically important discrepancies in diagnosis. In U.S. hospitals in the year 2000, researchers estimated that the correct cause of death was not detected in 8% to 23% of cases while as many as 8% of all deaths had a diagnostic discrepancy that may have harmed the patient. In addition, up to 5% of

autopsies disclosed clinically unsuspected complications of care.

<http://www.ahrq.gov/clinic/epcsums/autopsum.htm>

9. IOM Recommends National Focus on Selected Key Areas

A new report from the Institute of Medicine suggests that the nation's health care field should focus on 20 priority areas to improve health care quality and safety in the U.S. The 20 areas of focus are asthma; care coordination; children with special health care needs; diabetes; end-of-life care for advanced organ-system failure; evidence-based cancer screening; frailty associated with old age; hypertension; immunization; ischemic heart disease; major depression; medication management; nosocomial infections; obesity; pain control in advanced cancer; pregnancy and childbirth; self-management and health literacy; severe and persistent mental illness; stroke; and tobacco-dependence treatment in adults. <http://www.nap.edu/books/0309085438/html/>

10. Fact Sheet on Preventing Pediatric Medical Errors

A partnership between the Agency for Healthcare Research and Quality and the American Academy of Pediatrics has been forged to help inform pediatricians and parents about ways to prevent medical errors in children. Both groups are promoting a new fact sheet, "20 Tips to Help Prevent Medical Errors in Children," which offers tips on avoiding medical errors related to prescription medicines, hospital stays, and surgery. <http://www.ahrq.gov/consumer/20tipkid.htm>

11. ISMP Creates Quarterly Action Item List

The Institute for Safe Medication Practices has summarized and compiled 16 key items from its "ISMP Medication Safety Alert!" for October through December 2002 into a single document to promote the proactive identification and prevention of medication errors. <http://www.ismp.org/MSAarticles/A1Q03Action.htm>

12. IOM Patient-Safety Data Standards

The purpose of the Institute of Medicine Committee on Patient Safety Data Standards is to produce a detailed plan to facilitate the development of data standards applicable to the collection, coding, and classification of patient safety information. The plan will apply to both adverse-event data and errors data. Updated information on the work of the committee will be posted to this Web site.

<http://www.iom.edu/IOM/IOMHome.nsf/Pages/Patient+Safety+Data+Standards>

13. Health Care in America Outlined in 'Escape Fire'

Donald M. Berwick, M.D., president and CEO of the Institute for Healthcare Improvement, provides a compelling account of his and his wife's personal experiences in the health care system in "Escape Fire: Lessons for the Future of Health Care". Now available in book form from The Commonwealth Fund, Berwick identifies quality problems endemic to the health system and then sketches an ambitious program for reform.

http://www.cmwf.org/programs/quality/berwick_escapefire_lowres_563.pdf

14. USP Launches New MEDMARXSM Version 5.0

MEDMARX 5.0 delivers more power and improved features through a redesigned interface, simplified integration, predefined reports, improved hospital system comparisons, reporting and analysis, and enhanced charts and graphs to uncover patterns and trends. In addition, 5.0 subscribers can:

- Access a new primary reporting page that collects all mandatory fields into one screen for faster report entry to help hospitals avoid future errors by capturing information about actions taken and recommendations given;
- Draw on new hospital system tools that facilitate comparisons, reporting, and analysis across multiple sister facilities;
- Take advantage of online training programs and self-paced courses that acclimate new and novice users to the powerful functionality of Medmarx; and
- Add on the optional data interface that enables the seamless integration of medication error data from hospital risk management systems and other databases directly into Medmarx. (Note: this feature will be available later this year).

For a demonstration of Medmarx 5.0, call a Medmarx account manager at 1-877-Medmarx, e-mail ems@usp.org, or visit www.usp.org.

You are currently subscribed to USP Patient Safety CAPSLink. To refer colleagues or friends to subscribe to this newsletter [click here](#). To unsubscribe click on this [link](#).

USP operates two complementary error reporting programs; the **Medication Errors Reporting Program** which operates in cooperation with the Institute for Safe Medication Practices and **MedMARXSM**. MedMARX is an Internet-accessible, anonymous medication error reporting program and quality improvement tool used to track and trend medication errors. For more information, visit www.usp.org

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