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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. The USP 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. FDA Tests Early-Warning System

FDA is launching a series of tests at 80 hospitals and nursing homes in the U.S. designed to improve the tracking of adverse drug events and medical devices. One experiment involves a computer program that alerts FDA when medical tests diagnose signs of liver trouble or other problems with the use of selected medications-- the first step toward an early-warning system for risks associated with new drugs. Other FDA experiments that will be undertaken to reduce medical mistakes and preventable drug side effects

- Create electronic medicine labels through a program called "Daily Med" enabling doctors to locate in seconds via computer or Palm Pilot lists of dangerous drug interactions. New warnings will be added daily.
- Prevent medical device errors and detect defective devices faster, through

a network for health workers to report equipment problems.

- Require that bar codes be placed on drug packaging for hospital-administered drugs.
- Develop a newsletter informing participating hospitals about others' mistakes so they are not repeated.

[Click here to read more](#)

2. Surgical Complications Decline with Repetition

A study published in the *Journal of the American College of Surgeons* found that frequent performance of radical prostatectomies by a surgeon led to better patient outcomes. Patients of surgeons who performed the operation infrequently (i.e., "low-volume surgeons") had twice the rate of complications, including impotence and incontinence, and tended to have an increased length of stay by one day. The contentious link between procedure volume and clinical quality suggests that the old adage "practice makes perfect" is most vital at the individual, not the institutional, level.

[Click here to read more](#)

3. Medical Residents Unlikely to Report Errors

Results of a recent survey disclosed at last week's American College of Preventive Medicine meeting provided evidence that error-reporting systems are underused, largely because of prevailing hospital culture. Medical residents and nurses at a Connecticut community hospital were surveyed and while 35 of 36 nurses at the hospital knew about the facility's error-reporting system, only 13 of 24 residents had the same awareness. When it came to actually using the error-reporting system, only three residents and 26 nurses said they had done so.

Survey respondents also indicated that they were more likely to use their error-reporting program to report harmful versus non-harmful errors and most said that they were uncomfortable talking to patients about errors. Medical residents were more likely than nurses to say that the hospital did not have a supportive environment for reporting medical errors. The study's author stated that physicians who do not learn how to document mistakes during residency are unlikely to do so later on.

[Click here to read more](#)

4. Ephedra's Effects Prompt the Most Calls

Poison control centers in 2001 fielded far more inquiries about adverse reactions to ephedra-containing products than to any other herbal product, according to a study funded by the National Center for Complementary and Alternative Medicine.

[Click here to read more \(a\)](#)

[Click here to read more \(b\)](#)

5. CPOE Can Reduce Errors and Save Billions

A study from the not-for-profit Center for Information Technology Leadership states that adopting ambulatory computer physician order entry (CPOE) systems nationwide would prevent more than 2 million medical errors and save \$44 billion annually. Hospitals that adopt intermediate and advanced ambulatory CPOE systems can

expect to recoup their investments in just two years. Advanced systems that include clinical decision support tools prevent 10 times as many medical errors as basic systems but can cost five times more. The researchers presented their findings at the Healthcare Information and Management Systems Society annual conference in San Diego in early February; the full report will be available in March.

Some hospital CFO's may question the value of implementing CPOE systems because of some publicized problems including technical and operational challenges and lack of physician buy-in. However, hospitals already using CPOE systems contend that the benefits outweigh the costs and challenges of implementation.

Successful CPOE implementation rests on four pillars



Source: Teich, *iHealth Beat*, 1/29/03.

6. AHRQ Launches Web-Based Patient Safety Journal

Morbidity & Mortality Rounds on the Web, a monthly, online peer-reviewed journal by the Agency for Healthcare Research and Quality, debut this month and showcases patient safety lessons drawn from actual medical error cases. The inaugural issue features a case involving the administration of the wrong drug causing the patient to stop breathing unexpectedly. Each month, AHRQ plans to portray five cases of medical errors and patient safety problems along with commentaries from distinguished experts and a forum for readers' comments. One of the five cases will be expanded into an interactive learning module. [Click here to read more](#)

7. Medical Errors After Discharge

Although many studies of medical errors have focused on the estimated 3% - 4% of hospitalized patients who experience harmful mistakes, a new study examines the problem of errors that appear after a patient has been discharged. Researchers from Harvard Medical School and the University of Ottawa concluded that the transition from hospital to home may be a source of errors that are more numerous, though less deadly, than mistakes made in hospitals. The report, published in the Feb. 4 issue of *Annals of Internal Medicine* states that nearly 20% of discharged patients were victims of an "adverse event" and that two-thirds of these incidents could have been prevented or minimized by better communication among doctors or between doctors and patients. [Click here to read more](#)

8. Bar-Coding Technology Frustrates Nurses

Researchers at the Ohio State University Institute of Ergonomics published a study late last year of the VA's bar-coded medication administration (BCMA) system and found RNs have faced a number of problems adapting to the system negating some of the technology's error-reduction value. [Click here to read more](#)

9. Bioterrorism and Patient Safety: Hospitals Weigh Risks of Smallpox Vaccinations

Hospitals across the country are receiving shipments of the smallpox vaccine as part of the Bush administration's plan to vaccinate health care providers. However, many institutions are still concerned about the risks of vaccinating employees and some are declining to participate, for now, in the program. Concerns regarding the vaccine's potential adverse effects, worker's compensation issues, and the possibility of inadvertent exposure of vulnerable individuals (e.g., cancer patients) to vaccinia shed by vaccinated volunteers are cited for reasons not to participate. [Click here to read more](#)

10. Legal System is Biggest Obstacle to Fixing Health Care System

According to Philip Howard, chairman of the bipartisan group Common Good, the legal system is the biggest hurdle to fixing the U.S. health care system. Howard spoke at a recent AARP Public Policy Meeting in Washington, and stated that liability and legal fears are forcing physicians to either reduce or stop certain medical procedures, which in turn limits access to care. He equated enormous jury awards to economic death penalties for health care providers and stated that in a few weeks, Common Good, with board members such as former Rep. Newt Gingrich, R-GA, and former Sen. Alan Simpson, R-WY, will issue a "manifesto" to restore trust in the American legal system. [Click here to read more \(a\)](#) or [Click here to read more \(b\)](#)

11. House Committee Passes Patient Safety Bill

The "Patient Safety and Quality Improvement Act" was recently passed by the House Energy and Commerce Committee. Under bill H.R. 663, health care professionals could report mistakes to private groups called "patient safety organizations" (PSO's).

PSO's would collect information on medical errors and other patient safety events, analyze the data for trends, and recommend ways to prevent future mistakes. The bill also provides legal protection for any information that is collected in order to advance patient safety research and education. The measure also offers grants to help hospitals invest in patient safety technologies.

12. Orientation, Training Cited as Top Root Cause of Medication Errors

Sixty percent of the sentinel events involving medication errors from 1995 - 2002 involved problems with employee orientation or training according to the annual set of sentinel-event statistics compiled by the Joint Commission on Accreditation of Health-care Organizations. [Click here to read more](#)

13. AHRQ's New National Quality Measures Clearinghouse™

AHRQ recently launched its Web-based National Quality Measures Clearinghouse™ (NQMC). The site is designed to be a one-stop shop for physicians, hospitals, health plans, and others interested in quality measures and contains the most current evidence-based quality measures available to evaluate and improve the quality of health care. Users can search the NQMC for measures that target a particular disease/condition, treatment/intervention, age range, gender, vulnerable population, setting of care, or contributing organization. [Click here to read more](#)

14. Refrigerated Medications at Risk for Errors

There are many drug products that require refrigeration and refrigerators are used throughout the hospital by both pharmacy and nursing personnel. Over the past 3 years, USP's MEDMARXSM medication-error reporting program has received nearly 1,000 reports that involve refrigerated medications. USP has been able to identify several chilling themes involving the use of a refrigerator to store medications:

- **Accessibility and Poor Storage:** Easy access to products that are poorly or improperly stored in a refrigerator creates the risk of drug mix-ups. Multiple types and strengths of vaccines, insulins, and antibiotics that are readily available in common storage bins or drawers within the refrigerator have led to numerous wrong-drug and wrong dose errors. An adequate number of clearly labeled storage bins must be used to separate different products and different strengths.
- **Products with similar packaging and labeling:** Given the storage space limitations of refrigerators, there is an increased potential to confuse similar looking packages and labels. Devise a system that eliminates or minimizes all look-alike products within the small confines of a refrigerator.

For more information on MEDMARX, visit www.MEDMARX.com

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 presented in cooperation with the Institute for Safe Medication Practices and MEDMARX. MEDMARXSM 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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