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Patient Safety, Risk, and Quality Update

From Allied World and ECRI Institute
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The following news and guidance were recently made available without login from ECRI Institute's *Healthcare Risk Control* and related services. If you have any questions, please email Ajay Aggarwal at Ajay.Aggarwal@awac.com.

Implementing Health IT Safe Practices to Reduce Diagnostic Errors

Diagnoses that are delayed, missed, and incorrect are among the most common causes of error that can result in patient harm and inappropriate care. However, some diagnostic errors may be avoided by effectively utilizing health information technology (IT).

Working directly with healthcare organizations, the *Partnership for Health IT Patient Safety* recently explored how to implement tactics to close the loop on diagnostic evaluations. Clinicians were able to better use their existing technology and modify their practice to better track this key information.

Resources include:

- **White Paper: Implementing Closing the Loop Safe Practices for Diagnostic Results**
- **Close the Loop in Your Organization: A Step-by-Step Guide**
- **Safety Recommendations & Implementation Strategies: Closing the Loop**
- **Health IT Safe Practices for Closing the Loop Toolkit**
- **Closing the Loop: Evidence-based Literature Review**

See more from the ***Partnership for Health IT Patient Safety.***

News

The Search for a Better Clinical Alarm Continues

Customising alarm limits that allow clinicians to tailor notifications to patients, improving data visualisation, and ensuring high-priority alarms do not sound during less serious events are among improvements vendors are developing for patient monitoring systems, says a February 10, 2020, article from *Healthcare Business News*.

Read the full summary.

Reducing Risk of Suicide among Nurses: A Portable and Replicable Program

A prevention program that may be able to detect nurses who are at risk for suicide is discussed in a February 3, 2020, study in *Worldviews on Evidence-Based Nursing*. The authors offered evidence-developed action recommendations to reduce risk of nurse suicide.

Read the full summary.

For Patient Satisfaction, Hospitality May Matter More than Outcomes

Quality of care and patient survival rates do not significantly impact patient satisfaction ratings as significantly as hospitality aspects of care (such as quiet rooms and communication from nurses) do, say the authors of a February 13, 2020, study in *Social Forces*.

Read the full summary.

No Such Thing as a Risk-Free Setting for Giving Birth, Says National Academies Report

There is no such thing as a risk-free setting for giving birth, say the authors of Birth Settings in America, a new report from the National Academies of Sciences, Engineering, and Medicine.

Read the full summary.

Pharmacists and Pharmacy Techs Are at Their "Breaking Point": New York Times Details Medication Errors at Chain Pharmacies

Ear drops in place of eye drops; blood pressure pills swapped with asthma pills; a powerful chemotherapy drug dispensed instead of the antidepressant that had been prescribed; a steroid mistakenly given to an infant for reflux. These and other serious medication mix-ups occurring in large chain pharmacies are described in a harrowing report in the January 31, 2020, *New York Times*.

Read the full summary.

Joint Commission Journal Looks at Education Program that Focuses on Unprofessional Behaviour

Unprofessional behaviour by physicians can be improved with a short education program on professionalism, according to a study in the February 2020 issue of the *Joint Commission Journal on Quality and Safety*.

Read the full summary.