Quality lines

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Verbal orders and patient safety: a call for a defined research agenda

This issue of QSHC focuses a critical look at verbal orders and their role in healthcare quality and patient safety. A critical review points out that, while verbal orders have been identified as a potential source of error, they have not been explored in depth, but there is little empirical evidence to support limiting their use. Nevertheless the potential for miscommunication and misunderstanding argues for a systematic approach to verbal orders. A related paper from the same research team provides detailed analyses from two exploratory studies that systematically examined the content and context of verbal orders. The findings indicate that verbal orders: represent a substantial portion of all orders; may include multiple individual orders in a single event; may include high risk and/or commonly confused drugs; are used with widely different frequencies depending on the professional context; and do not appear to change as health professionals become more experienced with the electronic medical record. Based on these studies and the critical review, a verbal order research agenda is proposed. An accompanying commentary stakes a place for the verbal order in healthcare and echoes the call for more effective research into its appropriate and safe use. ***See pages 164, 165, 169***

Inaccurate discharge summaries and patient harm

The discharge summary is an essential tool for relaying relevant information about a patient and its accuracy is generally taken for granted. This study reviewed a series of discharges summaries from one institution for medication accuracy. Up to two-thirds of the reviewed discharge summaries, and one-quarter of medications, were affected by such errors, 19% of them being potentially harmful. Future work should seek to understand the larger impact of such errors, and whether newer initiatives such as the electronic medical record, and focused medication-reconciliation efforts can address these gaps in care. ***See page 205***

Preliminary experience with a Trigger Tool for identifying Adverse Drug Events in ambulatory care

While Trigger Tools have been used successfully for identifying Adverse Drug Events (ADE's) in hospital settings, little is known about their utility in ambulatory settings. This exploratory study evaluated a 39-item trigger tool for identifying ADE's among older adults in six primary care practices. Triggers that were identified by research assistants underwent review by a physician and pharmacist. Most of the triggers had positive predictive values of less than 5% for ADE's, whilst 9 of the 39 triggers accounted for 94.4% of the ADE's detected. This suggests the utility of a shorter tool. The adoption of such tools by practicing physicians offers an opportunity that should be studied and considered further. ***See page 199***

Academic detailing as a strategy for healthcare improvement

The usefulness of academic detailing to gain better levels of quality and safety in healthcare is well supported. This report describes an approach to translating these methods into an ongoing service for primary-carers in Midwestern USA. It addresses the important question of the likely uptake of such services if they are offered to busy US primary care practitioners. One-to-one office visits were used repetitively as the basis for trained communicators to deliver support and evidence for achieving better and more reliable clinical outcomes. Between visits, additional services were offered to help to build positive relationships between the service providers and practitioners in the local community. The study has explored a number of practical approaches to evaluating these services from the perspective of a funding authority intent not on research, but rather, on practice improvement. ***See page 225***