Nasjonale elektroniske melde-ordninger i spesialisthelsetjenesten: Hvilke finnes, hvilke effekter har de, og hvordan evalueres melde-ordningene?

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Hovedfunn

I Norge er det innført et elektronisk nasjonalt meldesystem for uønskede pasienthendelser i spesialisthelsetjenesten. Vi har søkt etter litteratur som beskriver nasjonale elektroniske meldesystemer og etter studier om effekten av nasjonale elektroniske meldesystemer, og om hvordan de er evaluert.

- Vi identifiserte sju land med nasjonale elektroniske meldesystemer for uønskede hendelser: Australia, Canada, England & Wales, Finland, Italia, Japan og Taiwan
- Vi fant ingen studier som hadde vurdert effekt av nasjonale eller regionale elektroniske meldesystem
- Vi fant en liten tidsserie som hadde vurdert effekt av å utvide et elektronisk meldesystem for medikamenthendelser til å gjelde alle uønskede hendelser ved et amerikansk sykehus. Studien ble gjennomført for fjorten år siden. Vi er svært usikre på overføringsverdien til dagens Norge
- Vi fant ingen studier som hadde rapportert hvordan landene evaluerer sine nasjonale meldesystemer

Tittel:

Nasjonale elektroniske melde-ordninger i spesialisthelsetje-nesten: Hvilke finnes, hvilke effekter har de, og hvordan evalueres meldeordningene?

Publikasjonstype:

Hurtigoversikt

En hurtigoversikt er resultatet av å sammenfatte forskningsbasert kunnskap

- med kort tidsfrist og
- med mindre om-fattende metode enn ved systematisk kunnskaps-oppsummering.

Svarer ikke på alt:

- Ikke omfattende søkestrategi
- Søk i få litteraturbaser
- Ingen gradering av studienes kvalitet
- Ikke vurdert av ekstern fagfelle
- Enkel intern kvalitetssjekk av prosjektplan og sluttprodukt
- Ingen anbefalinger

Hvem står bak denne publikasjonen?

Kunnskapssenteret har gjennomført oppdraget på eget initiativ

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Når ble litteratursøket utført?

Søk etter studier ble avsluttet oktober 2011.

Key messages (English)

Norway has introduced an electronic national incidents reporting system for the health care services. We have searched for literature that describes incident reporting systems in other countries. We have searched for studies of the effect of electronic incident reporting systems in hospitals, and for literature describing how other countries evaluate their incident reporting systems.

- We found reports of seven countries that has an electronic national incidents reporting system: Australia, Canada, England & Wales, Finland, Italy, Japan and Taiwan
- We did not find studies of the effect of national or regional incident reporting systems
- One small interrupted time series of one hospital had expanded the electronic system of medical reporting to electronic reporting of all incidents. This hospital is in USA, and the change happened fourteen years ago. We are uncertain about generalizability.
- We did not find any description of how other countries have evaluated their electronic national incident reporting systems

Title:
National electronic incident reporting systems in hospitals: Which systems exist, what is their effect, and how are they evaluated?

Type of publication:

Rapid review

A rapid review is a review that makes use of less comprehensive methods than a systematic review due to limited timeframe, e.g. less comprehensive search strategy, search in fewer databases, no grading of the quality of selected studies, no external peer review, and simpler quality check of both project plan and final manuscript.

Doesn't answer everything:

Doesn't answer everything:

- Limited search strategy
- Search in few databases
- No grading of study quality
- No recommendations

Publisher:

Norwegian Knowledge Centre for the Health Services

Updated:

Last search for studies: October 2011.

Innhold

Forord

Nasjonalt kunnskapssenter for helsetjenesten fikk i oppdrag fra Stortinget å overta ansvaret for meldeordningssystemet for uønskede pasienthendelser i spesialisthelsetjenesten i juli 2012. Kunnskapssenteret har på eget initiativ oppsummert tilgjengelig forskning om effekten av nasjonale elektroniske meldeordninger for sykehus. Vi har også søkt å identifisere hvilke land som har et nasjonalt elektronisk meldesystem for uønskede pasienthendelser, og hvordan de evaluerer sitt meldesystem.

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- Ingeborg B Lidal, Kunnskapssenteret
- Astrid M Nøstberg, bibliotekar, Helsedirektoratet
- Anne Karin Lindahl, Kunnskapssenteret

Denne oversikten er ment å hjelpe beslutningstakere i helsetjenesten til å fatte velinformerte beslutninger som kan forbedre kvaliteten i helsetjenestene.

Gro Jamtvedt	Gunn E Vist	Gunn E Vist
Avdelingsdirektør	*Seksjonsleder*	*Prosjektleder*

Problemstilling

Å vurdere effekten av nasjonale elektroniske meldeordninger for uønskede pasienthendelser og andre feil og uhell som kunne ha ført til uønskede pasienthendelser i spesialisthelsetjenesten. Vi har også søkt å identifisere hvilke land som har et nasjonalt elektronisk meldesystem for uønskede pasienthendelser, og hvordan de evaluerer sitt meldesystem.

Innledning

Bakgrunn

I 2000 kom det en rapport 'To err is human' forfattet av Kohn og medarbeidere der de hadde beregnet at mellom 44 000 og 98 000 mennesker dør på grunn av uønskede hendelser i forbindelse med medisinsk behandling i amerikanske sykehus, hvert år. Uavhengige av presisjonen på disse beregningene, så har de satt søkelyset på at uønskede hendelser forekommer på sykehus, og at mange av disse kunne ha vært unngått.

Uønskede hendelser omfatter flere dimensjoner som interagerer, det snakkes både om svikt i utføring, menneskelige feil, systemfeil og hendige uhell som beskrevet av Peter Hjort i 2000. Vi har her benyttet utrykket uønskede hendelser.

Verdens helseorganisasjon utførte en undersøkelse der de kartla meldesystemer og søkte beskrivelser av de forskjellige systemene. Dette arbeidet førte til at WHO i 2005 ga en anbefaling om å innføre både meldesystemer og læringssystemer for å redusere uønskede hendelser i helsetjenesten.

Stortinget besluttet at Kunnskapssenteret skulle overta ansvaret for meldeordningssystemet for uønskede pasienthendelser i henhold til spesialisthelsetjenestelovens § 3-3 i Norge, fra 01.o7.2012. Kunnskapssenteret har i forbindelse med etableringen av en slik meldeordning, ønsket å vite effekten av elektroniske meldeordninger. Både sammenlignet med ingen meldesystem og forskjellige elektroniske meldeordninger sammenlignet med hverandre for å vurdere om noen er bedre enn andre. En slik oversikt vil kunne informere valg av måter å vurdere resultatene av den norske meldeordningen på når denne er på plass. Denne dokumentasjonen vil kunne danne grunnlag for den fremtidige norske evalueringen.

Det ville derfor også være av interesse å samle en oversikt over hvilke elektroniske meldesystemer som finnes og evalueringer andre har gjort seg før oss om slike nasjonale elektroniske meldesystemer, og å se om det finnes vitenskapelige studier som både har evaluert meldesystemene og kan støtte valg av evalueringsmetode i Norge. Vi vil samle informasjon om hvordan de nasjonale elektroniske meldesystemene er evaluert, og hvilke resultater evalueringene har frembrakt.

Et elektronisk nasjonalt meldesystem vil kunne danne grunnlaget for å bygge opp kunnskap som kan brukes til å designe konkrete tiltak for å kunne forbedre pasientsikkerheten, slik at man kan hindre at de uønskede hendelsene skjer igjen. Forutsetningene for det omfatter både at det finnes tilgjengelige meldesystemer som gjør det lett å melde om uønskede hendelser, og at personene som kan melde om disse hendelsene er sikre på at de ikke blir straffet eller «uthengt» for at de gir opplysningene. De som mottar meldingene må ha mulighet til på en konstruktiv måte å systematisere kunnskapen, slik at man finner mulige årsaker til at hendelsene har skjedd og rapportere om hvordan dette kan løses, slik at disse uønskede hendelsene ikke gjentas, verken i den organisasjonen som meldte fra eller i andre organisasjoner. Dermed må det også skapes systemer for å spre kunnskapen fra analysen av meldingene.

Parallelt vil det finnes internkontrollsystemer på sykehus som del av sykehusets kvalitetskontroll. Disse behandles internt i linje på sykehuset parallelt med det nasjonale systemet.

Metode

Litteratursøking

I dette prosjektet søkte vi systematisk i mange databaser etter litteratur om meldeordninger/ meldesystemer for feil og uønskede hendelser i spesialisthelsetjenesten. Vi søkte uten filtre, det vi si at vi lette etter publikasjoner og rapporter uten å begrense oss til spesielle studiedesign eller språk. Søket tok utgangspunkt i søket fra en tidligere rapport fra Canada (White 2008). Vi utvidet og oppdaterte dette litteratursøket i samarbeid med forskningsbibliotekar Astrid Merete Nøstberg. Vi brukte en tidsbegrensning i søket da vi gikk ut fra at det var usannsynlig at publikasjoner før 1995 beskrev meldesystem av høy relevans for innføring av et nasjonalt elektronisk meldesystem i Norge 2012.

Forskningsbibliotekar Astrid Merete Nøstberg planla og utførte samtlige søk. Den fullstendige søkestrategien er gitt i vedlegg 1. Søk etter studier ble avsluttet i oktober 2011. Det ble søkt i følgende databaser:

Medline
Embase
Cochrane Database of Systematic Reviews
DARE
Cochrane CENTRAL
Methods studies and HTA
SweMed+

Minst to personer leste uavhengig av hverandre alle titler og sammendrag identifisert i litteratursøket for å vurdere om de var aktuelle for vår problemstilling. I denne utvelgelsen grupperte vi de potensielt relevante referanser inn i undergrupper som besvarer de forskjellige underspørsmålene i denne oversikten. Mange referanser ble vurdert som mulig relevant for flere undergrupper. De forskjellige spørsmålene ble så vurdert separat, og med metoder tilpasset det aktuelle underspørsmålet.

Inklusjonskriterier

Gruppe 1.
Eksisterende nasjonale elektroniske meldeordninger/ meldesystemer både nasjonalt og internasjonalt.

Populasjon	Spesialisthelsetjenesten
Intervensjoner	Nasjonale elektroniske meldeordninger/ meldesystemer for uønskede hendelser i spesialisthelsetjenesten
Studiedesign	Ingen restriksjoner
Språk	Ingen restriksjoner i søket, publikasjoner på engelsk eller skandinavisk ble inkludert. Publikasjoner på andre språk ville ha blitt vurderet for oversettelse.

Gruppe 2.
Effekten av nasjonale elektroniske meldeordninger/meldesystem for spesialisthelse-tjenesten.

Populasjon	Spesialisthelsetjenesten, både enkeltsykehus og nasjonale systemer.
Intervensjoner	Elektroniske meldeordninger/ meldesystemer for uønskede hendelser i spesialisthelsetjenesten.
Sammenlikning	Ingen meldeordning eller andre meldeordninger. Både annen type elektroniske meldeordning og sammenlignet med ikke-elektroniske meldeordninger
Utfall	Antall og endring i antall uønskede hendelser Forskjellige typer/alvorlighetsgrad av uønskede hendelser Nestenuhell og komplikasjoner Læringskultur Pasientsikkerhetskultur
Studiedesign	Systematiske oversikter av høy kvalitet og primærstudier av følgende design: randomisert kontrollert studie (RCT), klinisk kontrollerte studier (CCT), kontrollerte før- og etter studier (CBA), avbrutte tidsserieanalyser (ITS).
Språk	Ingen restriksjoner i søket, publikasjoner på engelsk eller skandinavisk ble inkludert. Publikasjoner på andre språk ville ha blitt vurderet for oversettelse.

Gruppe 3.
Beskrive hvordan nasjonale elektroniske meldeordninger har blitt evaluert

Populasjon	Spesialisthelsetjenesten, nasjonale systemer.
Intervensjoner	Nasjonale elektroniske meldeordninger/ meldesystemer for uønskede hendelser i spesialisthelsetjenesten.
Utfall	Metoder meldeordningen er blitt evaluert etter, inklusive hvilke endepunkter som er evaluert og hvordan.
Studiedesign	Ingen restriksjoner
Språk	Ingen restriksjoner i søket, publikasjoner på engelsk eller skandinavisk ble inkludert. Publikasjoner på andre språk ville ha blitt vurderet for oversettelse.

Artikkelutvelging og håndtering av innhentet informasjon

Minst to personer (GEV, HHH, IBL, AKL) leste uavhengig av hverandre alle titler og sammendrag for å vurdere om studiene var aktuelle for våre problemstillinger. Mulig relevante artikler ble innhentet i og lest i fulltekst.

Fulltekstvurderingene ble utført gruppevis:

Gruppe 1
To personer av HHH, MM og GEV leste uavhengig av hverandre de innhentede artiklene, og vurderte om de oppfylte inklusjonskriteriene. Ved uenighet diskuterte de seg fram til enighet. GEV hentet ut informasjon fra studiene og HHH sjekket at riktig og relevant informasjon var inkludert.

Gruppe 2
To personer (GEV og HHH) leste de innhentede artiklene uavhengig av hverandre, og vurderte om de oppfylte inklusjonskriteriene. Ved uenighet diskuterte vi oss fram til enighet. Begge vurderte kvaliteten av studien ved bruk av sjekkliste som beskrevet i Kunnskapssenterets håndbok. HHH hentet ut data for inkluderte tabellen og GEV dobbeltsjekket uttrekket. Dersom det hadde vært mulig og hensiktsmessig å sammenslå resultater fra flere studier i meta- analyse ville vi ha gjort dette etter standard metoder slik som beskrevet i Cochrane håndboka.

Kvaliteten på den samlede dokumentasjonen for hvert av utfallsmålene ble vurdert ved hjelp av GRADE (Grading of Recommendations, Assesment, Development, and

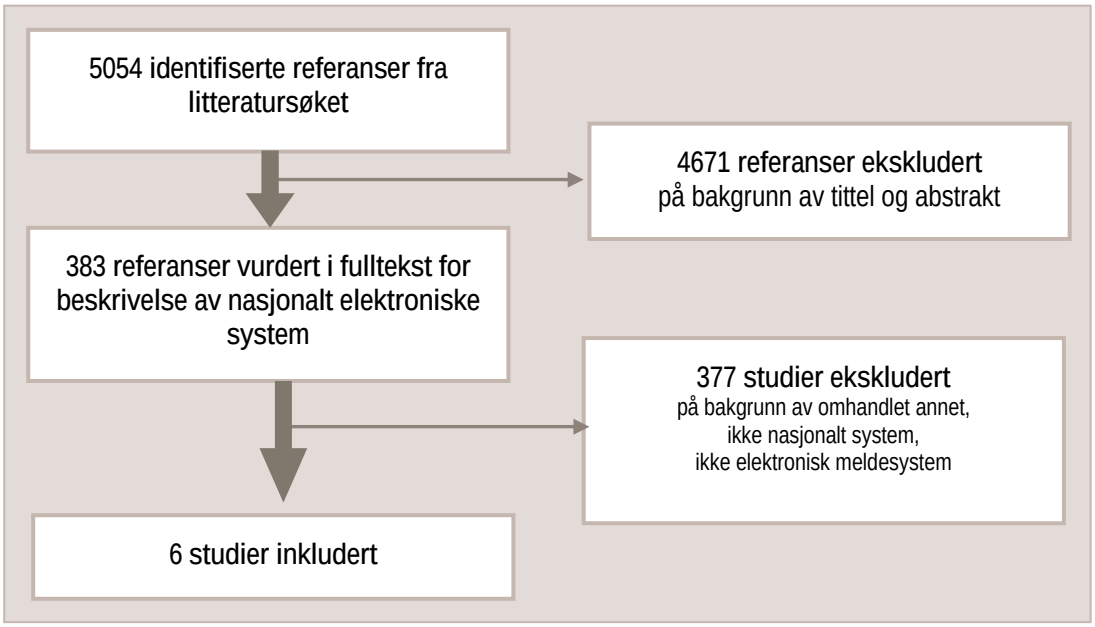
Evaluation). Graderingen gir en vurdering av hvilken tillit vi har til resultatene som presenteres i studiene. Vi beskriver kvaliteten som høy, middels, lav eller svært lav.

For en detaljert beskrivelse av Kunnskapssenterets arbeidsform henviser vi til vår metodebok, «Slik oppsummerer vi forskning», som finnes på våre nettsider: http://www.kunnskapssenteret.no.

Gruppe 3
To personer (HHH og GEV) leste de innhentede artiklene uavhengig av hverandre, og vurderte om de oppfylte inklusjonskriteriene. Ved uenighet diskuterte vi oss fram til enighet.

Resultat: Identifisering av nasjonale elektroniske meldesystem

Søket resulterte i 5054 unike referanser. Vi vurderte 383 av disse referansene som mulig relevante for beskrivelse av nasjonale elektroniske meldeordninger/ meldesystem, og leste disse i fulltekst. Av disse ble seks artikler inkludert (figur 1).



Figur 1. Flytskjema over identifisert litteratur og vurdering for inklusjon til spørsmål om effekt av meldesystemer

Seks artikler beskrev hva de hadde funnet når de hadde sett til andre land og på hvordan disse har organisert sine meldesystem, som ledd i planlegging av et eget system, eller for å beskrive sitt eget lands meldesystem.

Verdens helseorganisasjon utførte en undersøkelse der de kartla meldesystemer og søkte beskrivelser av de forskjellige systemene. Dette var et ledd i arbeidet med å lage anbefalinger om meldesystemer, som WHO ga ut i 2005. De beskrev meldesystemer i Australia, Danmark, England & Wales, Irland, Japan, Nederland, Slovenia, Sverige, Tsjekkia, og USA.

Hoffman og medarbeidere 2008, og White 2008, søkte informasjon om meldesystemer i arbeidet med å samle informasjon til vurdering for et Canadisk meldesystem. De så til Australia, Danmark, Japan, England & Wales, og USA.

Keistinen og Kinnunen 2008 beskriver meldesystemet i Finnland.

Ghirardini og medarbeidere 2009 beskriver oppstarten av meldesystemet i Italia.

Cheng og medarbeidere 2011 hadde sett til England & Wales, USA, Canada, Australia og Taiwan som del av planlegging av et meldesystem i Kina. De presentere meldesystemene og diskuterer dem opp mot hverandre.

Disse artiklene introduserte 14 land som er kort beskrevet nedenfor. Kun sju av disse er klart beskrevet som at de har et elektronisk og nasjonalt meldesystem for uønskede hendelser: Australia, Canada, England & Wales, Finland, Italia, Japan og Taiwan. For Irland, Nederland og Sverige var det beskrevet at melder på papir i post eller fax og over telefon. For Danmark, Slovenia og Tsjekkia var det ikke beskrevet hvordan meldingene ble rapportert, og for USA var det kun spesialiserte meldesystemer.

Land med elektronisk nasjonalt meldesystem for uønskede hendelser:
Australia har hatt et kommersielt og delvis obligatorisk, elektronisk meldesystem (AIMS) siden 1993 (ifølge WHO 2005), 1998 (i følge Cheng 2011). Alle kan rapportere alle uønskede hendelser og nestenuhell. Rapportene kan sendes på papir, elektronisk eller over telefon. AIMS har ifølge WHO 2005 det mest avanserte og utviklede klassifiseringssystemet for de uønskede hendelsene.

Canada har hatt et frivillig og nasjonalt elektronisk meldesystem (CMIRPS, non-profit) siden 2002. Alle pasientsikkerhetshendelser skal rapporteres.

England og Wales har hatt et obligatorisk og sentralt styrt elektronisk meldesystem fra 2003. Meldesystemet er integrert i de lokale risikoforvaltningssystemene og alle helsepersonell skal rapportere alle pasientsikkerhetshendelser. Hendelsene blir kategorisert og analysert for trender.

Finland har et internetbasert nasjonalt meldesystem for alle uønskede hendelser. Hver helsetjenesteinstitusjon har egen administratorkonto for å registrer uønskede hendelser, en sykepleier og en lege i hver avdeling har tilgang på denne kontoen.

Italia har hatt et elektronisk nasjonalt meldesystem siden 2009. Rapportering er frivillig

Japan har hatt et elektronisk meldesystem siden 2004, rapportering er obligatorisk for universitetssykehus, og frivillig for alle andre. Sykehus og andre helseinstitusjoner rapporterer alle uønskede hendelser og nestenuhell.

Taiwan har hatt et meldesystem siden 2003, i 2009 er dette et frivillig, nasjonalt elektronisk meldesystem for alle slags uønskede hendelser.

Andre land med nasjonale meldesystemer for uønskede hendelser

Danmark har hatt et obligatorisk meldesystem siden 2004. For å oppmuntre til læring, er dette systemet holdt adskilt fra sanksjoner. Helsepersonell rapporterer alle uønskede hendelser til en nasjonal database. Det var ikke beskrevet hvordan meldingene rapporteres.

Irland har hatt et meldesystem siden 2002, papirrapporter sendes til lokale risikoforvaltningssentre som registrer dem elektronisk. Alle helseinstitusjoner rapporterer alle uønskede hendelser og nestenuhell.

Nederland har et meldesystem der det er obligatorisk å melde om alvorlige uønskede hendelser, og frivillig å melde om andre uønskede hendelser. Rapporteringen kan skje via post, fax eller telefon.

Slovenia har hatt et frivillig meldesystem siden 2002. Sykehusene rapporterer uønskede hendelser til helsedepartementet. Det er ikke beskrevet om dette er et elektronisk system.

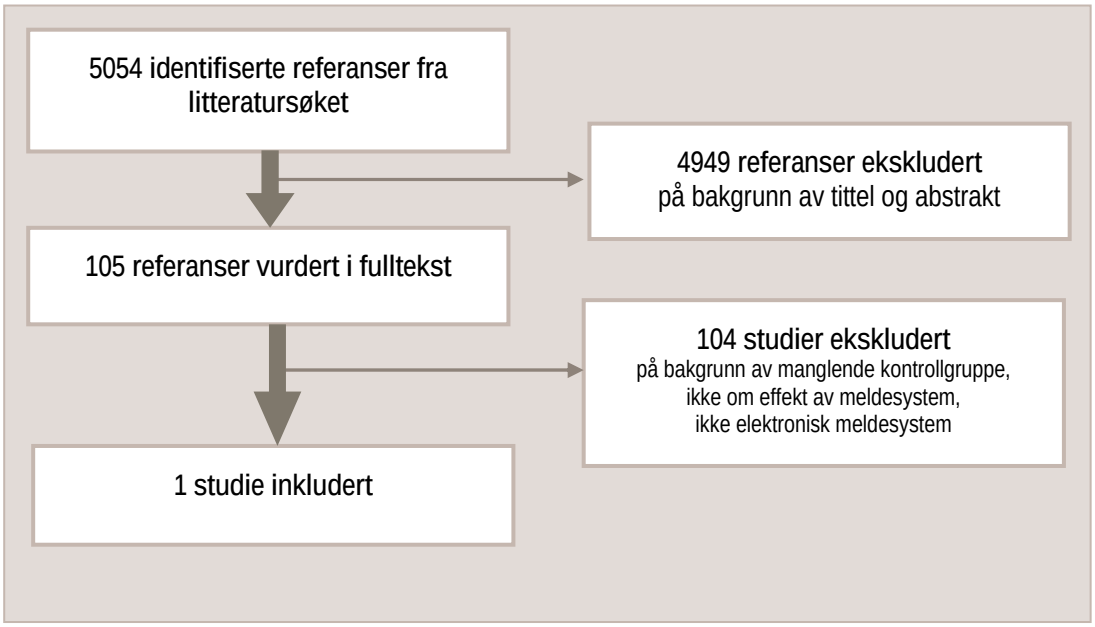
Sverige har et meldesystem som er obligatorisk for sykehusene og andre offisielle institusjoner, og frivillig for helsearbeidere, pasienter og andre personer. Rapportene sendes på papir via post eller fax.

Tsjekkia har et obligatorisk meldesystem som omfatter sykehusinfeksjoner, medisinreaksjoner, transfusjonshendelser og hendelser med medisinsk utstyr. Det gjøres forsøk med frivillig rapportering, og helsearbeidere kan melde. Det er ikke beskrevet om dette er et elektronisk system.

USA har flere forskjellige systemer. Institute of Safe Medication Practices (ISMP, nasjonal) tar imot meldinger om medisinrelaterte uønskede hendelser fra helsepersonell, organisasjoner og pasienter. Rapportene kan leveres online, elektronisk, via telefon, post eller fax. Både MERP (non-profit) siden 1987, og MEDMARX (frivillig, kommersielt system) siden 1988, og JCAHO (frivillig, akkrediteringsorganisasjon) siden 1995 tar alle kun imot meldinger om medisinrelaterte hendelser. I tillegg finnes mange lokale systemer.

Effekt av elektroniske meldesystem

Søket resulterte i 5054 unike referanser. Vi vurderte 105 av disse referansene som mulig relevante for spørsmålet om effekt av elektroniske meldesystemer, og leste disse i fulltekst. Av disse ble én studie inkludert (figur 1).



Figur 1. Flytskjema over identifisert litteratur og vurdering for inklusjon til spørsmål om effekt av meldesystemer

Vi fant ingen studier som hadde sett på effekten av nasjonale elektroniske meldesystemer. Vi fant heller ikke noen studier som hadde vurdert effekten av å innføre elektronisk meldesystem i flere sykehus samtidig.

Den ene inkluderte studien hadde vurdert effekten av elektronisk meldesystem i ett enkelt sykehus. Mer informasjon om meldesystemet vises i tabell 1, vedlegg 2, og beskrivelser nedenfor. Studien var utført i USA.

Tabell 1. Oversikt over inkluderte studier. Mer detaljerte beskrivelse av studien finnes i vedlegg 2.

Land Referanse	Organisatorisk Nasjonalt/ Regionalt/ Sykehus	Elektronisk meldesystem	Sammenlignende system
Nasjonale elektroniske meldesystem			
Ingen funnet			
Regionale/ flere sykehus/ enheter med felles elektronisk meldesystem			
Ingen funnet			
Elektronisk meldesystem innført i ett sykehus			
USA, Dixon 2002	Sykehus: Baylor University Medical Centre, Dallas	Elektronisk rapportering av alle uønskede hendelser	Medisinske relaterte uønskede hendelser rapportert via sykehusets intranett, de ikke-medisinske uønskede hendelsene ble rapportert på papir

Elektroniske meldesystem i ett sykehus

Dixon 2002 rapporterer om innføring av elektronisk meldesystem for alle uønskede hendelser, det vil si at det utvidet et tidligere meldesystem for medisinrelaterte uønskede hendelser til å gjelde alle uønskede hendelser. Dette skjedde på ett sykehus i Dallas, USA, i ett sykehus med noen færre enn 1000 senger. Før denne utvidelsen ble kun medisinsk uønskede hendelser rapportert elektronisk og andre uønskede hendelser ble rapportert på papir. Etter juli 2000 ble alle uønskede hendelser rapportert elektronisk. Hovedendepunktet var antall ikke-medisinske feil som ble rapportert per måned.

Før innføring av elektronisk rapporteringssystem ble det fylt ut en papirrapport. Denne skulle leveres til lederen som gjennomgikk rapporten, før den så ble levert videre til kvalitetsavdelingen. Herfra ble informasjon registrert, analysert og videreformidlet til risikostyringsansvarlige og arkiv. Denne prosessen tok gjennomsnittlig 7,6 dager. Det elektroniske meldesystemet var tilgjengelig fra alle PC'er tilknyttet sykehusets intranett for alle som kunne logge seg på med eget brukernavn og passord. Det elektroniske meldesystemet ble utviklet på sykehuset og var inndelt i 10 hovedkategorier av meldinger. Det var lagt vekt på avkryssing, det var et spørsmål – svar oppsett med minst mulig fritekst. I tiden like før og i oppstartsperioden til det utvidede elektroniske systemet, ble det gjennomført opplæring av ansatte og informasjonsopplegg både for opplæring i meldingssystemet og for å oppmuntre til å melde både uønskede hendelser og nestenulykker, og å sette fokus på rapporteringen heller enn personen som rapporterer.

Risiko for feil og systematiske skjevheter i Dixon 2002:
Denne studien er en tidsserie utført på ett sykehus over en periode på 22 måneder. Alle ansatte var deltagere hele tiden og visste hvilken måte de skulle rapportere

uønskede hendelser på. Det er uklart om det var noe frafall, for eksempel kan det ha vært rapporter som ble påbegynt og ikke fullført eller mistet (papir rotet bort/gjemt eller elektroniske ikke lagret korrekt eller slettet). Det forventede hovedendepunktet er objektivt og rapportert, og vi er ikke oppmerksom på andre feil eller mangler ved denne studien. Det vil sannsynlig ha vært noe utskifting av personell i denne tidsperioden, og mulig andre endringer som kan ha påvirket meldekulturen blant de ansatte på sykehuset.

Dixon 2002 var også inkludert i den systematiske oversikten til Parmelli 2012, de hadde utført ny analyse av dataene fra Dixon 2002 som ITS på en fornuftig måte. Vi har derfor basert oss på deres resultater og har ikke utført egne analyser. Da det ble benyttet papirrapportering av ikke-medisinske uønskede hendelser var det et gjennomsnitt på 128 rapporter per måned. Etter utvidelsen av det elektroniske meldesystemet til å også inkludere ikke-medisinske uønskede hendelser ble det rapportert en ikke-signifikant økning på mellom 31 til 34 rapporter per måned det følgende året (Tabell 2).

Tabell 2. Oppsummeringstabell for sammenligningen av utvidet elektronisk meldesystem på ett sykehus sammenlignet med tidligere meldinger på papir

Elektronisk meldesystem sammenlignet med papirbasert meldesystem for ikke-medisinske uønskede hendelser

Populasjon: Sykehus med 1000 senger
Settings: Sykehus i USA i år 2000
Intervensjon: Elektronisk meldesystem
Sammenligning: Papirsystem

Utfall	Antatt risiko **Papirbasert meldesystem**	Sammenlignende risiko **Elektronisk meldesystem**	**Relativ effect (95% CI)**	**Antall deltakere (studier)**	**Kvaliteten på dokumentasjonen (GRADE)**
Antall meldinger per måned Oppfølging: 1 år	Gjennomsnittlig antall meldinger var **128 per måned**	Gjennomsnittlig antall meldinger var **31 til 34 flere per måned**		Uklart (1 studie)	⊕OOO **Svært lav**[1,2]

*The basis for the **assumed risk** (e.g. the median control group risk across studies) is provided in footnotes. The **corresponding risk** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).
CI: Confidence interval;

GRADE Working Group som definerer kvaliteten på dokumentasjonen slik:
Høy kvalitet: Vi har stor tillit til at effektestimatet ligger nær den sanne effekten.
Middels kvalitet: Vi har middels tillit til effektestimatet: effektestimatet ligger sannsynligvis nær den sanne effekten, men effektestimatet kan også være vesentlig ulik den sanne effekten.
Lav kvalitet: Vi har begrenset tillit til effektestimatet: den sanne effekten kan være vesentlig ulik effektestimatet.
Svært lav kvalitet: Vi har svært liten tillit til at effektestimatet ligger nær den sanne effekten.

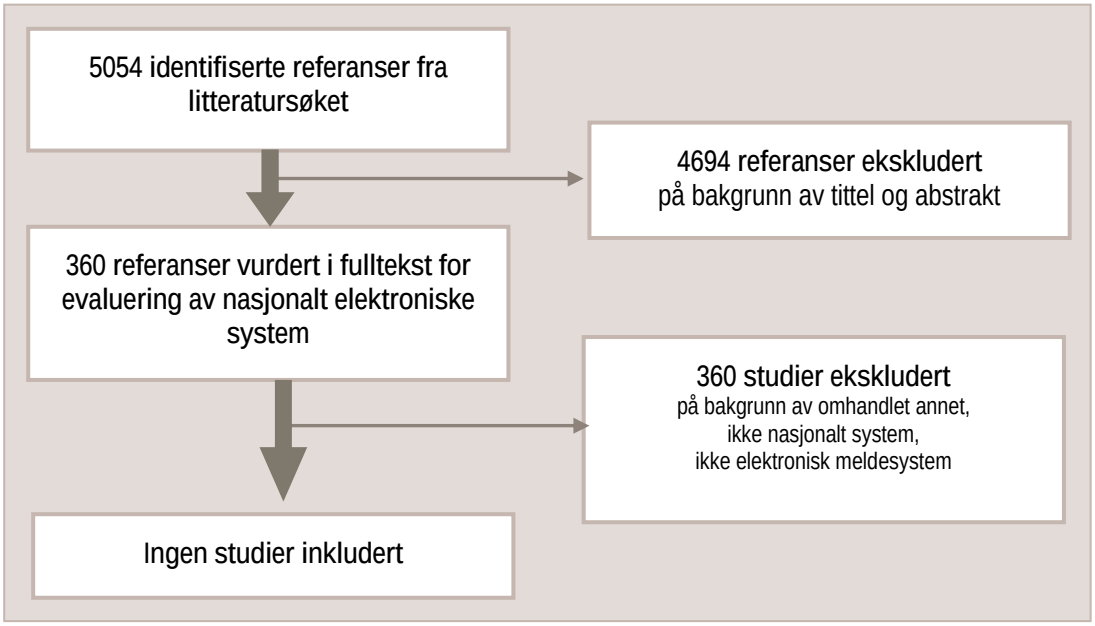
1. Vi er usikre på overføringsverdien fra endringer i ett lite sykehus i USA i 2000 og til et nasjonalt system i Norge i 2012.
2. Kun en liten studie

Oppsummert kan vi si dette om effekten av elektroniske meldeordninger:

- Vi mangler informasjon om effekten av å innføre nasjonalt elektroniske meldeordning/ meldesystem
- Vi mangler informasjon om effekten av å innføre elektroniske meldeordning/ meldesystem for en region/ flere sykehus samtidig og i samarbeid
- Dokumentasjonen er av for lav kvalitet til å konkludere om effekten av elektronisk meldesystem på ett sykehus

Evaluering av nasjonale elektroniske meldesystem

Søket resulterte i 5054 unike referanser. Vi vurderte 360 av disse referansene som mulig relevante for spørsmålet om evaluering av nasjonalt elektroniske meldeordning/ meldesystem, og leste disse i fulltekst (figur 1).



Figur 1. Flytskjema over identifisert litteratur og vurdering for inklusjon til spørsmål om evaluering av nasjonale elektroniske meldesystemer

Det var mange av studiene som evaluerte rapporterte hendelser, men dessverre ingen av studiene som evaluerte et nasjonalt elektronisk meldesystem. Vi fant ikke dokumentasjon på hvordan andre land evaluerer sine nasjonale elektroniske meldesystemer.

Diskusjon

Vi har søkt å belyse flere forskjellige aspekter av nasjonale elektroniske meldeordninger for uønskede pasienthendelser i spesialisthelsetjenesten.

Vi har identifisert sju land med nasjonale elektroniske meldesystemer for uønskede hendelser: Australia, Canada, England & Wales, Finland, Italia, Japan og Taiwan.

Vi har søkt etter publikasjoner om effekt av elektronisk meldesystem for feil og uønskede hendelser i sykehus og på nasjonalt plan sammenlignet med andre meldesystem for rapportering av uønskede hendelser.

Den ene inkluderte studien er en tidsserie fra et lite sykehus i USA utført i 2000. Overførbarheten til norske forhold så mange år senere er diskutabel. Kvaliteten på dokumentasjonen for elektronisk meldesystem sammenlignet med meldesystem delvis på papir og delvis elektronisk er av svært lav kvalitet.

Til tross for at det finnes en stor mengde artikler skrevet om meldeordninger, både elektroniske meldesystemer og andre, fant vi kun én liten effektstudie. Gjennomgående er det svært få studier, og studiene har generelt hverken kontrollgruppe eller ikke nok målepunkter til at det er mulig å benytte resultatene til en tidsserieanalyse.

Etter at vi hadde avsluttet vårt litteratursøk og inkludert den ene studien, publiserte Parmelli med flere en systematisk oversikt med et nært beslektet spørsmål. Parmelli med flere 2012, hadde vurdert effekten av intervensjoner for å øke rapportering av uønskede hendelser i helsetjenesten. Av de fire studiene inkludert i Parmelli med flere 2012, var det kun Dixon med flere 2002 som oppfylte inklusjonskriteriene for vår oversikt.

Vi fant heller ikke dokumentasjon på hvordan andre land evaluerer sine meldesystemer.

Mye av den generelle litteraturen omkring meldesystemer og tiltak for å unngå uønskede hendelser i spesialisthelsetjenesten inneholder spesifikke anbefalinger både på hva, hvordan og til hvilke tider ting skal gjøres. Lite av disse er fremsatt sammen med referanser til studier som viser at måtene å gjøre ting på er bedre enn andre måter. Vi har heller ikke søkt spesifikt etter studier om effekten av for eksem-

pel obligatoriske meldesystemer sammenlignet med frivillige, eller effekter av hvem som melder, eller hvilke tidsbegrensninger, eller hvordan læring fra meldingene skal organiseres. Det er mange relevante og viktige spørsmål som vi ikke har søkt å belyse. Generelt noterer vi at det er få studier innen fagfeltet.

Vi velger å si litt om én av de få studiene som vi har identifisert selv om vi ikke kunne inkludere den i våre sammenligninger. Williams med flere 2003 utførte et telefonintervju i alle 50 statene i Amerika. De identifiserte 15 stater som både hadde statelig obligatorisk meldesystemer samtidig som de hadde et frivillig meldesystem i forbindelse med akkreditering via The Joint Commision on Accrediation of Healthcare Organizations (JCAHO). Ni av statene benyttet definisjoner som samsvarte med dem som JCAHO benytter, og ble inkludert i studien. Så sammenlignet de hvor mange pasientskader som var rapportert til hver av meldeordningene i 1999. Williams med flere 2003, fant at det var flere rapporterte skademeldinger via det statlige obligatoriske meldesystemet enn via JCAHO meldesystemet i de samme 9 statene i samme tidsperiode. Som mulig forklaring på denne forskjellen, nevner de at JCAHO krever at meldingene inkluderer hendelsesanalyse og plan for å hindre at hendelsen skjer om igjen, og plan for formidling av hva som er lært. Noe som krever betraktelig mer ressurser per melding. Begge systemene som er vurdert i denne studien, omhandler kun medisinrelaterte uønskede hendelser, og tar ikke med andre uønskede hendelser.

Fordeler og ulemper med systematiske oversikter

Vi har systematisk søkt i relevante elektroniske databaser, og vurdert litteraturen basert på eksplisitte inklusjons- og eksklusjonskriterier. Vi har kritisk vurdert de relevante studiene, og har vurdert vår tillitt til dokumentasjonen for de viktige utfallene ved GRADE.

I en systematisk oversikt er man avhengig at det allerede er utført og publisert studier som svarer på de spørsmålene som man søker å besvare. Selvfølgelig er det også nyttig å avdekke der det ikke er utført relevant forskning også.

En annen ulempe er at systematiske oversikter raskt kan bli utdaterte. Vårt søk er fra 2011, og selv om Parmelli med flere 2012 som søkte i mars 2012 ikke identifiserte flere studier som vi kunne ha inkludert, er det mulig at det nå er publisert flere studier om effekten av meldesystemer som vi ikke vet om.

Konklusjon

Vi har søkt å belyse flere forskjellige aspekter av nasjonale elektroniske meldeordninger for uønskede pasienthendelser i spesialisthelsetjenesten.

Vi har identifisert sju land med nasjonale elektroniske meldesystemer for uønskede hendelser: Australia, Canada, England & Wales, Finland, Italia, Japan og Taiwan.

Vi fant ingen studier som hadde vurdert effekten av nasjonale eller regionale elektroniske meldesystem. Vi fant en liten studie som hadde vurdert effekten av å utvide et elektronisk meldesystem i ett sykehus i USA for fjorten år siden. Vi er veldig usikre på overføringsverdien til dagens Norge. Vi er usikre på hvilken effekt innføringen av meldesystemet vil oppnå.

Vi fant ingen studier som hadde evaluert et elektronisk nasjonalt meldesystem, og har dessverre lite eksempler på gode evalueringsmåter å videreformidle.

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Vedlegg 1 Søkestrategier

Meldesystemer: søkestrategi i Ovid Medline

Søk: Astrid Nøstberg
Database: Ovid Ovid MEDLINE(R) 1948 to October Week 1 2011
Dato: 12.10.2011, **Antall treff**: 3426,
1. Adverse Drug Reaction Reporting Systems/
2. Mandatory Reporting/
3. adverse drug reaction reporting system$.tw.
4. (mandator$ adj3 report$).tw.
5. abuse reporting.tw.
6. (incident$ adj4 report$).tw.
7. national report$.tw.
8. event report$.tw.
9. (voluntar$ adj3 report$).tw.
10. critical incident$ method$.tw.
11. or/1-10
12. exp Medical Errors/
13. Iatrogenic Disease/
14. (medica$ adj3 (error$ or mistake$)).tw.
15. (surg$ adj3 (error$ or mistake$ or misadventure$)).tw.
16. retained instrument$.tw.
17. (diagnos$ adj2 (error$ or mistake$)).tw.
18. ((failure or false) adj1 diagnos$).tw.
19. misdiagnos#s.tw.
20. (medication$ adj2 (error$ or mistake$ or reconciliation$)).tw.
21. drug administration error$.tw.
22. wrong drug administration.tw.
23. ((observer or intra-observer or intraobserver or interobserver or inter-observer) adj2 (variation$ or variabilit$)).tw.
24. observer bias.tw.
25. (therapeutic$ adj3 (error$ or accident$)).tw.
26. (treatment$ adj3 error$).tw.
27. (adverse$ adj3 (event$ or effect$)).tw.
28. ((health care or healthcare or health-care) adj3 error$).tw.
29. (sentinel adj3 event$).tw.
30. (nurs$ adj3 (error$ or mistake$)).tw.
31. (physician$ adj3 (error$ or mistake$)).tw.
32. (patient care adj3 (error$ or mistake$)).tw.
33. near$ miss$2.tw.
34. (critical$ adj3 (incident$ or outcome$)).tw.
35. (adverse$ adj3 outcome$).tw.
36. (unanticipated adj4 outcome$).tw.
37. (iatrogenic adj (disease$ or agent$ or complication$ or damage$ or disorder$ or illness$ or infection$ or injur$3 or lesion$ or neuropath$ or ophthalmopath$ or pals$3 or paralys#s or rhinorrhea$ or sensiti#ation$)).tw.
38. iatrogenes#s.tw.
39. iatropathogenes#s.tw.
40. or/12-39

41. (report$ adj5 error$).mp.
42. 40 or 41
43. 11 and 42
44. limit 43 to yr="1995 -Current"

Meldesystemer: søkestrategi i Ovid Embase

Søk: Astrid Nøstberg
Database: Embase 1980 to 2011 Week 40
Dato: 12.10.2011, **Antall treff**: 2889
1. mandatory reporting/
2. voluntary reporting/
3. critical incidents method/
4. adverse drug reaction reporting system$.tw.
5. (mandator$ adj3 report$).tw.
6. abuse reporting.tw.
7. (incident$ adj4 report$).tw.
8. national report$.tw.
9. event report$.tw.
10. (voluntar$ adj3 report$).tw.
11. critical incident$ method$.tw.
12. (electronic adj2 (prescribing or prescription$)).tw.
13. (e-prescribing$ or e-prescription$).tw.
14. or/1-13
15. exp medical error/
16. iatrogenic disease/
17. (medica$ adj3 (error$ or mistake$)).tw.
18. (surg$ adj3 (error$ or mistake$ or misadventure$)).tw.
19. retained instrument$.tw.
20. (diagnos$ adj2 (error$ or mistake$)).tw.
21. ((failure or false) adj1 diagno$).tw.
22. misdiagnos#s.tw.
23. (medication$ adj2 (error$ or mistake$ or reconciliation$)).tw.
24. drug administration error$.tw.
25. wrong drug administration.tw.
26. ((observer or intra-observer or intraobserver or interobserver or inter-observer) adj2 (variation$ or variabilit$)).tw.
27. observer bias.tw.
28. (therapeutic$ adj3 (error$ or accident$)).tw.
29. (treatment$ adj3 error$).tw.
30. (adverse$ adj3 (event$ or effect$)).tw.
31. ((health care or healthcare or health-care) adj3 error$).tw.
32. (sentinel adj3 event$).tw.
33. (nurs$ adj3 (error$ or mistake$)).tw.
34. (physician$ adj3 (error$ or mistake$)).tw.
35. (patient care adj3 (error$ or mistake$)).tw.
36. near$ miss$2.tw.
37. (critical$ adj3 (incident$ or outcome$)).tw.
38. (adverse$ adj3 outcome$).tw.
39. (unanticipated adj4 outcome$).tw.
40. (iatrogenic adj (disease$ or agent$ or complication$ or damage$ or disorder$ or illness$ or infection$ or injur$3 or lesion$ or neuropath$ or ophthalmopath$ or pals$3 or paralys#s or rhinorrhea$ or sensiti#ation$)).tw.
41. iatrogenes#s.tw.
42. iatropathogenes#s.tw.
43. or/15-42
44. (report$ adj5 error$).mp.
45. 43 or 44
46. 14 and 45
47. limit 46 to yr="1995 -Current"

Meldesystemer: søkestrategi i The Cochrane Library

Søk: Astrid Nøstberg
Database: The Cochrane Library:
Cochrane Database of Systematic Reviews, Issue 10 of 12, Oct 2011
DARE, Cochrane Central Register of Controlled Trials, Methods Studies og Technology Assessments, Issue 4 of 4, Oct 2011
Dato: 12.10.2011, **Antall treff**: CDSR 37 treff, DARE 16 treff, CENTRAL 679 treff , Methods Studies 22, HTA 2 treff, Economic Evaluations 4 treff, **Totalt antall treff:** 760 treff

#1 MeSH descriptor Adverse Drug Reaction Reporting Systems, this term only 77
#2 MeSH descriptor Mandatory Reporting, this term only 7
#3 (adverse NEXT drug NEXT reaction NEXT reporting NEXT system*):ti,ab,kw 86
#4 (mandator* NEAR/3 report*):ti,ab,kw 15
#5 (abuse NEXT reporting):ti,ab,kw 9
#6 (incident* NEAR/4 report*):ti,ab,kw 73
#7 (national NEXT report):ti,ab,kw 4
#8 (event NEXT report*):ti,ab,kw 760
#9 (voluntar* NEAR/3 report*):ti,ab,kw 22
#10 (critical NEXT incident* NEXT method*):ti,ab,kw 3
#11 (electronic NEAR/2 (prescribing or prescription*)):ti,ab,kw 25
#12 (e-prescribing* or e-prescription*):ti,ab,kw 5
#13 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12) 978
#14 MeSH descriptor Medical Errors explode all trees 1917
#15 MeSH descriptor Iatrogenic Disease, this term only 61
#16 (medica* NEAR/3 (error* or mistake*)):ti,ab,kw 319
#17 (surg* NEAR/3 (error* or mistake* or misadventure*)):ti,ab,kw 61
#18 (retained NEXT instrument*):ti,ab,kw 1
#19 (diagnos* NEAR/2 (error* or mistake*)):ti,ab,kw 347
#20 ((failure or false) NEAR/1 diagno*):ti,ab,kw 329
#21 (misdiagnos*s):ti,ab,kw 51
#22 (medication* NEAR/2 (error* or mistake* or reconciliation*)):ti,ab,kw 201
#23 (drug NEXT administration NEXT error*):ti,ab,kw 2
#24 (wrong NEXT drug NEXT administration):ti,ab,kw 0
#25 ((observer or intra-observer or intraobserver or interobserver or inter-observer) NEAR/2 (variation* or variabilit*)):ti,ab,kw 1706
#26 (observer NEXT bias):ti,ab,kw 50
#27 (therapeutic* NEAR/3 (error* or accident*)):ti,ab,kw 22
#28 (treatment* NEAR/3 error*):ti,ab,kw 71
#29 (adverse* NEAR/3 (event* or effect*)):ti,ab,kw 113881
#30 (((health NEXT care) or healthcare or health-care) NEAR/3 error*) 10
#31 (sentinel NEAR/3 event*):ti,ab,kw 10
#32 (nurs* NEAR/3 (error* or mistake*)):ti,ab,kw 31
#33 (physician* NEAR/3 (error* or mistake*)):ti,ab,kw 13
#34 ((patient NEXT care) NEAR/3 (error* or mistake*)):ti,ab,kw 4
#35 (near* NEXT miss*):ti,ab,kw 15
#36 (critical* NEAR/3 (incident* or outcome*)):ti,ab,kw 167
#37 (adverse* NEAR/3 outcome*):ti,ab,kw 3594
#38 (unanticipated NEAR/4 outcome*):ti,ab,kw 3
#39 (iatrogenic NEXT (disease* or agent* or complication* or damage* or disorder* or illness* or infection* or injur* or lesion* or neuropath* or ophthalmopath* or pals* or paralys*s or rhinorrhea* or sensiti*ation*)):ti,ab,kw 114
#40 (iatrogenes*):ti,ab,kw 5
#41 (iatropathogenes*):ti,ab,kw 0
#42 (#14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41) 117519
#43 (report* NEAR/5 error*) 716
#44 (#42 OR #43) 117989
#45 (#13 AND #44) 854

#46 (#45), from 1995 t

Meldesystemer: søkestrategi i Swemed

Søk: Astrid Nøstberg
Database: Swemed+, **Dato**: 12.10.2011, **Antall treff**: 61 treff

S1 Adverse-Drug-Reaction-Reporting-Systems.fm. 209
S2 Mandatory-Reporting.fm. 53
S3 "adverse drug reaction reporting system$" 0
S4 mandator$ report$ 55
S5 "abuse reporting" 0
S6 incident$ report$ 51
S7 "national report$" 0
S8 "event report$" 0
S9 voluntar$ report$ 3
S10 "critical incident$ method$" 0
S11 (electronic prescribing) or (electronic prescription$) 26
S12 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 323
S13 Explodesökning på Medical-Errors 834
S14 Iatrogenic-Disease.fm. 72
S15 (medica$ error$) or (medica$ mistake$) or (medica$ reconciliation$) 594
S16 (surg$ error$) or (surg$ mistake$) or (surg$ misadventure$) 50
S17 "retained instrument$" 0
S18 (diagnos$ error$) or (diagnos$ mistake$) 199
S19 (failure diagno$) or (false diagno$) 152
S20 misdiagnos$ 8
S21 "drug administration error$" 0
S22 "wrong drug administration" 0
S23 "observer variation$" or "intra-observer variation$" or "intraobserver variation$" or "interobserver variation$" or "inter-observer variation$" 141
S24 "observer variabilit$" or "intra-observer variabilit$" or "intraobserver variabilit$" or "interobserver variabilit$" or "inter-observer variabilit$" 0
S25 "observer bias" 0
S26 (therapeutic$ error$) or (therapeutic$ accident$) 16
S27 treatment$ error$ 38
S28 "adverse$ event$" or "adverse$ effect$" 76
S29 ("health care" error$) or (healthcare error$) or (health-care error$) 191
S30 sentinel event$ 7
S31 (nurs$ error$) or (nurs$ mistake$) 65
S32 (physician$ error$) or (physician$ mistake$) 87
S33 ("patient care" error$) or ("patient care" mistake$) 17
S34 near$ miss$ 4
S35 "critical$ incident$" or "critical$ outcome$" 2
S36 "adverse$ outcome$" 1
S37 unanticipated outcome 0
S38 "iatrogenic disease$" or "iatrogenic agent$" or "iatrogenic complication$" or "iatrogenic damage$" or "iatrogenic disorder$" or "iatrogenic illness$" or "iatrogenic infection$" or "iatrogenic injur$" or "iatrogenic lesion$" or "iatrogenic neuropath$" or "iatrogenic ophthalmopath$" or "iatrogenic pals$" or "iatrogenic paralys$" or "iatrogenic rhinorrhea$" or "iatrogenic sensitization$" or "iatrogenic sensitisation$" 73
S39 iatrogenes$ 0
S40 iatropathogenes$ 0
S41 S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 1205
S42 report$ error$ 71
S43 S41 OR S42 1207
S44 S12 AND S43 61
S45 AND S44 61
S46 S44 61

Vedlegg 2 Included studies table

Reference	Dixon 2002
Country	USA
Design	Interrupted times series
The experiment group	CQCC defined data collection variables and designed screen layouts, formats, and process flows. This work resulted in 10 standardized patient occurrence reporting categories. Next, they developed question stems and answer options that were unique for each category. They minimized free-text entry by using standardized answer options that required only pointing and clicking with a mouse. They established a telephone hotline, realizing that there might be some situations when employees may which to report but remain anonymous.
The control group	Incident report, documented manually on paper forms. Medication variances were entered electronically. After completing a paper report, the employee gave it to his or her manager, who reviewed it and forwarded it to the CQCC (Center for Quality and Care Coordination) personnel, who logged the report, abstracted the data into an electronic spreadsheet for analysis and trending, and forwarded it to risk management for final review and archiving.
Patient group	None specified
Participants	Baylor University Medical Center, Dallas.
Number of participants	1 hospital, with just fewer than 1,000 beds.
Period of intervention	Web forms went live July 2000
Outcome	Number of event, average time from event to report submission
Results	With paper forms CQCC received on average 128 submission per month (excluding medication-related patient events), and average of 7.6 days after the incident date. During the first 12 months after the implementation of the Web-based forms, the average monthly submissions increased to 175, with 82% submitted within 24 hours of the event. The last quarter in which paper forms were used averaged 121 submission per month, of which 17.6% were submitted within 24 hours, averaging 7.8 days from the event to receipt. The same quarter 1 year after going live averaged 222 Web forms per month. The percentage submitted within 24 hours increased to 83.3% and the interval average decreased to 1.6 days, in addition, there was no manual data abstracttion. In the 18 months after implementation, the number of Web forms submitted per month varied slightly, but still remains above the number of paper submissions. Calls to the hotline are extremely rare.
Intention of the study	Reporting the experience in converting from paper-based to Web-based patient occurrence reporting system.

Vedlegg 3 Tabell over ekskluderte studier for beskrivelse av nasjonale elektroniske meldesystemer

Referanse	Eksklusjonsgrunn
Approaches to reducing medication errors. Jt Comm Perspect16(6):17-Dec.	Om pen håndskrift for å redusere medisinske feil/misforståelser
Approved: adverse event reporting for New York office-based surgery practices. Jt Comm Perspect 2008;28(6):7.	Omtale av en lov
Coordinating sentinel event monitoring with state agencies. Jt Comm Perspect19(6):16-Dec.	Omhandler mulig samarbeid mellom stater og Joint Commision
JCAHO initiates Sentinel Event Alert. Am J Health Syst Pharm 1998;55(8):764.	Omhandler kun medisinrelaterte hendelser
Joint Commission Board supports effective medical error reporting system. Jt Comm Perspect20(5):12-Oct.	Støtteerklæring
Medical errors: Focusing more on what and why less on who. Journal of Oncology Practice 2007;3(2):66-70.	Ikke nasjonalt system
Medication errors. Just how bad is the problem? Hosp Peer Rev 1998;23(6):104-7.	Ikke nasjonalt system
Methods for improving the reporting of adverse effects. Prescrire Int 2011;20(114):71.	Ikke nasjonalt system
Minnesota's reporting on errors helps ORs fine-tune patient safety. OR Manager 2007;23(4):1, 7.	Omhandler kun feil-side rapportering
Next step in electronic prescribing: government proposes new federal regulations. MGMA connexion / Medical group Management Association 2005;5(4):14-6.	Elektronisk foreskrivning – ikke meldesystem
Update: Adverse events following civilian smallpox vaccination--United States, 2003. MMWR 2003;Morbidity and mortality weekly report. 52(16):360, 362-0, 363.	Omhandler ikke elektroniske meldesystem
Abayadeera A. Critical incident reporting. Sri Lankan Journal of Anaesthesiology 2010;18(1):3-4.	Omhandler kun anestesi
Abedi MR, Sorensen B, Ekblom-Kullberg S, Hjlmarsdttir I, Espinosa A. Haemovigilance in nordic countries: Report of donor complications 2007. Vox Sang 2009;Conference: 19th Regional Congress of the ISBT - Eastern Mediterreanean and Europe Cairo Egypt. Conference Start: 20090321 Conference End: 20090325. Conference Publication:(var.pagings):59-60.	Omhandler kun hemovigilans
Agarwal V, Divatia J, Patil V, Kulkarni A, Sareen R, Sampat S. Early experiences with critical incident reporting system in an indian ICU. Intensive Care Med 2009;Conference: 22nd Annual Congress of the European Society of Intensive Care Medicine, ESICM Vienna Austria. Conference Start: 20091011 Conference End: 20091014. Conference Publication:(var.pagings):S296.	Omhandler kun én enhet
Agency for Healthcare Research and Quality OfCRH. Patient safety and quality improvement. Notice of proposed rulemaking. Fed Regist 2008;73(29):8111-83.	Omtaler det formelle regelverket omkring meldesystemet i USA
Agha HM, Hariri M, Yavari F, Akbari N. Reporting of actual and near-miss events	Omhandler kun blodo-

for transfusion medicine: Improving transfusion safety, Iran, 20062007. Vox Sang 2009;Conference: 19th Regional Congress of the ISBT - Eastern Mediterreanean and Europe Cairo Egypt. Conference Start: 20090321 Conference End: 20090325. Conference Publication:(var.pagings):207-8.	verføring
Aghahoseini M, Akbari N, Hariri MM, Yavari F. Reporting of actual and near-miss events for improving transfusion safety in Isfahan blood transfusion organizatin in 2006-2007. Vox Sang 2010;Conference: 31st International Congress of the International Society of Blood Transfusion in Joint Cooperation with the 43rd Congress of the DGTI Berlin Germany. Conference Start: 20100626 Conference End: 20100701. Conference Publication:(var.pagings):135.	Omhandler kun blodo-verføring
Ahluwalia J, Marriott L. Critical incident reporting systems. Seminars In Fetal and Neonatal Medicine 2005;10(1):31-7.	Omhandler neonatal trigger hendelser
Alexander DC, Bundy DG, Shore AD, Morlock L, Hicks RW, Miller MR. Cardiovascular medication errors in children. Pediatrics 2009;124(1):324-32.	Omhandler kun barn
Alrwisan A, Ross J, Williams D. Medication incidents reported to an online reporting system in NHS Grampian. Br J Clin Pharmacol 2010;Conference: Proceedings of the BPS Clinical Pharmacological Section London United Kingdom. Conference Start: 20091215 Conference End: 20091217. Conference Publication:(var.pagings):286.	Diskuterer hvor i systemet meldingene kommer fra
American College of Emergency Physicians. Reporting of medical errors. Ann Emerg Med 2008;52(5):593.	Støtteerkæring
Amoore J, Ingram P. Quality improvement report: Learning from adverse incidents involving medical devices. BMJ 2002;325(7358):272-5.	Kvalitetsforbedring
Andersen SE, Christensen HR, Hilsted JC. Medication problems and risk management. Ugeskr Laeger 2001;163(39):5361-4.	Diskuterer medisinfeil og forsikringsproblematikk
Anderson DJ, Webster CS. A systems approach to the reduction of medication error on the hospital ward. J Adv Nurs 2001;35(1):34-41.	Diskuterer medisinfeil
Anderson JG. Information technology for detecting medication errors and adverse drug events. Expert Opinion on Drug Safety 2004;3(5):449-55.	Ikke nasjonalt system
Antonacci AC, Lam S, Lavarias V, Homel P, Eavey RD. Benchmarking surgical incident reports using a database and a triage system to reduce adverse outcomes. Arch Surg 2008;143(12):1192-7.	Omhandler kun kirurgi
Apold J, Daniels T, Sonneborn M. Promoting collaboration and transparency in patient safety. Joint Commission Journal on Quality and Patient Safety 2006;32(12):672-5.	Forklarer pasientsikkerhet
Arah OA, Klazinga NS. How safe is the safety paradigm? Quality and Safety in Health Care 2004;13(3):226-32.	Beskriver forskjellige initiativer i UK, Canada, Australia og USA
Arah OA, Bent PD. Professional monitoring and critical incident reporting using personal digital assistants (multiple letters). Med J Aust 2003;178(7):359.	Brev om at setting (context) er viktig å få med i diskusjoner om kvalitetesforbedring
Sarlija D, timac R, Vuk T, Jukic I. Transfusion adverse reactions and events in Croatia. Vox Sang 2011;Conference: 21st Regional Congress of the ISBT, Europe Lisbon Portugal. Conference Start: 20110618 Conference End: 20110622. Conference Publication:(var.pagings):317.	Omhandler kun blod-relaterte hendelser
Armitage C. TRAIL: A model to promote active learning from adverse events. Quality in Primary Care 2005;13(3):159-62.	Ikke nasjonalt system
Armitage G, Newell R, Wright J. Improving the quality of drug error reporting. J Eval Clin Pract 2010;16(6):1189-97.	Ikke nasjonalt system
Armitage G, Newell R, Wright J. Reporting drug errors in a British acute hospital trust. Clinical Governance 2007;12(2):102-14.	Ikke nasjonalt system
Arnold A, Delaney GP, Cassapi L, Barton M. The use of categorized time-trend reporting of radiation oncology incidents: a proactive analytical approach to improving quality and safety over time. Int J Radiat Oncol Biol Phys 2010;78(5):1548-54.	Omhandler kun strålingsbehandling og kreftpasienter
Arnold PC. Mandatory reporting of professional incompetence. Med J Aust 2008;189(3):132-3.	Omtale og synspunkter
Ashcroft DM, Morecroft C, Parker D, Noyce P. Reporting, reflecting on and learning from adverse events in community pharmacy: Development and evaluation of an incident reporting form. Pharmaceutical Journal 2005;274(7350):615-7.	Utvikling av form for apotek-meldinger

Ashcroft DM, Cooke J. Retrospective analysis of medication incidents reported using an on-line reporting system. Pharm World Sci 2006;28(6):359-65.	Omhandler kun medisinrelaterte hendelser
Auroy Y. Patient safety and root casue analysis. Transfus Clin Biol 2010.	Omhandler årsaksanalyse
Bagian JP, Gosbee J, Lee CZ, Williams L, McKnight SD, Mannos DM. The Veterans Affairs root cause analysis system in action. Jt Comm J Qual Improv 2002;28(10):531-45.	Omhandler årsaksanalyse
Bailey TC. Real-time notification of medication errors. Health Manag Technol 2000;21(6):24-6.	Omhandler foreskrivning
Baird M, Smith A. Accuracy of reporters' assignment of patient harm in anaesthetic critical incidents from the UK National Reporting and Learning Scheme. Eur J Anaesthesiol 2009;Conference: European Anaesthesiology Congress, EUROANAESTHESIA 2009 Milan Italy. Conference Start: 20090606 Conference End: 20090609. Conference Publication:(var.pagings):204-5.	Beskriver ikke systemet
Bak M. A 5-year retrospective analysis on adverse events associated with medication at department of anaesthesiology and intensive care, Odense University Hospital, Denmark. Acta Anaesthesiologica Scandinavica, Supplement 2009;Conference: 30th Congress of the Scandinavian Society of Anaesthesiologists Odense Denmark. Conference Start: 20090610 Conference End: 20090613. Conference Publication:(var.pagings):58.	Omhandler kun én avdeling
Baker M. Patient safety incidents in primary care: Reporting, learning and finding solutions. Clinical Risk 2005;11(4):145-7.	Omtale og meningsytring
Baldwin I, Beckman U, Shaw L, Morrison A. Australian Incident Monitoring Study in intensive care: local unit review meetings and report management. Anaesth Intensive Care 1998;26(3):294-7.	Omhandler intensivavdeling
Baldwin K. How the health protection agency contributes to a world class radiotherapy service. Clin Oncol 2011;Conference: UK Radiation Oncology Conference 2011 Manchester United Kingdom. Conference Start: 20110411 Conference End: 20110413. Conference Publication:(var.pagings):S27.	Omhandler radiotherapy
Ball MJ, Douglas JV. Redefining and improving patient safety. Methods Inf Med 2002;41(4):271-6.	Omhandler pasientsikkerhet generelt og diskuterer noen mulige løsninger
Baneres J, Orrego C, Sunol R, Urena V. Systems for registering and reporting adverse events and incidents: A strategy for learning from mistakes. Revista de Calidad Asistencial 2005;20(4):216-22.	Spansk oversiktsartikkel som beskriver meldesystemer vi allerede har beskrivelser om
Barishansky RM, Glick DE. Reportable incidents. Establishing policies and procedures for when calls go wrong. EMS magazine 2009;38(3):43-7.	Omhandler policy og trening
Barnard D, Dumkee M, Bains B, Gallivan B. Implementing a Good Catch program in an integrated health system. Healthcare quarterly (Toronto, Ont) 2006;9 Spec No:22-7.	Omhandler nestehendelser i én region i Canada
Bartolome A, Gomez-Arnau JI, Garcia d, V, Gonzalez-Arevalo A, Santa-Ursula JA, Hidalgo I. Patient safety and adverse incident reporting systems. Revista de Calidad Asistencial 2005;20(4):228-34.	Omhandler kun én avdeling
Battles JB, Stevens DP. Adverse event reporting systems and safer healthcare. Quality and Safety in Health Care 2009;18(1):2.	Omtale og synspunkter
Battles JB, Kaplan HS, van der Schaaf TW, Shea CE. The attributes of medical event-reporting systems: Experience with a prototype medical event-reporting system for transfusion medicine. Arch Pathol Lab Med 1998;122(3):231-15.	Omhandler blodoverføring
Beard P, Smyrski L. Reporting for learning and improvement: the Manitoba and Saskatchewan experience. Healthcare quarterly (Toronto, Ont) 2006;9 Spec No:61-4.	Ikke nasjonalt system
Becker C. NY's best not good enough. Despite being a leader in adverse-event reporting, audit reveals some shortcomings, need for reform in N.Y.'s tracking system. Mod Healthc 2010;34(40):6-7.	Omtale og meningsytring
Beckers EA, Dinkelaar RB, te Boekhorst PA, van Ingen HE, van Rhenen DJ. Reports of transfusion incidents: experiences from the first year of hemovigilance in the region of the former ZWN (South West Netherlands) blood bank in Rotterdam. Ned Tijdschr Geneeskd 2003;147(31):1508-12.	Omhandler blodoverføringer
Beckmann U, Bohringer C, Carless R, Gillies DM, Runciman WB, Wu AW, et al. Evaluation of two methods for quality improvement in intensive care: facilitated incident monitoring and retrospective medical chart review. Crit Care Med	Omhandler intensivavdelingen

2003;31(4):1006-11.	
Beckmann U, Gillies DM, Berenholtz SM, Wu AW, Pronovost P. Incidents relating to the intra-hospital transfer of critically ill patients. An analysis of the reports submitted to the Australian Incident Monitoring Study in Intensive Care. Intensive Care Med 2004;30(8):1579-85.	Omhandler pasienttransport
Bell G. Lessons for pediatric anesthesia from audit and incident reporting. Paediatr Anaesth 2011;21(7):758-64.	Omhandler kun anestesi og barn
Bencheikh RS, Benabdallah G. Medication errors: pharmacovigilance centres in detection and prevention. Br J Clin Pharmacol 2009;67(6):687-90.	Omhandler kun medisinrelaterte hendelser
Berghauser MA, Masjosthusmann K, Rellensmann G. CIRS. Analysis of medical errors with the help of a voluntary anonymous critical incident reporting system (CIRS) in a neonatal and pediatric intensive care unit. Monatsschrift fur Kinderheilkunde 2010;158(4):378-83.	Ikke nasjonalt system
Bernheim C, Schmitt E, Dufay E. Adverse drug events and risk management of medication errors. Oncologie 2005;7(2):104-19.	Analyse av hendelser
Beverly CJ. Medical error self-reporting can be easily implemented. Point. Nursing Leadership Forum 2001;6(1):4, 9-4,11.	Ikke nasjonalt system
Beydon L, Conreux F, Le GR, Safran D, Cazalaa JB, 'Sous-commission de Materiovigilance' for Anaesthesia and Intensive Care. Analysis of the French health ministry's national register of incidents involving medical devices in anaesthesia and intensive care. Br J Anaesth 2001;86(3):382-7.	Omhandler kun anestesi på intensivavdelingen
Beyer M, Rohe J, Rusitska M, Blauth E, Gerlach FM. The German error reporting system for general practice: Structure, first results. Z Allgemeinmed 2005;81(4):147-53.	Meldesystem for allmennleger i Tyskland
Bjorn B, Anhoj J, Lilja B. Reporting of patient safety incidents: experience from five years with a national reporting system. Ugeskr Laeger 2009;171(20):1677-80.	Generelle omtaler
Bjorn B, Rabol LI, Jensen EB, Pedersen BL. Wrong-site surgery: incidence and prevention. Ugeskr Laeger 2006;168(48):4205-9.	Omhandler kun feilsidekirurgi
Bock J, Hove L, Andersen LI, Krogh Chistoffersen J. Skader skal anmeldes. Ugeskrift for Laeger 2011;173(33):1990-1 2011.	Omhandler skadetilfeller, men ikke meldesystemet
Bolsin SN, Colson M, Patrick A, Creati B, Bent P. Critical incident reporting and learning. Br J Anaesth 2010;105(5):698.	Ikke nasjonalt system
Bolsin SN, Faunce T, Colson M. Using portable digital technology for clinical care and critical incidents: a new model. Aust Health Rev 2005;29(3):297-305.	Omhandler anestesi og mobilt meldesystem
Bonnevie B, Jensen BA. Medicinordinationssystemer og medicindispensering i Danmark. Hyppighed af og intervention mod medicindokumentationsfejl og medicindispenseringsfejl. Ugeskrift for Laeger 2002;164(38):4656-9.	Oversiktsartikkel om foreskrivning
Bruce J, Russell EM, Mollison J, Krukowski ZH. The measurement and monitoring of surgical adverse events. Health Technology Assessment (Winchester, England) 2001;5(22):1-194.	Omhandler kun kirurgi
Brun A. Preliminary results of an anonymous internet-based reporting system for critical incidents in ambulatory primary care. Ther Umsch 2005;62(3):175-8.	Omhandler primærhelsetjenesten
Budnitz DS, Pollock DA, Mendelsohn AB, Weidenbach KN, McDonald AK, Annest JL. Emergency department visits for outpatient adverse drug events: demonstration for a national surveillance system. Ann Emerg Med 2005;45(2):197-206.	Omhandler legemiddelrelaterte hendelser på akuttmottaket
Budnitz DS, Pollock DA, Weidenbach KN, Mendelsohn AB, Schroeder TJ, Annest JL. National surveillance of emergency department visits for outpatient adverse drug events. JAMA 2006;296(15):1858-66.	Omhandler legemiddelrelaterte hendelser på akuttmottaket
Busse DK, Wright DJ. Classification and analysis of incidents in complex medical environments. Top Health Inf Manage 2000;20(4):1-11.	Ikke nasjonalt system
Callum J. The medical event reporting system for transfusion medicine. Vox Sang 2002;83 Suppl 1:21-2.	Omhandler kun blodoverføringer
Callum JL, Merkley LL, Coovadia AS, Lima AP, Kaplan HS. Experience with the medical event reporting system for transfusion medicine (MERS-TM) at three hospitals. Transfusion and Apheresis Science 2004;31(2):133-43.	Omhandler kun blodoverføringer
Callum JL, Kaplan HS, Merkley LL, Pinkerton PH, Rabin FB, Romans RA, et al. Reporting of near-miss events for transfusion medicine: improving transfusion safety. Transfusion (Paris) 2001;41(10):1204-11.	Omhandler kun blodoverføringer
Cambern K. A quality improvement program. Paediatrics and Child Health 2009;19(SUPPL. 2):S172-S175.	Ikke nasjonalt system

Cano FG, Rozenfeld S. Adverse drug events in hospitals: a systematic review. Cad Saude Publica 2009;25:Suppl-72.	Oversiktsartikkel om medisinfeil på sykehus
Carroll-Solomon PA, Denny DS. A real-time medical event reporting and prevention system in long-term care. J Healthc Qual 1919;27(2):4-11.	Omhandler kun religiøse institusjoner for langtidspleie
Cassiani SH. Medication errors: prevention strategies. Rev Bras Enferm 2000;53(3):424-30.	Presenterer fire farmasiintervensjoner som muligens reduserer feil
Cavell G. Medication incident reports - Improving the quality of reporting. Hospital Pharmacist 2006;13(2):53-5.	Hendelsesvurdering av farmasøyt for å gruppere hendelsene
Centers for Disease Control and Prevention (CDC). Monitoring hospital-acquired infections to promote patient safety--United States, 1990-1999. MMWR - Morbidity and Mortality Weekly Report 2000;49(8):149-53.	Omhandler kun sykehusinfeksjoner
Chamberlain N. The folly of rewarding silence while hoping for open reporting of adverse medical events--how to realign the rewards. N Z Med J 2008;121(1282):58-66.	Presenterer sine synspunkter
Chandraharan E, Arulkumaran S. Serious untoward incident. Obstetrics, Gynaecology and Reproductive Medicine 2007;17(5):163-4.	Omtaler vurderinger av hva som er alvorlige hendelser
Charpentier C, Chevalier N, Rajezakowski S, Penavayre M, Chenevier D. Evaluation of a computerized system for medication errors reporting. International Journal of Clinical Pharmacy 2011;Conference: 39th ESCP European Symposium on Clinical Pharmacy and 13th SFPC Congress: Clinical Pharmacy at the Front Line of Innovations Lyon France. Conference Start: 20101021 Conference End: 20101023. Conference Publication:(var.pagings):357.	Omhandler kun medisinrelaterte hendelser
Chen PP, Ma M, Chan S, Oh TE. Incident reporting in acute pain management. Anaesthesia 1998;53(8):730-5.	Omhandler kun akutte smerter
Chin TL. Using automation to reduce medication errors. Health Data Manag 1997;5(7):74-83.	Ikke nasjonalt system
Choy CY. Critical incident monitoring in anaesthesia. Current Opinion in Anaesthesiology 2008;21(2):183-6.	Omhandler kun anestesi
Choy YC. Critical incident monitoring in anaesthesia. Med J Malaysia 2006;61(5):577-85.	Omhandler kun anestesi
Clemens K, Muller T. Critical incident reporting system at the University Hospital of Rostock - A project to improve patient safety. Krankenhauspharmazie 2006;27(11):505-9.	Ikke nasjonalt system
Clergue F, Sotirov N. Practice safety. How to cope with adverse events or errors in ICU? Reanimation 2003;12(SUPPL. 2):49s-54s.	Presenterer sine synspunkter
Coldiron B, Fisher AH, Adelman E, Yelverton CB, Balkrishnan R, Feldman MA, et al. Adverse event reporting: Lessons learned from 4 years of Florida office data. Dermatol Surg 2005;31(9 PART 1):1079-92.	Omhandler ikke sykehus
Coldiron B, Shreve E, Balkrishnan R. Patient injuries from surgical procedures performed in medical offices: three years of Florida data. Dermatol Surg 1443;30(12:Pt:1):t-43.	Omhandler ikke sykehus
Couig MP. Reporting adverse events and product problems. MedWatch provides comprehensive resource for health professionals. AWHONN Lifelines 2000;4(4):22-4.	Argumenterer for nytten av å følge med på MedWatch
Cousins DD. Developing a uniform reporting system for preventable adverse drug events. Clin Ther 1998;20:Suppl-58.	MedMARx, USA. System for medisin relaterte hendelser
Cozart H, Horvath MM, Long A, Whitehurst J, Eckstrand J, Ferranti J. Culture counts--sustainable inpatient computerized surveillance across Duke University Health System. Qual Manag Health Care 2010;19(4):282-91.	Ikke nasjonalt system, kun medisinrelaterte hendelser
Crespin DJ, Modi AV, Wei D, Williams CE, Greene SB, Pierson S, et al. Repeat medication errors in nursing homes: Contributing factors and their association with patient harm. American Journal of Geriatric Pharmacotherapy 2010;8(3):258-70.	Omhandler gjentatte feil på pleiehjem, diskuterer mulige årsaker
Cui X-H, Sun N-Y, Li Y-P, Zhang Z-J, Wang L, Zhou J, et al. International comparative analyses of incidents reporting systems for healthcare risk management. Chinese Journal of Evidence-Based Medicine 2011;11(3):237-46.	Omtaler meldesystemer for UK, USA, Canada, Australia og Taiwan, på kinesisk. Samme forfattergruppe som beskriver de samme landene i Cheng 2011 som er inkludert
Cunningham J, Coffey M, Knoos T, Holmberg O. Radiation Oncology Safety In-	Omhandler kun stråling og

formation System (ROSIS)--profiles of participants and the first 1074 incident reports. Radiother Oncol 2010;97(3):601-7.	kreftpasienter
D'Souza DC, Koller LJ, Ng K, Thornton PD. Reporting, review and application of near-miss prescribing medication incident data. Journal of Pharmacy Practice and Research 2004;34(3):190-3.	Ikke nasjonalt system
Daniels JP, King AD, Cochrane DD, Carr R, Shaw NT, Lim J, et al. A human factors and survey methodology-based design of a web-based adverse event reporting system for families. Int J Med Inf 2010;79(5):339-48.	Ikke nasjonalt system
Date Y, Ishikawa S, Fujisawa A, Uchida T, Nakazawa K, Makita K. Malposition of epidural catheter: an 8-year retrospective analysis on an incident reporting system at an urban university hospital. Masui - Japanese Journal of Anesthesiology 2010;59(10):1224-7.	Ikke nasjonalt system
Daurat G. Reporting and notification of transfusion serious adverse events in France. Transfus Clin Biol 2010;17(5-6):362-5.	Omhandler kun hemovigilans
David Y, Hyman W, Woodruff VD, Howell M. Overcoming barriers to success: Collecting medical device incident data. Biomed Instrum Technol 2007;41(6):471-5.	Omhandler kun utstyrsrelaterte hendelser
Davis K, Hui CH, Quested B. Transfusing safely: a 2006 guide for nurses. Aust Nurs J 2005;13(6):17-20.	Best practice retningslinje for sykepleiere ved blodoverføringer
Deimann LG. Reports of transfusion incidents: experiences from the first year of hemovigilance in the region of the former ZWN (South West Netherlands) blood bank in Rotterdam. Ned Tijdschr Geneeskd 2004;148(1):50.	Ikke nasjonalt system som kun omhandler hemovigilans
Devaseelan P, Adams B. An audit of critical incident reporting. Journal of Maternal-Fetal and Neonatal Medicine 2010;Conference: 22nd European Congress of Perinatal Medicine, 2010 Granada Spain. Conference Start: 20100526 Conference End: 20100529. Conference Publication:(var.pagings):241-2.	Ikke nasjonalt system
Di DP, Melotti RM, Bova F, Basini V, Cinotti R. Experimentation of an anaestesiologic incident monitoring system in Emilia-Romagna Region (Italy) hospitals. Revista de Calidad Asistencial 2005;20(2):61-5.	Ikke nasjonalt system
Dickens DS, Sinsabaugh D, Fahner JB. Characteristics of pediatric chemotherapy medication errors in a national error reporting database. Cancer 446;112(2):445-6.	Ikke nasjonalt system
Dillon H, Rosbergen M, Hutchinson S. Use of an anonymous medication incident reporting system on a critical care unit. Critical Care 2010;Conference: 30th International Symposium on Intensive Care and Emergency Medicine, ISICEM Brussels Belgium. Conference Start: 20100309 Conference End: 20100312. Conference Publication:(var.pagings):S151.	Omhandler kun én avdeling
Dixon JF. Going paperless with custom-built Web-based patient occurrence reporting. Jt Comm J Qual Improv 2002;28(7):387-95.	Omhandler kun ett sykehus
Doecke CJ. The Australian Medication Safety Working Group: developing a strategy for reducing adverse drug events in the Australian health system. J Qual Clin Pract 1999;19(1):5.	Lederartikkel
Dollarhide AW, Rutledge T, Weinger MB, Dresselhaus TR. Use of a handheld computer application for voluntary medication event reporting by inpatient nurses and physicians. J Gen Intern Med 2008;23(4):418-22.	Rapportering fra utvalgte personer
Dolores MM, Rancano I, Garcia V, Vallina C, Herranz V, Vazquez F. Use of different patient safety reporting systems: Much ado about nothing? Revista de Calidad Asistencial 2010;25(4):232-6.	Ikke nasjonalt system
Dominguez FE, Kolios G, Schlosser K, Wissner W, Rothmund M. Introduction of a critical incident reporting system in a surgical university clinic. What can be achieved in a short term? Dtsch Med Wochenschr 2008;133(23):1229-34.	Omhandler kun én klinikk
Dunscombe P, Gackle M, Ploquin J, Clark B. Eils: A multi-institutional database for incident learning, benchmarking and quality improvement. Radiother Oncol 2011;Conference: ESTRO Anniversary - GEC-ESTRO - EIOF - 11th Biennial London United Kingdom. Conference Start: 20110508 Conference End: 20110512. Conference Publication:(var.pagings):S540.	Ikke nasjonalt system
Edwards N, Myers R, Isaac R, Winmill H, Martin J, Reynolds F. The birmingham risk and quality improvement model (BRISK): Changing the patient safety culture in paediatric intensive care. Pediatric Critical Care Medicine 2011;Conference: 6th World Congress on Pediatric Critical Care: One World Sharing Knowledge Syd-	Ikke nasjonalt system

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Uth H-J, Wiese N. Central collecting and evaluating of major accidents and near-miss-events in the Federal Republic of Germany - Results, experiences, perspectives. J Hazard Mater 2004;111(1-3):139-45.	Ulykkesrapportering i Tyskland (inclusive nesteulykker)
Van Der Linden SJ. Tailor-made medication safety training. Bone Marrow Transplant 2011;Conference: European Group for Blood and Marrow Transplantation, EBMT 2011 Paris France. Conference Start: 20110403 Conference End: 20110406. Conference Publication:(var.pagings):S402.	Ikke nasjonalt system
van d, V, Cornet R, de JE. Design and implementation of an ICU incident registry. Int J Med Inf 2007;76(2-3):103-8.	Ikke nasjonalt system
Varricchio F. The vaccine adverse event reporting system. Journal of Toxicology - Clinical Toxicology 1998;36(7):765-8.	US meldesystem for vaksine-relaterte hendelser
Varricchio F, Iskander J, Destefano F, Ball R, Pless R, Braun MM, et al. Understanding vaccine safety information from the Vaccine Adverse Event Reporting System. Pediatr Infect Dis J 2004;23(4):287-94.	Omhandler kun vaksiner
Vogus TJ, Sutcliffe KM. The impact of safety organizing, trusted leadership, and care pathways on reported medication errors in hospital nursing units. Med Care 2007;45(10):997-1002.	Omhandler kun medisinrelaterte hendelser
Waring WS, McGettigan P. Clinical toxicology and drug regulation: A United Kingdom perspective. Clin Toxicol 2011;49(6):452-6.	Omhandler kun medisinrelaterte hendelser
Weil-Olivier C, Jacquet A. Immunization: adverse event reporting system. Arch Pediatr 2006;13(6):646-8.	Omhandler kun vaksine
Weingart SN, Simchowitz B, Shiman L, Brouillard D, Cyrulik A, Davis RB, et al. Clinicians' assessments of electronic medication safety alerts in ambulatory care. Arch Intern Med 2009;169(17):1627-32.	Ikke på sykehus
Weingart SN, Price J, Duncombe D, Connor M, Conley K, Conlin GJ, et al. Enhancing safety reporting in adult ambulatory oncology with a clinician champion: a practice innovation. J Nurs Care Qual 2009;24(3):203-10.	Omhandler kun kreft
Weissman JS, Annas CL, Epstein AM, Schneider EC, Clarridge B, Kirle L, et al. Error reporting and disclosure systems: views from hospital leaders. JAMA 2005;293(11):1359-66.	Synspunkter fra sykehusledere
Wilhelmus KR, Stulting RD, Sugar J, Khan MM. Primary corneal graft failure: A national reporting system. Arch Ophthalmol 1995;113(12):1497-502.	Omhandler kun øyne
Williams JS. New adverse event reporting system enhances value, scope. Biomed Instrum Technol 2008;42(1):41-2.	Omhandler kun ett sykehus
Williams SK, Osborn SS. The development of the National Reporting and Learning System in England and Wales, 2001-2005. Med J Aust 2006;184(10:Suppl):Suppl-8.	Diskuterer erfaringer og meninger
Woods DM, Johnson J, Holl JL, Mehra M, Thomas EJ, Ogata ES, et al. Anatomy of a patient safety event: A pediatric patient safety taxonomy. Quality and Safety in Health Care 2005;14(6):422-7.	Omhandler taxonomi for hendelser med barn
Young D. Voluntary reporting system gauges Wisconsin hospital data. Am J Health Syst Pharm 1104;61(11):1102.	Ikke nasjonalt system
Zafar A, AHRQ PBRN Resource Center. MEADERS: Medication Errors and Adverse Drug Event Reporting system. AMIA 2007;1167.	Omhandler kun medisinrelaterte hendelser

Vedlegg 4 Tabell over ekskluderte studier for effekt av elektroniske meldesystem

Referanse	Eksklusjonsgrunn
Anderson JG. A systems approach to preventing adverse drug events. Stud Health Technol Inform 2003;92:95-102.	Ikke en studie
Anderson JG, Ramanujam R, Hensel DJ, Sirio CA. Reporting trends in a regional medication error data-sharing system. Health Care Management Science 2010;13(1):74-83.	Ingen kontrollgruppe
Badami K, Dinesh D, Ghosh S, Dagger J, Flanagan P. Haemovigilance in New Zealand - Four years and counting.. Transfus Med 2010;Conference: HSANZ/ANZSBT/ASTH(HAA):216-7.	Ingen kontrollgruppe, og ikke nok målepunkter til ITS
Bagian JP, Gosbee J, Lee CZ, Williams L, McKnight SD, Mannos DM. The Veterans Affairs root cause analysis system in action. Jt Comm J Qual Improv 2002;28(10):531-45.	Omhandler 'root cause analysis system'
Baird M, Smith A. Accuracy of reporters' assignment of patient harm in anaesthetic critical incidents from the UK National Reporting and Learning Scheme. Eur J Anaesthesiol 2009;Conference: European Anaesthesiology Congress, EUROANAESTHESIA 2009 Milan Italy. Conference Start: 20090606 Conference End: 20090609. Conference Publication:(var.pagings):204-5.	Omhandler validitet, ikke effekt av elektronisk meldesystem
Bak M. A 5-year retrospective analysis on adverse events associated with medication at department of anaesthesiology and intensive care, Odense University Hospital, Denmark. Acta Anaesthesiologica Scandinavica, Supplement 2009;Conference: 30th Congress of the Scandinavian Society of Anaesthesiologists Odense Denmark. Conference Start: 20090610 Conference End: 20090613. Conference Publication:(var.pagings):58.	Ikke kontrollgruppe
Barnard D, Dumkee M, Bains B, Gallivan B. Implementing a Good Catch program in an integrated health system. Healthcare quarterly (Toronto, Ont) 2006;9 Spec No:22-7.	Omhandler ikke effekt av elektronisk meldesystem
Bartolome A, Gomez-Arnau JI, Garcia d, V, Gonzalez-Arevalo A, Santa-Ursula JA, Hidalgo I. Patient safety and adverse incident reporting systems. Revista de Calidad Asistencial 2005;20(4):228-34.	Ikke kontrollgruppe
Bartolome RA, Diaz-Canabate JI, Santa-Ursula Tolosa JA, Marzal Baro JM, Gonzalez AA, Garcia Valle del MS, et al. Application of a critical incident reporting and analysis system in an anesthesiology department. Rev Esp Anestesiol Reanim 2006;53(8):471-8.	Ikke kontrollgruppe
Bonnevie B, Jensen BA. Medicinordinationssystemer og medicindispensering i Danmark. Hyppighed af og intervention mod medicindokumentationsfejl og medicindispenseringsfejl. Ugeskrift for Laeger 2002;164(38):4656-9.	Oversiktsartikkel
Bradley VM, Steltenkamp CL, Hite KB. Evaluation of reported medication errors before and after implementation of computerized practitioner order entry. J Healthc Inf Manag 2006;20(4):46-53.	Ingen kontrollgruppe
Braithwaite J, Westbrook MT, Travaglia JF, Iedema R, Mallock NA, Long D, et al. Are health systems changing in support of patient safety? A multi-methods evaluation of education, attitudes and practice. Int J Health Care Qual Assur 2007;20(7):585-601.	Omhandler ikke effekt av elektronisk meldesystem

Bruce J, Russell EM, Mollison J, Krukowski ZH. The measurement and monitoring of surgical adverse events. Health Technology Assessment (Winchester, England) 2001;5(22):1-194.	Omhandler ikke effekt av elektronisk meldesystem
Cousins D, Rosario C, Scarpello J. Insulin, hospitals and harm: a review of patient safety incidents reported to the National Patient Safety Agency. Clinical Medicine 2011;11(1):28-30.	Omhandler ikke effekt av elektronisk meldesystem
Dillon H, Rosbergen M, Hutchinson S. Use of an anonymous medication incident reporting system on a critical care unit. Critical Care 2010;Conference: 30th International Symposium on Intensive Care and Emergency Medicine, ISICEM Brussels Belgium. Conference Start: 20100309 Conference End: 20100312. Conference Publication:(var.pagings):S151.	Kun en avdeling, ICU
Dollarhide AW, Rutledge T, Weinger MB, Dresselhaus TR. Use of a handheld computer application for voluntary medication event reporting by inpatient nurses and physicians. J Gen Intern Med 2008;23(4):418-22.	Ingen kontrollgruppe
Dolores MM, Rancano I, Garcia V, Vallina C, Herranz V, Vazquez F. Use of different patient safety reporting systems: Much ado about nothing? Revista de Calidad Asistencial 2010;25(4):232-6.	Oversiktsartikkel
Dominguez FE, Kolios G, Schlosser K, Wissner W, Rothmund M. Introduction of a critical incident reporting system in a surgical university clinic. What can be achieved in a short term? Dtsch Med Wochenschr 2008;133(23):1229-34.	Ingen kontrollgruppe
Duckers M, Faber M, Cruijsberg J, Grol R, Schoonhoven L, Wensing M. Safety and risk management interventions in Hospitals: A systematic review of the literature. Med Care Res Rev 2009;66(6 SUPPL.):90S-119S.	Oversiktsartikkel
Evans SM, Smith BJ, Esterman A, Runciman WB, Maddern G, Stead K, et al. Evaluation of an intervention aimed at improving voluntary incident reporting in hospitals. Quality and Safety in Health Care 2007;16(3):169-75.	1 side papirrapportering sammenlignet med 3 siders papirrapportering
Flynn EA, Barker KN, Pepper GA, Bates DW, Mikeal RL. Comparison of methods for detecting medication errors in 36 hospitals and skilled-nursing facilities. Am J Health Syst Pharm 2002;59(5):436-46.	Ikke elektronisk rapportering
Ford EC, Terezakis S, Pronovost P, Myers L, Bell R, Wong J, et al. Patient safety in radiation oncology: Tools for improvement. International Journal of Radiation Oncology Biology Physics 2010;Conference: 52nd Annual Meeting of the American Society for Radiation Oncology San Diego, CA United States. Conference Start: 20101031 Conference End: 20101104. Conference Publication:(var.pagings):S568-S569.	Kun en avdeling, radiation oncology
Franklin BD, Birch S, Savage I, Wong I, Woloshynowych M, Jacklin A, et al. Methodological variability in detecting prescribing errors and consequences for the evaluation of interventions. Pharmacoepidemiology and Drug Safety 2009;18(11):992-9.	Inkluderte kun foreskrivningsfeil
Franklin BD, Jacklin A, Barber N. The impact of an electronic prescribing and administration system on the safety and quality of medication administration. International Journal of Pharmacy Practice 2008;16(6):375-9.	Ikke om meldesystemer
Golden MS. An incident reporting system: documented at the point of service. J Healthc Risk Manag 1998;18(2):18-26.	Ikke tidsriktig kontroll
Grant MJ, Larsen GY. Effect of an anonymous reporting system on near-miss and harmful medical error reporting in a pediatric intensive care unit. J Nurs Care Qual 2007;22(3):213-21.	Papirsystem sammenlignet med papirsystem
Greene SB, Williams CE, Pierson S, Hansen RA, Carey TS. Online medication error graphic reports: a pilot in North Carolina nursing homes. Journal of patient safety 2011;7(2):92-8.	Omhandler ikke effekt av meldesystemer
Guffey P, Szolnoki J, Caldwell J, Polaner D. Design and implementation of a near-miss reporting system at a large, academic pediatric anesthesia department. Paediatr Anaesth 2011;21(7):810-4.	Ingen kontrollgruppe
Haw C, Cahill C. A computerized system for reporting medication events in psychiatry: the first two years of operation. J Psychiatr Ment Health Nurs 2011;18(4):308-15.	Ingen kontrollgruppe
Hickner J, Zafar A, Kuo GM, Fagnan LJ, Forjuoh SN, Knox LM, et al. Field test results of a new ambulatory care Medication Error and Adverse Drug Event Reporting System--MEADERS. Annals of Family Medicine 2010;8(6):517-25.	Ingen kontrollgruppe
James KL, Barlow D, Hiom S, Roberts D, Whittlesea C. Development and use	Ingen kontrollgruppe

of the critical incident technique in evaluating causes of dispensing incidents. International Journal of Pharmacy Practice 2008;16(4):239-49.	
Jha AK, Kuperman GJ, Teich JM, Leape L, Shea B, Rittenberg E, et al. Identifying adverse drug events: development of a computer-based monitor and comparison with chart review and stimulated voluntary report. J Am Med Inform Assoc 1998;5(3):305-14.	Omhandlet kun medisinfeil
Karsh BT, Escoto KH, Beasley JW, Holden RJ. Toward a theoretical approach to medical error reporting system research and design. Applied Ergonomics 2006; 37:283-95.	Oversiktsartikkel
Katariya J, Mani RK, Govil D, Basu R, Cyrill J, Sibi M, et al. The difference between self-reported and independently audited medication errors in an indian ICU. Intensive Care Med 2010;Conference: 23rd Annual Congress of the European Society of Intensive Care Medicine, ESICM Barcelona Spain. Conference Start: 20101009 Conference End: 20101013. Conference Publication:(var.pagings):S399.	Kun en avdeling, medical – surgical intensive care unit
Katz RI, Lagasse RS. Factors influencing the reporting of adverse perioperative outcomes to a quality management program. Anesth Analg 2000;90(2):344-50.	Ikke elektronisk rapporteringssystem
Kessels-Habraken M, De JJ, Van der Schaaf T, Rutte C. Prospective risk analysis prior to retrospective incident reporting and analysis as a means to enhance incident reporting behaviour: a quasi-experimental field study. Soc Sci Med 2010;70(9):1309-16.	Omhandler innføring av risikoanalyse, ikke elektronisk meldesystem
Kiessig T, De V, I, Pernom C, Philipp R, Krause K-P. Validation of the iTrace data acquisition software in a plasmapheresis operation. Vox Sang 2011;Conference: 21st Regional Congress of the ISBT, Europe Lisbon Portugal. Conference Start: 20110618 Conference End: 20110622. Conference Publication:(var.pagings):133.	Ikke om meldesystemer
Kilbridge PM, Classen DC. Automated surveillance for adverse events in hospitalized patients: back to the future. Quality and Safety in Health Care 2006;15(3):148-9.	Ingen egne data
King ES, Moyer DV, Couturie MJ, Gaughan JP, Shulkin DJ. Getting doctors to report medical errors: project DISCLOSE. Joint Commission Journal on Quality and Patient Safety 2006;32(7):382-92.	Sammenligner papirform med papirform
Knudsen P, Herborg H, Mortensen AR, Knudsen M, Hellebek A. Preventing medication errors in community pharmacy: frequency and seriousness of medication errors. Quality and Safety in Health Care 2007;16(4):291-6.	Omhandler ikke meldesystemer
Kozer E, Scolnik D, Jarvis AD, Koren G. The effect of detection approaches on the reported incidence of tenfold errors. Drug Saf 2006;29(2):169-74.	Ingen egne data
Kunac DL, Harrison-Woolrych M, Tatley MV. Pharmacovigilance in New Zealand: The role of the New Zealand Pharmacovigilance Centre in facilitating safer medicines use. N Z Med J 2008;121(1283):76-89.	Omhandler medisiner, ikke feil eller meldesystemer
Kunac DL, Reith DM. Preventable medication-related events in hospitalised children in New Zealand. N Z Med J 2008;121(1272):17-32.	Omhandlet kun medisinfeil
Lacasa C, Andreu C, Garcia CC, Polo C, Miguel M, Arilla M, et al. Is the observation method useful for the prevention of medication errors in hospitals? Farmaceutico Hospitales 2007;(188):39-43.	Ingen kontrollgruppe
Lampela P, Hartikainen S, Sulkava R, Huupponen R. Adverse drug effects in elderly people -- a disparity between clinical examination and adverse effects self-reported by the patient. Eur J Clin Pharmacol 2007;63(5):509-15.	Omhandler ikke effekt av elektronisk meldesystem
Levtzion-Korach O, Frankel A, Alcalai H, Keohane C, Orav J, Graydon-Baker E, et al. Integrating incident data from five reporting systems to assess patient safety: making sense of the elephant. Joint Commission Journal on Quality and Patient Safety 2010;36(9):402-10.	Fem forskjellige rapporteringssystemer for pasientsikkerhet i samme sykehus samtidig.
Lightdale JR, Mahoney LB, Fredette ME, Valim C, Wong S, DiNardo JA. Nurse reports of adverse events during sedation procedures at a pediatric hospital. J Perianesth Nurs 2009;24(5):300-6.	Omhandler kun bivirkninger, ikke andre uønskede hendelser
Ligi I, Millet V, Sartor C, Jouve E, Tardieu S, Sambuc R, et al. Iatrogenic events in neonates: beneficial effects of prevention strategies and continuous monitoring. Pediatrics 2010;126(6):e1461-e1468.	Før og etter - studie uten kontrollgruppe
Linder JA, Haas JS, Iyer A, Labuzetta MA, Ibara M, Celeste M, et al. Secondary use of electronic health record data: spontaneous triggered adverse drug	Omhandler ikke effekt av elektronisk meldesystem

event reporting. Pharmacoepidemiology and Drug Safety 2010;19(12):1211-5.	
Low DK, Belcher JV. Reporting medication errors through computerized medication administration. CIN: Computers, Informatics, Nursing 2002;20(5):178-83.	Omhandler ikke effekt av elektronisk meldesystem
Macnab A, Sun C, Lowe J. Randomized, controlled trial of three levels of critical incident stress intervention. Prehospital Disaster Med 2003;18(4):367-71.	Ikke om meldesystemer
Maidment ID, Thorn A. A medication error reporting scheme: Analysis of the first 12 months. Psychiatric Bulletin 2005;29(8):298-301.	Ingen kontrollgruppe
Maistrello I, Morgutti M, Maltempi M, Dantes M. Adverse drug reactions in hospitalized patients: An operational procedure to improve reporting and investigate underreporting. Pharmacoepidemiology and Drug Safety 1995;4(2):101-6.	Omhandler ikke elektronisk meldesystem, og kun om medisinreaksjoner
Marsh P, Kendrick D. Using a diary to record near misses and minor injuries--which method of administration is best? Inj Prev 1999;5(4):305-9.	Omhandler ikke effekten av elektronisk meldesystem
Melton GB, Hripcsak G. Automated detection of adverse events using natural language processing of discharge summaries. J Am Med Inform Assoc 2005;12(4):448-57.	Omhandler ikke elektronisk meldesystem for uønskede hendelser
Mirza SK, Deyo RA, Heagerty PJ, Turner JA, Lee LA, Goodkin R. Towards standardized measurement of adverse events in spine surgery: conceptual model and pilot evaluation. BMC Musculoskeletal Disorders 2006;7:53.	Kun kirurgisk avdeling var inkludert
Missbach-Kroll A, Nussbaumer P, Kuenz M, Sommer C, Furrer M. First experience with a critical incident reporting system in surgery. Chirurg 2005;76(9):868-75.	Ingen kontrollgruppe
Miyata S, Kawai T, Yamamoto S, Takada M, Iwatani Y, Uchida O, et al. Network computer-assisted transfusion-management system for accurate blood component-recipient identification at the bedside. Transfusion (Paris) 2004;44(3):364-72.	Ikke om meldsystem
Mutic S, Brame RS, Oddiraju S, Parikh P, Westfall MA, Hopkins ML, et al. Event (error and near-miss) reporting and learning system for process improvement in radiation oncology. Med Phys 2010;37(9):5027-36.	Kun en avdeling, radiation oncology
Noble DJ, Panesar SS, Pronovost PJ. A public health approach to patient safety reporting systems is urgently needed. Journal of patient safety 2011;7(2):109-12	Oversiktsartikkel
Nuckols TK, Bell DS, Paddock SM, Hilborne LH. Comparing process- and outcome-oriented approaches to voluntary incident reporting in two hospitals. Joint Commission Journal on Quality and Patient Safety 2009;35(3):139-45.	Ingen kontrollgruppe
Nyssen A-S, Blavier A. Error detection: A study in anaesthesia. Ergonomics 2006;49(5-6):517-25.	Omhandler ikke meldesystem
Oken A, Rasmussen MD, Slagle JM, Jain S, Kuykendall T, Ordonez N, et al. A facilitated survey instrument captures significantly more anesthesia events than does traditional voluntary event reporting. Anesthesiology 2007;107(6):909-22.	Papirrapportering sammenlignet med intervju
Parker J, Holtby S. Incident reporting and JACIE standards - A three-centre study. Bone Marrow Transplant 2011;Conference: European Group for Blood and Marrow Transplantation, EBMT 2011 Paris France. Conference Start: 20110403 Conference End: 20110406. Conference Publication:(var.pagings):S443.	Omhandler ikke effekt av meldesystemer
Pettker C, Thung S, Raab C, Copel J, Funai E. A comprehensive OB patient safety program improves safety climate and culture. Am J Obstet Gynecol 2009;Conference: 2010 30th Annual Meeting of the Society for Maternal-Fetal Medicine, SMFM Chicago, IL United States. Conference Start: 20100201 Conference End: 20100206 Sponsor: March of Dimes. Conference Publication:(var.pagings):S152.	Ingen kontrollgruppe
Pettker C, Thung S, Copel J, Funai E, Raab C. A comprehensive OB patient safety program reduces liability claims. Am J Obstet Gynecol 2011;Conference: 2011 31st Annual Meeting of the Society for Maternal-Fetal Medicine: The Pregnancy Meeting San Francisco, CA United States. Conference Start: 20110207 Conference End: 20110212. Conference Publication:(var.pagings):S218-S219.	Omhandler søksmål, ikke andre uønskede hendelser
Pettker C. Impact of a patient safety programme on obstetric outcomes. International Journal of Gynecology and Obstetrics 2009;Conference: 19th FIGO World Congress of Gynecology and Obstetrics Cape Town South Africa. Con-	Ingen kontrollgruppe

ference Start: 20091004 Conference End: 20091009. Conference Publication:(var.pagings):S68.	
Piontek F, Kohli R, Conlon P, Ellis JJ, Jablonski J, Kini N. Effects of an adverse-drug-event alert system on cost and quality outcomes in community hospitals. Am J Health Syst Pharm 2010;67(8):613-20.	Omhandler ikke effekt av meldesystemer
Powell GE, Ryan PB, Pattishall EN. Comparison of quantitative signal detection using observational and spontaneous adverse event data. Pharmacoepidemiology and Drug Safety 2010;Conference: 26th International Conference on Pharmacoepidemiology and Therapeutic Risk Management Brighton United Kingdom. Conference Start: 20100819 Conference End: 20100822. Conference Publication:(var.pagings):S184.	Omhandler ikke effekt av meldesystemer
Pronovost PJ, Thompson DA, Holzmueller CG, Lubomski LH, Dorman T, Dickman F, et al. Toward learning from patient safety reporting systems. J Crit Care 2006;21(4):305-15.	Ikke kontrollgruppe
Punjasawadwong Y, Suraseranivongse S, Charuluxananan S, Jantorn P, Thienthong S, Chanchayanon T, et al. Multicentered study of model of anesthesia related adverse events in Thailand by incident report (the Thai Anesthesia Incident Monitoring Study): methodology. J Med Assoc Thai 2007;90(11):2529-37.	Ikke kontrollgruppe
Ricci M, Goldman AP, de Leval MR, Cohen GA, Devaney F, Carthey J. Pitfalls of adverse event reporting in paediatric cardiac intensive care. Arch Dis Child 2004;89(9):856-9.	Kun en avdeling, paediatric cardiac intensive care
Roberts LL, Ward MM, Brokel JM, Wakefield DS, Crandall DK, Conlon P. Impact of health information technology on detection of potential adverse drug events at the ordering stage. Am J Health Syst Pharm 2010;67(21):1838-46.	Ikke om meldesystemer
Rosebraugh CJ, Tsong Y, Zhou F, Chen M, Mackey AC, Flowers C, et al. Improving the quality of adverse drug reaction reporting by 4th-year medical students. Pharmacoepidemiology and Drug Safety 2003;12(2):97-101.	Omhandler ikke effekt av meldesystemer
Samore MH, Evans RS, Lassen A, Gould P, Lloyd J, Gardner RM, et al. Surveillance of medical device-related hazards and adverse events in hospitalized patients. JAMA 2004;291(3):325-34.	Kun utstyrsrelaterte hendelser ble rapportert
Santanam L, Parikh P, Brame RS, Lindsey A, Danieley J, LaBrash J, et al. Eliminating inconsistencies in simulation and treatment planning orders in radiation therapy. International Journal of Radiation Oncology Biology Physics 2010;Conference: 52nd Annual Meeting of the American Society for Radiation Oncology San Diego, CA United States. Conference Start: 20101031 Conference End: 20101104. Conference Publication:(var.pagings):S485.	Ingen kontrollgruppe
Scharf O, Colevas AD. Adverse event reporting in publications compared with sponsor database for cancer clinical trials. J Clin Oncol 2006;24(24):3933-8.	Omhandler ikke effekt av elektroniske meldesystemer
Schuerer DJ, Nast PA, Harris CB, Krauss MJ, Jones RM, Boyle WA, et al. A new safety event reporting system improves physician reporting in the surgical intensive care unit. J Am Coll Surg 2006;202(6):881-7.	Ikke tidsriktig kontroll
Silas R, Tibballs J. Adverse events and comparison of systematic and voluntary reporting from a paediatric intensive care unit. Quality and Safety in Health Care 2010;19(6):568-71.	Kun en avdeling på ett sykehus, paediatric intensive care unit
Stump LS. Re-engineering the medication error-reporting process: Removing the blame and improving the system. Am J Health Syst Pharm 2000;57(SUPPL. 4):S10-S17.	Papirbasert rapporteringssystem, ikke elektronisk
Takata GS, Taketomo CK, Waite S, California Pediatric Patient Safety Initiative. Characteristics of medication errors and adverse drug events in hospitals participating in the California Pediatric Patient Safety Initiative. Am J Health Syst Pharm 2008;65(21):2036-44.	Rapporterte kun på legemiddelrelaterte feil og uhell
Tam KW, Kwok KH, Fan YM, Tsui KB, Ng KK, Ho KY, et al. Detection and prevention of medication misadventures in general practice. Int J Qual Health Care 2008;20(3):192-9.	Omhandler allmennpraksis, ikke sykehus
Tamuz M, Harrison MI. Improving patient safety in hospitals: Contributions of high-reliability theory and normal accident theory. Health Serv Res 2006;41(4 II):1654-76.	Omhandler ikke effekt av elektronisk meldesystem
Taylor JA, Brownstein D, Klein EJ, Strandjord TP. Evaluation of an anonymous system to report medical errors in pediatric inpatients. Journal of Hospital Medicine (Online) 2007;2(4):226-33.	Ikke tidsriktig kontrollgruppe, og ikke nok målepunkter til ITS

Thompson DA, Lubomski L, Holzmueller C, Wu A, Morlock L, Fahey M, et al. Integrating the intensive care unit safety reporting system with existing incident reporting systems. Joint Commission Journal on Quality and Patient Safety 2005;31(10):585-93.	Ikke kontrollgruppe
Trifiro G, Patadia V, Schuemie MJ, Coloma PM, Gini R, Herings R, et al. EU-ADR healthcare database network vs. spontaneous reporting system database: preliminary comparison of signal detection. Stud Health Technol Inform 2011;166:25-30.	Ikke om meldesystemer
Tuttle D, Holloway R, Baird T, Sheehan B, Skelton WK. Electronic reporting to improve patient safety. Quality and Safety in Health Care 2004;13(4):281-6.	Rapporterte antall meldinger mottatt på papir i år 2000 og antall elektroniske meldinger i 2002. Ikke nok målepunkter til å omregne til ITS.
Tuttle D, Panzer RJ, Baird T. Using administrative data to improve compliance with mandatory state event reporting. Jt Comm J Qual Improv 2002;28(6):349-58.	Ikke kontrollgruppe
Varadarajan R, Barker KN, Flynn EA, Thomas RE. Comparison of two error-detection methods in a mail service pharmacy serving health facilities. Journal of the American Pharmacists Association: JAPhA 2008;48(3):371-8.	Ikke på sykehus
Velez-Diaz-Pallares M, Delgado SE, Perez Menendez-Conde C, Bermejo VT. Analysis of errors in manual versus electronic prescriptions in trauma patients. Farmacia Hospitalaria 2011;35(3):135-9.	Ikke fokus på meldesystemer
Vidi VD, Matheny ME, Donnelly S, Resnic FS. An evaluation of a distributed medical device safety surveillance system: the DELTA network study. Contemporary Clinical Trials 2011;32(3):309-17.	Ikke en studie, protokoll til studie om uønskede hendelser i medisinsk utstyr
Wagner LM, Capezuti E, Taylor JA, Sattin RW, Ouslander JG. Impact of a falls menu-driven incident-reporting system on documentation and quality improvement in nursing homes. Gerontologist 2005;45(6):835-42.	Omhandler kun fall
Wagner LM, Capezuti E, Clark PC, Parmelee PA, Ouslander JG. Use of a falls incident reporting system to improve care process documentation in nursing homes. Quality and Safety in Health Care 2008;17(2):104-8.	Omhandler kun fall
Wai K, Jacobs B, Stockwell D. Recognizing opioid and benzodiazepine related adverse drug events in children through an automated detection system. J Investig Med 2011;Conference: American Federation for Medical Research Eastern Regional Meeting, AFMR 2011 Washington, DC United States. Conference Start: 20110426 Conference End: 20110427. Conference Publication:(var.pagings):631-2.	Omhandler kun to medisiner
Walsh K, Antony J. Improving patient safety and quality: what are the challenges and gaps in introducing an integrated electronic adverse incident and recording system within health care industry? Int J Health Care Qual Assur 2007;20(2-3):107-15.	Artikkelen har ingen egne data
Weingart SN, Callanan LD, Ship AN, Aronson MD. A physician-based voluntary reporting system for adverse events and medical errors. J Gen Intern Med 2001;16(12):809-14.	Omhandler ikke elektronisk meldesystem
Weingart SN, Ship AN, Aronson MD. Confidential clinician-reported surveillance of adverse events among medical inpatients. J Gen Intern Med 2000;15(7):470-7.	Kun en avdeling
Wetzels R, Wolters R, van WC, Wensing M. Mix of methods is needed to identify adverse events in general practice: a prospective observational study. BMC Family Practice 2008;9:35.	Omhandler allmennleger, ikke sykehus
Whitsett CF, Robichaux MG. Assessment of blood administration procedures: problems identified by direct observation and administrative incident reporting. Transfusion (Paris) 2001;41(5):581-6.	Omhandler kun håndtering av blod
Williams DJ, Olsen S, Crichton W, Witte K, Flin R, Ingram J, et al. Detection of adverse events in a Scottish hospital using a consensus-based methodology. Scott Med J 2008;53(4):26-30.	Kun tre akuttavdelinger i ett sykshus er inkludert.
Williams LK, Pladevall M, Fendrick AM, Lafata JE, McMahon LF. Differences in the reporting of care-related patient injuries to existing reporting systems. Joint Commission Journal on Quality and Safety 2003;29(9):460-7.	Tverrsnitts-studie av ni sykehus med både nasjonalt obligatorisk meldesystem og meldesystem i tilknytning til akkreditering. Ett

	utfall for én tidsperiode.
Wingenfeld C, Abbara-Czardybon M, Arbab D, Frank D. Patient safety in orthopaedics: implementation and first experience with CIRS and team time-out. Zeitschrift fur Orthopadie and Unfallchirurgie 2010;148(5):525-31.	Ingen kontrollgruppe
Wolff AM, Bourke J, Campbell IA, Leembruggen DW. Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program. Med J Aust 2001;174(12):621-5.	Omhandler ikke elektronisk meldesystem
Wright M, Parker G. Incident monitoring in psychiatry. J Qual Clin Pract 1998;18(4):249-61.	Omhandler ikke elektronisk meldesystem
Zwart DL, van Rensen EL, Kalkman CJ, Verheij TJ. Central or local incident reporting? A comparative study in Dutch GP out-of-hours services. Br J Gen Pract 2011;61(584):183-7.	Ikke i sykehus, lokalt versus sentralt elektronisk meldesystem for primærleger

Vedlegg 5: Tabell over ekskluderte studier for evaluering av nasjonale elektroniske meldesystemer

Referanse	Eksklusjonsgrunn
Next step in electronic prescribing: government proposes new federal regulations. MGMA connexion / Medical group Management Association 2005;5(4):14-6.	Elektronisk foreskrivning – ikke meldesystem
Abedi MR, Sorensen B, Ekblom-Kullberg S, Hjlmarsdttir I, Espinosa A. Haemovigilance in nordic countries: Report of donor complications 2007. Vox Sang 2009;Conference: 19th Regional Congress of the ISBT - Eastern Mediterreanean and Europe Cairo Egypt. Conference Start: 20090321 Conference End: 20090325. Conference Publication:(var.pagings):59-60.	Omhandler kun hemovigilans om donorproblemer
Abeysekera A, Bergman IJ, Kluger MT, Short TG. Drug error in anaesthetic practice: a review of 896 reports from the Australian Incident Monitoring Study database. Anaesthesia 2005;60(3):220-7.	Omhandler kun anestesi, ikke selve meldesystemet
Agarwal V, Divatia J, Patil V, Kulkarni A, Sareen R, Sampat S. Early experiences with critical incident reporting system in an indian ICU. Intensive Care Med 2009;Conference: 22nd Annual Congress of the European Society of Intensive Care Medicine, ESICM Vienna Austria. Conference Start: 20091011 Conference End: 20091014. Conference Publication:(var.pagings):S296.	Omhandler kun én enhet
Agha HM, Hariri M, Yavari F, Akbari N. Reporting of actual and near-miss events for transfusion medicine: Improving transfusion safety, Iran, 20062007. Vox Sang 2009;Conference: 19th Regional Congress of the ISBT - Eastern Mediterreanean and Europe Cairo Egypt. Conference Start: 20090321 Conference End: 20090325. Conference Publication:(var.pagings):207-8.	Omhandler kun blodoverføring
Aghahoseini M, Akbari N, Hariri MM, Yavari F. Reporting of actual and near-miss events for improving transfusion safety in Isfahan blood transfusion organizatin in 2006-2007. Vox Sang 2010;Conference: 31st International Congress of the International Society of Blood Transfusion in Joint Cooperation with the 43rd Congress of the DGTI Berlin Germany. Conference Start: 20100626 Conference End: 20100701. Conference Publication:(var.pagings):135.	Omhandler kun blodoverføring
Ahluwalia J, Marriott L. Critical incident reporting systems. Seminars In Fetal and Neonatal Medicine 2005;10(1):31-7.	Omhandler neonatal trigger hendelser
Alrwisan A, Ross J, Williams D. Medication incidents reported to an online reporting system in NHS Grampian. Br J Clin Pharmacol 2010;Conference: Proceedings of the BPS Clinical Pharmacological Section London United Kingdom. Conference Start: 20091215 Conference End: 20091217. Conference Publication:(var.pagings):286.	Diskuterer hvor i systemet meldingene kommer fra
Amoore J, Ingram P. Quality improvement report: Learning from adverse incidents involving medical devices. BMJ 2002;325(7358):272-5.	Kvalitetsforbedring
Andersen SE, Christensen HR, Hilsted JC. Medication problems and risk management. Ugeskr Laeger 2001;163(39):5361-4.	Diskuterer medisinfeil og forsikringsproblematikk
Anderson JG. A systems approach to preventing adverse drug events. Stud Health Technol Inform 2003;92:95-102.	Omhandler kun medisinfeil

Anderson JG, Ramanujam R, Hensel DJ, Sirio CA. Reporting trends in a regional medication error data-sharing system. Health Care Management Science 2010;13(1):74-83.	Deling av data på regional nivå
Ang JP, Bain C, Mehra R, Stott A, Shelton A, McNicol L, et al. Anaesthesia Safety Project: User compliance and factors influencing it. Anaesth Intensive Care 2011;Conference: Combined Scientific Meeting of the Australian and New Zealand College of Anaesthetists and the Hong Kong College of Anaesthesiologists 2011 Hong Kong Hong Kong. Conference Start: 20110514 Conference End: 20110517. Conference Publication:(var.pagings):691-2.	Omhandler kun anestesi og kun på fire institusjoner
Antonow JA, Smith AB, Silver MP. Medication error reporting: a survey of nursing staff. J Nurs Care Qual 2000;15(1):42-8.	Omhandler kun ett sykehus
Aranaz-Andres JM, Aibar-Remon C, Limon-Ramirez R, Amarilla A, Restrepo FR, Urroz O, et al. IBEAS design: adverse events prevalence in Latin American hospitals. Revista de Calidad Asistencial 2011;calid.(3):194-200.	Rapporterer observasjoner fra én dag
Arnold A, Delaney GP, Cassapi L, Barton M. The use of categorized time-trend reporting of radiation oncology incidents: a proactive analytical approach to improving quality and safety over time. Int J Radiat Oncol Biol Phys 2010;78(5):1548-54.	Omhandler kun strålingsbehandling og kreftpasienter
Arnot-Smith J, Smith AF. Patient safety incidents involving neuromuscular blockade: analysis of the UK National Reporting and Learning System data from 2006 to 2008. Anaesthesia 2010;65(11):1106-13.	Omhandler kun anestesi
Aroonpruksakul N, Leelanukrom R, Jantorn P, Charoensawan U, Suraseranivongse S, Thienthong S. Perioperative non-hypoxic bradycardia in pediatric patients: Thai anesthesia incident monitoring study (Thai AIMS). Asian Biomedicine 2008;2(6):477-83.	Omhandler kun anestesi
Ashcroft DM, Morecroft C, Parker D, Noyce P. Reporting, reflecting on and learning from adverse events in community pharmacy: Development and evaluation of an incident reporting form. Pharmaceutical Journal 2005;274(7350):615-7.	Utvikling av form for apotekmeldinger
Bagian JP, Gosbee J, Lee CZ, Williams L, McKnight SD, Mannos DM. The Veterans Affairs root cause analysis system in action. Jt Comm J Qual Improv 2002;28(10):531-45.	Omhandler årsaksanalyse
Baird M, Smith A. Accuracy of reporters' assignment of patient harm in anaesthetic critical incidents from the UK National Reporting and Learning Scheme. Eur J Anaesthesiol 2009;Conference: European Anaesthesiology Congress, EUROANAESTHESIA 2009 Milan Italy. Conference Start: 20090606 Conference End: 20090609. Conference Publication:(var.pagings):204-5.	Ikke om erfaringene
Bak M. A 5-year retrospective analysis on adverse events associated with medication at department of anaesthesiology and intensive care, Odense University Hospital, Denmark. Acta Anaesthesiologica Scandinavica, Supplement 2009;Conference: 30th Congress of the Scandinavian Society of Anaesthesiologists Odense Denmark. Conference Start: 20090610 Conference End: 20090613. Conference Publication:(var.pagings):58.	Omhandler kun én avdeling
Baker M. Patient safety incidents in primary care: Reporting, learning and finding solutions. Clinical Risk 2005;11(4):145-7.	Omtale og meningsytring
Bateman R, Donyai P. Errors associated with the preparation of aseptic products in UK hospital pharmacies: lessons from the national aseptic error reporting scheme. Quality and Safety in Health Care 2010;19(5):e29.	Omhandler fordeling av forskjellige meldinger
Becker C. NY's best not good enough. Despite being a leader in adverse-event reporting, audit reveals some shortcomings, need for reform in N.Y.'s tracking system. Mod Healthc 2010;34(40):6-7.	Omtale og meningsytring
Beckmann U, Gillies DM, Berenholtz SM, Wu AW, Pronovost P. Incidents relating to the intra-hospital transfer of critically ill patients. An analysis of the reports submitted to the Australian Incident Monitoring Study in Intensive Care. Intensive Care Med 2004;30(8):1579-85.	Omhandler pasienttransport
Belknap SM, Georgopoulos CH, West DP, Yarnold PR, Kelly WN. Quality of methods for assessing and reporting serious adverse events in clinical trials of cancer drugs. Clin Pharmacol Ther 2010;88(2):231-6.	Omhandler kun medisinrelaterte feil i eksperimenter
Bencheikh RS, Benabdallah G. Medication errors: pharmacovigilance centres in detection and prevention. Br J Clin Pharmacol 2009;67(6):687-90.	Omhandler kun medisinrelaterte hendelser

Beydon L, Conreux F, Le GR, Safran D, Cazalaa JB, 'Sous-commission de Materiovigilance' for Anaesthesia and Intensive Care. Analysis of the French health ministry's national register of incidents involving medical devices in anaesthesia and intensive care. Br J Anaesth 2001;86(3):382-7.	Omhandler kun anestesi og intensivavdelinger
Bilimoria KY, Kmiecik TE, DaRosa DA, Halverson A, Eskandari MK, Bell RH, Jr., et al. Development of an online morbidity, mortality, and near-miss reporting system to identify patterns of adverse events in surgical patients. Arch Surg 311;144(4):305-11.	Kun ett sykehus
Bissonnette J-P, Medlam G. Trend analysis of radiation therapy incidents over seven years. Radiother Oncol 2010;96(1):139-44.	Ser på hendelser I relasjon til strålebehandling og bruk
Bjorn B, Anhoj J, Lilja B. Reporting of patient safety incidents: experience from five years with a national reporting system. Ugeskr Laeger 2009;171(20):1677-80.	Omtale av meldesystemet i Danmark
Bjorn B, Rabol LI, Jensen EB, Pedersen BL. Wrong-site surgery: incidence and prevention. Ugeskr Laeger 2006;168(48):4205-9.	Omhandler kun feilsidekirurgi
Bradley VM, Steltenkamp CL, Hite KB. Evaluation of reported medication errors before and after implementation of computerized practitioner order entry. J Healthc Inf Manag 2006;20(4):46-53.	Omhandler ett universitetssykehus
Braithwaite J, Westbrook MT, Travaglia JF, Iedema R, Mallock NA, Long D, et al. Are health systems changing in support of patient safety? A multi-methods evaluation of education, attitudes and practice. Int J Health Care Qual Assur 2007;20(7):585-601.	Ikke om elektroniske meldesystem
Bruce J, Russell EM, Mollison J, Krukowski ZH. The measurement and monitoring of surgical adverse events. Health Technology Assessment (Winchester, England) 2001;5(22):1-194.	Omhandler kun kirurgi
Brun A. Preliminary results of an anonymous internet-based reporting system for critical incidents in ambulatory primary care. Ther Umsch 2005;62(3):175-8.	Omhandler primærhelsetjenesten
Buckley TA, Short TG, Rowbottom YM, Oh TE. Critical incident reporting in the intensive care unit. Anaesthesia 1997;52(5):403-9.	Omhandler en avdeling
Burkoski V. Identifying risk: the limitations of incident reporting. Can Nurse 2007;103(3):12-4.	Diskuterer begrensninger
Callum JL, Merkley LL, Coovadia AS, Lima AP, Kaplan HS. Experience with the medical event reporting system for transfusion medicine (MERS-TM) at three hospitals. Transfusion and Apheresis Science 2004;31(2):133-43.	Omhandler kun blodoverføringer
Callum JL, Kaplan HS, Merkley LL, Pinkerton PH, Rabin FB, Romans RA, et al. Reporting of near-miss events for transfusion medicine: improving transfusion safety. Transfusion (Paris) 2001;41(10):1204-11.	Omhandler kun blodoverføringer
Camano G, I, Garcia BA, Lopez SM, Frias MH, Hernandez Garcia JM. Implementation of a patient safety program in obstetrics: Learning from mistakes. Progresos de Obstetricia y Ginecologia 2010;53(6):223-30.	Omhandler kun obstetrikk
Cano FG, Rozenfeld S. Adverse drug events in hospitals: a systematic review. Cad Saude Publica 2009;25:Suppl-72.	Oversiktsartikkel om medisinfeil på sykehus
Capuzzo M, Nawfal I, Campi M, Valpondi V, Verri M, Alvisi R. Reporting of unintended events in an intensive care unit: comparison between staff and observer. BMC Emergency Medicine 2005;5(1):3.	Omhandler kun ett sykehus
Carrillo-Esper R. The error in the practice of anesthesiology. Revista Mexicana de Anestesiologia 2011;34(2):103-10.	Omtale og oversikt om anestesimeldinger
Chandraharan E, Arulkumaran S. Serious untoward incident. Obstetrics, Gynaecology and Reproductive Medicine 2007;17(5):163-4.	Omtaler vurderinger av hva som er alvorlige hendelser
Charpentier C, Chevalier N, Rajezakowski S, Penavayre M, Chenevier D. Evaluation of a computerized system for medication errors reporting. International Journal of Clinical Pharmacy 2011;Conference: 39th ESCP European Symposium on Clinical Pharmacy and 13th SFPC Congress: Clinical Pharmacy at the Front Line of Innovations Lyon France. Conference Start: 20101021 Conference End: 20101023. Conference Publication:(var.pagings):357.	Omhandler kun medisinrelaterte hendelser
Chen PP, Ma M, Chan S, Oh TE. Incident reporting in acute pain management. Anaesthesia 1998;53(8):730-5.	Omhandler kun akutte smerter
Cheng L, Sun N, Li Y, Zhang Z, Wang L, Zhou J, et al. International comparative analyses of incidents reporting systems for healthcare risk management.	Omtaler meldesystemene i UK, USA, Canada, Australia og Taiwan,

Journal of Evidence-based Medicine 2011;4(1):32-47.	gir også noe informasjon om evaluering av hendelsene – ikke evaluering av meldeordningene
Choo J, Hutchinson A, Bucknall T. Nurses' role in medication safety. J Nurs Manag 2010;18(7):853-61.	Diskuterer sykepleiers rolle
Choy CY. Critical incident monitoring in anaesthesia. Current Opinion in Anaesthesiology 2008;21(2):183-6.	Omhandler kun anestesi
Clarke I. Learning from critical incidents. Advances in Psychiatric Treatment 2008;14(6):460-8.	Historisk om meldesystemer
Clarke JR. How a system for reporting medical errors can and cannot improve patient safety. Am Surg 1126;72(11):1088-91.	Omhandler kun medisinrelaterte feil
Clemens K, Muller T. Critical incident reporting system at the University Hospital of Rostock - A project to improve patient safety. Krankenhauspharmazie 2006;27(11):505-9.	Omhandler kun ett sykehus
Coldiron B, Fisher AH, Adelman E, Yelverton CB, Balkrishnan R, Feldman MA, et al. Adverse event reporting: Lessons learned from 4 years of Florida office data. Dermatol Surg 2005;31(9 PART 1):1079-92.	Omhandler ikke sykehus
Coldiron B, Shreve E, Balkrishnan R. Patient injuries from surgical procedures performed in medical offices: three years of Florida data. Dermatol Surg 1443;30(12:Pt:1):t-43.	Omhandler ikke sykehus
Conceicao LSM, Arajo M, Rocha F, Oliveira AC, Gaspar J, Lopes MDC. Six years experience of an internal incident reporting system. Radiother Oncol 2011;Conference: ESTRO Anniversary - GEC-ESTRO - EIOF - 11th Biennial London United Kingdom. Conference Start: 20110508 Conference End: 20110512. Conference Publication:(var.pagings):S541.	Omhandler kun en avdeling
Coppock J. Diligence on incident reporting. Australian Journal of Pharmacy 2008;89(1062):36.	Meningsytring
Cousins D, Rosario C, Scarpello J. Insulin, hospitals and harm: a review of patient safety incidents reported to the National Patient Safety Agency. Clinical Medicine 2011;11(1):28-30.	Omhandler kun insulin
Cox J, D'Amato S, Tillotson DJ. Reducing medication errors. American journal of medical quality : the official journal of the American College of Medical Quality 2001;16(3):81-6.	Omhandler kun en institusjon
Cozart H, Horvath MM, Long A, Whitehurst J, Eckstrand J, Ferranti J. Culture counts--sustainable inpatient computerized surveillance across Duke University Health System. Qual Manag Health Care 2010;19(4):282-91.	Omhandler kun medisinrelaterte hendelser
Crawford SY, Cohen MR, Tafesse E. Systems factors in the reporting of serious medication errors in hospitals. J Med Syst 2003;27(6):543-51.	Ser på forhold mellom apotek og medisinfeil på sykehuset
Cui X-H, Sun N-Y, Li Y-P, Zhang Z-J, Wang L, Zhou J, et al. International comparative analyses of incidents reporting systems for healthcare risk management. Chinese Journal of Evidence-Based Medicine 2011;11(3):237-46.	Websøk etter dokumenter om risikomanagment
Cunningham J, Coffey M, Knoos T, Holmberg O. Radiation Oncology Safety Information System (ROSIS)--profiles of participants and the first 1074 incident reports. Radiother Oncol 2010;97(3):601-7.	Omhandler kun stråling og kreftpasienter
Deimann LG. Reports of transfusion incidents: experiences from the first year of hemovigilance in the region of the former ZWN (South West Netherlands) blood bank in Rotterdam. Ned Tijdschr Geneeskd 2004;148(1):50.	Omhandler kun hemovigilans
Dillon H, Rosbergen M, Hutchinson S. Use of an anonymous medication incident reporting system on a critical care unit. Critical Care 2010;Conference: 30th International Symposium on Intensive Care and Emergency Medicine, ISICEM Brussels Belgium. Conference Start: 20100309 Conference End: 20100312. Conference Publication:(var.pagings):S151.	Omhandler kun én avdeling
Dixon JF. Going paperless with custom-built Web-based patient occurrence reporting. Jt Comm J Qual Improv 2002;28(7):387-95.	Omhandler kun ett sykehus
Dollarhide AW, Rutledge T, Weinger MB, Dresselhaus TR. Use of a handheld computer application for voluntary medication event reporting by inpatient nurses and physicians. J Gen Intern Med 2008;23(4):418-22.	Rapportering fra utvalgte personer
Dolores MM, Rancano I, Garcia V, Vallina C, Herranz V, Vazquez F. Use of different patient safety reporting systems: Much ado about nothing? Revista de Calidad Asistencial 2010;25(4):232-6.	Om meldingene – ikke om elektronisk meldesystem

Dominguez FE, Kolios G, Schlosser K, Wissner W, Rothmund M. Introduction of a critical incident reporting system in a surgical university clinic. What can be achieved in a short term? Dtsch Med Wochenschr 2008;133(23):1229-34.	Omhandler kun én klinikk
Duan JZ. Two commonly used methods for exposure-adverse events analysis: comparisons and evaluations. J Clin Pharmacol 2009;49(5):540-52.	Ikke om meldesystemer
Duckers M, Faber M, Cruijsberg J, Grol R, Schoonhoven L, Wensing M. Safety and risk management interventions in Hospitals: A systematic review of the literature. Med Care Res Rev 2009;66(6 SUPPL.):90S-119S.	Systematisk oversikt, - ingen nasjonale systemer
Evans SM, Smith BJ, Esterman A, Runciman WB, Maddern G, Stead K, et al. Evaluation of an intervention aimed at improving voluntary incident reporting in hospitals. Quality and Safety in Health Care 2007;16(3):169-75.	Omhandler to rapporteringssystemer på papir
Fan L, Smith A, Boenning D, Castro G, Champagne S, Loeb JM, et al. Building a Hospital Incident Reporting Ontology (HIRO) in the Web Ontology Language (OWL) using the JCAHO Patient Safety Event Taxonomy (PSET). AMIA 2005;952.	Omtaler programmeringsspråk for meldesystemer
Farley DO, Haviland A, Champagne S, Jain AK, Battles JB, Munier WB, et al. Adverse-event-reporting practices by US hospitals: results of a national survey. Quality and Safety in Health Care 2008;17(6):416-23.	Informasjon fra spørreundersøkelse om meldesystemer i USA, inneholder ikke innfor om evaluering
Fennigkoh L. Human factors and the control of medical error. Biomed Instrum Technol 2005;39(4):307-12.	Omtale og diskusjon
Fernald DH, Pace WD, Harris DM, West DR, Main DS, Westfall JM. Event reporting to a primary care patient safety reporting system: a report from the ASIPS collaborative. Annals of Family Medicine 2004;2(4):327-32.	Omhandler primærhelsetjenesten
Ferranti J, Horvath MM, Cozart H, Whitehurst J, Eckstrand J. Reevaluating the safety profile of pediatrics: a comparison of computerized adverse drug event surveillance and voluntary reporting in the pediatric environment. Pediatrics 2008;121(5):e1201-e1207.	Omhandler kun barn
Festini F, Bisogni S, Galici V, Neri S. Voluntary incident reporting by nurses in a pediatric hospital: a pilot study. Assistenza Infermieristica e Ricerca:Air 2008;27(1):27-32.	Omhandler kun ett sykehus
Figueiras A, Tato F, Fontainas J, Takkouche B, Gestal-Otero JJ. Physicians' attitudes towards voluntary reporting of adverse drug events. J Eval Clin Pract 2001;7(4):347-54.	Omhandler kun medisinrelaterte feil
Fiori G, Ravizza D, Trovato C, De RG, Tamayo D, Crosta C. Experience of incident reporting. Giornale Italiano di Endoscopia Digestiva 2009;32(3):215-24.	Omhandler kun en avdeling
Firth-Cozens J. Organisational trust: the keystone to patient safety. Quality and Safety in Health Care 2004;13(1):56-61.	Diskusjoner om tillit
Flynn EA, Barker KN, Pepper GA, Bates DW, Mikeal RL. Comparison of methods for detecting medication errors in 36 hospitals and skilled-nursing facilities. Am J Health Syst Pharm 2002;59(5):436-46.	Ikke elektronisk rapportering
Ford EC, Terezakis S, Pronovost P, Myers L, Bell R, Wong J, et al. Patient safety in radiation oncology: Tools for improvement. International Journal of Radiation Oncology Biology Physics 2010;Conference: 52nd Annual Meeting of the American Society for Radiation Oncology San Diego, CA United States. Conference Start: 20101031 Conference End: 20101104. Conference Publication:(var.pagings):S568-S569.	Omhandler kun én avdeling
Forrey RA, Pedersen CA, Schneider PJ. Interrater agreement with a standard scheme for classifying medication errors. Am J Health Syst Pharm 2007;64(2):175-81.	Omhandler kun medisiner
France DJ, Cartwright J, Jones V, Thompson V, Whitlock JA. Improving pediatric chemotherapy safety through voluntary incident reporting: lessons from the field. J Pediatr Oncol Nurs 2004;21(4):200-6.	Omhandler kun kjemoterapi
Franklin BD, Birch S, Savage I, Wong I, Woloshynowych M, Jacklin A, et al. Methodological variability in detecting prescribing errors and consequences for the evaluation of interventions. Pharmacoepidemiology and Drug Safety 2009;18(11):992-9.	Omhandler kun foreskrivningsfeil
Franklin BD, O'Grady K, Donyai P, Jacklin A, Barber N. The impact of a closed-loop electronic prescribing and administration system on prescribing errors, administration errors and staff time: A before-and-after study. Quality	Omhandler kun foreskrivningsfeil

and Safety in Health Care 2007;16(4):279-84.	
Franklin BD, Jacklin A, Barber N. The impact of an electronic prescribing and administration system on the safety and quality of medication administration. International Journal of Pharmacy Practice 2008;16(6):375-9.	Omhandler kun foreskrivningsfeil
Freestone L, Bolsin SN, Colson M, Patrick A, Creati B. Voluntary incident reporting by anaesthetic trainees in an Australian hospital. Int J Qual Health Care 2006;18(6):452-7.	Omhandler kun anestesi
Frey B, Buettiker V, Hug MI, Waldvogel K, Gessler P, Ghelfi D, et al. Does critical incident reporting contribute to medication error prevention? Eur J Pediatr 2002;161(11):594-9.	Forebygging av foreskrivningsfeil
Fuchs D, Marsolek I, Friesdorf W. Analyzing the requirements for a computer based optimization of the medication process. J Clin Monit Comput 2010;Conference: 20th Meeting of the European Society for Computing and Technology in Anaesthesia and Intensive Care, ESCTAIC Berlin Germany. Conference Start: 20090923 Conference End: 20090926. Conference Publication:(var.pagings):10-2.	Omhandler medisinrapportering og analyse
Garbutt J, Brownstein DR, Klein EJ, Waterman A, Krauss MJ, Marcuse EK, et al. Reporting and disclosing medical errors: pediatricians' attitudes and behaviors. Arch Pediatr Adolesc Med 2007;161(2):179-85.	Omhandler barneleger
Gawkrodger DJ. Risk management in dermatology: an analysis of data available from several British-based reporting systems. Br J Dermatol 2011;164(3):537-43.	Omhandler kun dermatologi
Golden MS. An incident reporting system: documented at the point of service. J Healthc Risk Manag 1998;18(2):18-26.	Framsnakker elektroniske meldesystem
Gong Y, Richardson J, Zhijian L, Alafaireet P, Yoo I. Analyzing voluntary medical incident reports. AMIA 2008;955.	Omhandler kun ett universitetssykehus
Greene SB, Williams CE, Pierson S, Hansen RA, Carey TS. Online medication error graphic reports: a pilot in North Carolina nursing homes. Journal of patient safety 2011;7(2):92-8.	Omhandler kun medisinrelaterte hendelser på pleiehjem
Griffin FA, Classen DC. Detection of adverse events in surgical patients using the Trigger Tool approach. Quality and Safety in Health Care 2008;17(4):253-8.	Trigger tool med kirurgiske pasienter
Grimard L, Clark B, Brown R, Ploquin J, Kind A. Improvement in patient safety in a large academic radiation therapy program through incident learning: Three years' results. Journal of Medical Imaging and Radiation Oncology 2010;Conference: 61st Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists, RANZCR Perth, WA United States. Conference Start: 20101014 Conference End: 20101017. Conference Publication:(var.pagings):A65.	Omhandler kun en avdeling
Guffey P, Szolnoki J, Caldwell J, Polaner D. Design and implementation of a near-miss reporting system at a large, academic pediatric anesthesia department. Paediatr Anaesth 2011;21(7):810-4.	Omhandler kun en avdeling
Haines TP, Cornwell P, Fleming J, Varghese P, Gray L. Documentation of in-hospital falls on incident reports: qualitative investigation of an imperfect process. BMC Health Services Research 2008;8:254.	Omhandler kun fall
Hansis ML. Failure prevention in clinical practice through identification of failure examples. Ther Umsch 2005;62(3):179-83.	Diskusjoner
Harris CB, Krauss MJ, Coopersmith CM, Avidan M, Nast PA, Kollef MH, et al. Patient safety event reporting in critical care: a study of three intensive care units. Crit Care Med 2007;35(4):1068-76.	Kun intensivavdelinger
Hart D, Becker-Schwarze K. Reducing risks - Increasing safety: A critical incident reporting-system in paediatric clinics in North Germany. Gesundheitsokonomie und Qualitatsmanagement 2007;12(2):87-95.	Omhandler kun pediatri
Hartnell NR, Mackinnon NJ, Sketris I, Smith SM, Fleming M. Identifying, understanding, and overcoming barriers to medication error reporting in hospitals in Nova Scotia, Canada. Can J Hosp Pharm 2009;Conference: CSHP Summer Educational Sessions(SES):345-August.	Rapporterer fra fokusgruppemøter om barrierer og fasilitatorer
Haw C, Cahill C. A computerized system for reporting medication events in psychiatry: the first two years of operation. J Psychiatr Ment Health Nurs 2011;18(4):308-15.	Omhandler kun ett sykehus
Hession-Laband E, Mantell P. Lessons learned: use of event reporting by nurses	Omhandler kun ett sykshus

to improve patient safety and quality. J Pediatr Nurs 2011;26(2):149-55.	
Hickner J, Zafar A, Kuo GM, Fagnan LJ, Forjuoh SN, Knox LM, et al. Field test results of a new ambulatory care Medication Error and Adverse Drug Event Reporting System--MEADERS. Annals of Family Medicine 2010;8(6):517-25.	Omhandler kun medisinrelaterte hendelser
Hirose M, Regenbogen SE, Lipsitz S, Imanaka Y, Ishizaki T, Sekimoto M, et al. Lag time in an incident reporting system at a university hospital in Japan. Quality and Safety in Health Care 2007;16(2):101-4.	Omhandler kun ett sykshus
Hoerl KH. Accuracy of nurse reported adverse sedation events. Journal of Radiology Nursing 2010;29(3):85-6.	Omtale av studie på ett sykehus
Hofman L, Greenall J, McBride J, Jelincic V. Assessment of risk in medication-use systems: Learning from the medication safety self-assessment. Can J Hosp Pharm 2007;60(1):49-52.	Omhandler kun medisinrelaterte feil
Hohenhaus SM. Emergency nursing and medical error--a survey of two states. J Emerg Nurs 2008;34(1):20-5.	Omhandler kun akuttsykepleiere
Hua L, Gong Y. Developing a user-centered voluntary medical incident reporting system. Stud Health Technol Inform 2010;160(Pt:1):1-7.	Modell for analyse av hendelser
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