



**FDA PATIENT SAFETY NEWS:
[FDA PSN]**

EVALUATION OF A NEW TOOL FOR AN EMERGING CULTURE.

Final Report - February 2, 2004

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Abstract

In US hospitals, an estimated 44,000 - 98,000 people die each year from preventable medical errors.¹

Medication errors are cited as 'the most common healthcare mistake' according to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "Adverse drug events account for more than 770,000 injuries and deaths each year and cost up to \$5.6 million, per hospital depending on bed size."²

The Health Television System Inc. (HTS) develops, produces and distributes, via branded closed circuit television networks, patient education programming. HTS' relationships with key hospital decision-makers enables survey access to targeted healthcare professionals.

The Food and Drug Administration (FDA) Patient Safety News (PSN) is an internet-based based education vehicle for healthcare professionals, featuring information on new drugs, biologics and medical devices approved by FDA, safety notifications and product recalls and ways to protect patients when using medical products. Essentially, it's a government service that provides solutions to help prevent medication errors and misuse of FDA regulated products.

The Health Television System Inc (HTS) was contracted to:

- Develop a survey tool to assess awareness of and effectiveness of FDA PSN,
- Coordinate and facilitate surveying hospitals' targeted healthcare professionals,
- Conduct staff surveys in 4 HTS client hospitals, resulting in 104 completed surveys,
- Analyze completed surveys.

¹ *To Err Is Human: Building a Safer Health System*. November 1999 Institute of Medicine, Shaping the Future for Health

² Kass, B. *Reducing and Preventing Adverse Drug Events To Decrease Hospital Costs*. Research in Action, Issue 1. AHRQ Publication Number 01-0020, March 2001. Agency for Healthcare Research and Quality, Rockville, MD.
<http://www.ahrq.gov/qual/aderia/aderia.htm>

Conclusion

After watching the FDA PSN November broadcast, healthcare professionals reported its positive impact on their role in hospitals, and indicated their intention to communicate FDA messages and solutions within their institute to help promote a safe environment. Several locations within their work environment and home were chosen for FDA PSN access.

A high rating was given for grouping stories by specialties to facilitate easy access to stories of interest and to reduce time spent when researching for best practices.

The FDA PSN assessment initiative proved highly effective in increasing awareness of this government service - ultimately increasing utilization and implementation of FDA PSN as a solution-based patient safety tool.

More research is required to measure the impact that educating healthcare professionals on a regular bases has on adopting safe practices.

The hypothesis is that:

Completing the circle of reporting/providing feedback of the root-causes of and solutions for preventing medical errors to healthcare professionals will, in turn, result in implementation of solution strategies and reduction of errors.

Environmental Overview: The Cost of Patient Safety

Reducing medical errors and the need for implementing safety measure gained national importance in both the professional and consumer sectors with the release of the November 1999 Institute of Medicine (IOM) report “Err is Human Building a Safer Health System”

This report found “Adverse drug events account for more than 770,000 injuries and deaths each year and cost up to \$5.6 million, per hospital, depending on bed size.”² IOM “estimates that, in hospitals, preventable medication errors result in more than 7,000 deaths each year ”.³

The IOM report resulted from a directive by Department of Health and Human Services that the Institute of Medicine create a committee to develop a standard method/ plan to collect, code and classify patient safety information. The goal was to have commitment from all stakeholders to a “culture of safety and improved information system”.⁴

A key focus and committee recommendation was that, “the federal government pursue a robust applied research agenda on patient safety, focused on enhancing knowledge, developing tools, and disseminating results to maximize the impact of patient safety systems.”⁵

In 2003, FDA’s Fiscal Year 2003 Revised Final Performance Plan Adverse Events and Medical Errors³ indicates the desired outcome is to “reduce adverse events related to FDA-regulated products by improving post marketing surveillance and helping to prevent adverse outcomes related to medical errors”.⁵

² Kass, B. *Reducing and Preventing Adverse Drug Events To Decrease Hospital Costs*. Research in Action, Issue 1. AHRQ Publication Number 01-0020, March 2001. Agency for Healthcare Research and Quality, Rockville, MD.
<http://www.ahrq.gov/qual/aderia/aderia.htm>

³ Tamar N. *Make No Mistake: Medical Errors Can Be Deadly Serious*, FDA Consumer magazine September-October 2000. US Food and Drug Administration; Posted: 08-15-2000 http://www.fda.gov/fda/fcaturs/2000/500_crr.html

⁴ Patient Safety: Achieving a New Standard for Care; 2003 National Academy of Sciences; <http://books.nap.edu/catalog/10863.html/>

⁵ Department of Health and Human Services, US Food and Drug Administration – Congressional Justification: FY 2003 Revised Final Performance Plan www.fda.gov/ope/fyo4plan/2004pp-adverse.html

Continued in the FDA Fiscal Year 2003 and 2004 Key Strategies is the goal to elevate communication with health professionals to encourage reporting of medical errors and to feed collected data back to the healthcare professionals to reduce adverse and near missed events and provide education on solutions to reduce these events.⁵

It is also worth noting that the FDA in the Performance Goal for Fiscal Year 2004 would like to expand the Medical Product Surveillance Network System to a wider reach of hospitals, a performance goal to increase existing reach of 80 to 240 facilities.

The conclusion can be drawn that a critical component to reducing medical errors and helping facilitate a safe healthcare system is clear communication and sharing and disseminating information within the healthcare sector.

Hospital Environment

It is estimated that a yearly cost of \$5.6 million is spent per hospitals (depending on bed count), on adverse drug events alone. The length of stay increases by an average 8- 12 days for patients who experience an adverse drug event.²

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the largest private US accrediting body for healthcare facilities, refers to the 1999 IOM report as identifying that medical errors are a serious problem in the healthcare system, and “a concerted effort be made to improve the public’s awareness of the problem healthcare organizations across the country are making to make health care safety a priority”.⁶ As a result of this report, and data collected from reported sentinel events, JCAHO created its widely acclaimed Patient Safety Goals and Speak Up Program.

JCAHO requires hospitals to report sentinel events and analyze root-causes of any adverse events. In an effort to help reduce medical errors and adverse events in 2003 JCAHO added six (6) patient safety goals to their accrediting requirements. This action has required hospitals and healthcare professionals to

⁵ Department of Health and Human Services, US Food and Drug Administration – Congressional Justification: FY 2003 Revised Final Performance Plan
www.fda.gov/ope/fyo4plan/2004pp-adverse.html

² Kass, B. *Reducing and Preventing Adverse Drug Events To Decrease Hospital Costs*. Research in Action, Issue 1. AHRQ Publication Number 01-0020, March 2001. Agency for Healthcare Research and Quality, Rockville, MD.
<http://www.ahrq.gov/qual/aderia/aderia.htm>

⁶ Joint Commission on Accreditation of Healthcare Organization; National Patient Safety Goals, NPSG-03, page 1. 2003

take action. To have safety practices a priority, new patient safety goals will be added or existing goals will be replaced as new priorities are identified.⁵

Individually, hospitals are complying with the IOM recommendations to designate key personnel to lead their patient safety program and develop patient safety committees.

Individually, hospitals are also working at implementing safe practices and developing a safety system. From extraneous data collected during the HTS PSN survey, some strategies include: Promoting anonymous reporting of medical errors or near missed errors facilitates learning from the information collected, and implementing necessary preventative strategies.

Acceptance of the Internet as An Educational Resource for Healthcare Professionals

Internet is proving to be a powerful tool to disseminate information and education to a mass audience– with health a top usage.⁷

The internet has been referred to as ‘ the most powerful tool currently available to medical professionals ‘⁸ Usage increase has been tracked for the purpose of accessing information for clinical practice guidelines, evidence based research, accreditation information, journals and articles, and continuing education. Two separate studies surveying healthcare professionals concluded, respectively: 47% of oncology nurses and over 50% physicians treating HIV patients had access to the Internet at work.^{9 10} With an increase in usage doubling from two years previous noted within the physician-targeted survey.¹⁰

⁷ Bill G. Felkey and Brent I. Fox *Using the Internet to Enhance Pharmacy-Based Patient Care Services*. Journal of the American Pharmaceutical Association. J Am Pharm Assoc 41(4):529-538, 2001. © 2001 American Pharmaceutical Association

⁸ Zura A; Smith MP *Reg Anesth Pain Med* 2000 Jan-Feb;25(1):99-102 (ISSN: 1098-7339) Department of General Anesthesiology, The Cleveland Clinic Foundation, Ohio 44195, USA. zuraa@ccf.org.

⁹ Joshua Fogel, PhD *Internet Use and Topics in Advanced Practice Nursing* eJournal 2(4), 2002. © 2002 Medscape

¹⁰ Jeffrey L. Drezner, M.D., Ph.D. *A Study of Internet Use by Physicians Treating HIV Patients - Clinical Care Options for HIV*. Medscape HIV/AIDS eJournal 4(3), 1998.

Background

The FDA (Food and Drug Administration), under the Health and Human Resource Dept, regulates many products including: prescription, over-the counter medications, medical devices, hearing aids, contacts lenses, safety labeling, dietary supplements and nutrition. The FDA's "central public health role is to ensure that medical product are proven safe and efficacious prior to marketing, and that these products continue to be safely used once approved and marketed".²

FDA Patient Safety News is an internet-based service designed for healthcare professionals, featuring information on new drugs, biologics and medical devices approved by FDA, on FDA safety notifications and product recalls and on ways to protect patients when using medical products. This internet service increases direct communication with healthcare professionals on risk and provides solutions associated with product use.

The Health Television System Inc (HTS) is the parent company of Healthtv™ – an in-hospital television network used as a key educational tool for patient education by top-ranked hospitals across North America. Established in 1997, Healthtv covers a wide range of health-related topics including: cardiology, oncology, general medicine and surgery.

The HTS service includes: Original three-hour program loop, delivered as continuously broadcasting television network via hospitals closed-circuit television system, accessible on bedside televisions, waiting areas and clinics.

Support Materials/ Staff Awareness: HTS has established relationships with hospitals as a result of extensive staff support that includes staff newsletters, program guides, posters and regular staff inservices. This has increased aided viewership to an outstanding 72 percent.

Staff Inservicing / Contact Hours / CEU's: At each program update – approximately every 6 months. Inservices are conducted on inpatient and outpatient units. Participation is utilized by Hospitals for CEU/contact hours.

Outcome Measurement and QA Surveys are undertaken with patients and family members and key healthcare professionals in client hospitals.

² Tamar N. *Make No Mistake: Medical Errors Can Be Deadly Serious*, FDA Consumer magazine September-October 2000. US Food and Drug Administration; Posted: 08-15-2000 http://www.fda.gov/fda/fcaturs/2000/500_crr.html

Survey Objectives

- To evaluate professionals' awareness of *FDA PSN*
- To assess value of *FDA PSN* for healthcare professionals.
- To determine how *FDA PSN* would be used by healthcare professionals.
- To obtain feedback for improvement of *FDA PSN*.

Survey Locations

- *American Academy of Family Physician's Patient Education Conference*. San Antonio TX
- *University of Maryland Medical Center*, Baltimore MD
- *Kaleida Health System*, Buffalo NY
- *St. John's Medical Center*, Santa Monica CA
- *Good Samaritan Hospital*, Los Angeles CA

Survey Methodology

Project was undertaken using an attitudinal survey of participants' awareness and perceptions of the new *FDA PSN* product. Participants were selected using a convenience, random sample from four HTV client hospitals. Participants completed a 12 item survey after watching a segment of the *FDS PSN*. The same segment was used by all participants. Participation was voluntary, and responses were confidential.

Client hospitals were invited to voluntarily participate in the study, and four medical centers across the country subsequently joined the study. A letter was sent to participating hospitals' main management contact announcing Healthtv™/*FDA PSN* inservice and survey project.

Target group consisted of hospital management staff, physicians, staff members on several in-patient units, and key healthcare professionals working in QA and on patient safety matters, including committee groups (Safety Committees, Medication Safety Committees, Nursing/Pharmacy Committees, Leadership Committees)

Survey tool consisted of 12 closed -ended questions plus a set of questions focusing on professional demographic of participant. Surveys were handed out prior to viewing the *FDA PSN* broadcast and handed in at end of inservice. One survey was sent by facsimile to HTS head office.

A total of 104 healthcare professionals surveys were completed.

Inservice Description

Introduction of FDA's role, FDA PSN, and project objectives was explained at beginning of inservice. Access to FDA PSA broadcast and viewing options (print verses broadcast) was demonstrated using the FDA supplied VHS tape. Broadcast was viewed in 'as seen over internet' form verses full screen format. This helped emphasize internet-based accessibility.

Inservices were held on the nursing units, during committee and management meetings, and during an education fair. One inservice section was held during a credited workshop at the AAFP National Patient Education Conference. Each inservice took approximately 20 – 30 minutes in length with submitting completed survey questionnaire at end of session. Participants viewed a minimum of three different stories from the FDA's November PSN broadcast.

Survey Findings: Summary

Usage and Implementation of Message/Alerts:

83% of the survey participants were not aware of FDA PSN prior to inservice, but 98% will now use it as a resource for staff education and/ or promoting patient safety.

The majority of participants were registered nurses (68%), which is consistent with the in-hospital personnel ratio of nurse to other allied health professionals. A diverse representation of the multidisciplinary team members participated in the survey; 10% were medical physicians 6% pharmacists, 2% registered dieticians, 13% indicated other (physio and occupational health therapists, non-regulated support staff; unit clerk, patient care aids, house keeping)

54% indicated they were members of a hospital committee that encompasses aspects of patient safety, risk management and pharmacological treatment. 42% of the survey participants indicated they sit on the nursing practice/policy committee which reviews and updates policies and standards.

Indicated applications for usage was concentrated into two groups:

1. Educate/increase other healthcare professionals' awareness;
2. Implement patient safety alerts/message

Top reasons for use of information: present information at meetings inform superiors and help implement safety information in their work areas.

The overall rating of how effective they think the FDA PSN would be in assisting with their role in hospitals was 3.8 on a scale from 1-5, 5 being most effective.

73% requested receiving a regular monthly notice from the FDA PSA.

83% indicated an interest in stories not relevant to their specialty, citing the reason: encouraging interdepartmental communications of FDA PSN.

Inservices provided an opportunity to educate key healthcare professionals towards a positive outcome: to utilize FDA PSA as a key resource of information and implement recommendations to help prevent adverse outcomes related to medical errors.

Location Access and Preferred Method of Viewing FDA PSN:

Indicated action for accessing FDA PSN was: view broadcast over the internet (69%); and read stories over the internet (67%). In comparison only 17% said they would download broadcast and only 14% said they would view over satellite if available. A wide range of locations were noted from nurses station, department and in-patient hospital units, hospital office and at home.

Perception of FDA as an information source:

70% indicated that FDA being a credible source affects their decision to use FDA PSN; 60% felt other sources carried more weight than FDA; 50% felt other sources had more current information. "Current" did not refer to frequency of broadcasts, but the perception that FDA has less immediacy than other of sources (e.g. Pharma companies, product manufactures). There is a disconnect between FDA's regulatory role and how that guarantees the most accurate top-down information.

Format and Presentation:

69% found the stories informative and appealing. Grouping stories by specialty achieved a mean score of 4.1 on a scale from 1- 5, with '5' being 'strongly agree'

The majority stated the service would be more effective if the stories were grouped by specialty. Examples put forward: by disease state and areas of practice – e.g. Oncology, Cardiology, and Pediatrics etc. Consistent reason: this would help to reduce time when searching for information to implement best practices and when quickly viewing service to select stories of immediate interest.

Conclusion

After watching the FDA PSN November broadcast, healthcare professionals reported its positive impact on their role in hospitals, and indicated their intention to communicate FDA messages and solutions within their institute to help promote a safe environment. Several locations within their work environment and home were chosen for FDA PSN access.

A high rating was given for grouping stories by specialties to facilitate easy access to stories of interest and to reduce time spent when researching for best practices.

The FDA PSN assessment initiative proved highly effective in increasing awareness of this government service - ultimately increasing utilization and implementation of FDA PSN as a solution based patient safety tool.

More research is required to measure the impact that educating healthcare professionals on a regular bases has on adopting safe practices. The hypothesis is that: completing the circle of reporting/providing feedback of the root-causes of and solutions for preventing medical errors to healthcare professionals will, in turn, result in implementation of solution strategies and reduction of errors.

Recommendations

1. Increase usage of FDA's PSN by healthcare professionals

Allocate resources to increase use by healthcare professionals and to capitalize on the existing FDA – a tool that fulfills key needs:

- √ Provides top-down source information and solutions
- √ Is highly accessible to all targeted healthcare professionals
- √ Not time consuming to use

Rationale:

98% of healthcare professionals surveyed stated they would use the information to promote change for improved safety systems. Yet 83% of the healthcare professionals surveyed were not aware of FDA PSN prior to the inservice. Only 2% stated they would not use service.

- In light of the focus on patient safety, it is timely for the FDA to be providing education and information to healthcare professionals. With awareness of the service FDA PSN can be an integrated part of the patient safety system in all healthcare settings.
- Research and national agencies support increased communication to healthcare professional at direct point of care. Providing knowledge and increased awareness of medical errors and root-causes can change practices and prevent future medical errors.
- FDA PSN has the potential to positively impact a vast population of healthcare professionals where credible information is crucial for providing a safe healthcare environment for their population.

Accessibility

To maximize its use and usefulness, FDA PSN must capitalize on its unique ability: to provide the most immediate and accurate information and solutions , leading to proactive changes in practices and updated guidelines.

Participants indicated they would now access FDA PSN in several different locations. Top location cited was the at home (57%) and nurse' station (38%). Indicated action of accessing FDA PSN was view broadcast over the internet (69%) and read stories over the internet (67%). In comparison only 17% said they would download broadcast and only 14% said they would view over satellite if available.

Factors indicating a positive outcome on increased potential usage

1. Survey suggests extremely high acceptance and intent to use by healthcare professionals to implement safety practices to reduce preventable medication errors and solutions associated with appropriate product use.
2. IOM committee recommendations to develop a standard method to disseminate results of adverse events and medical errors to impact patient safety systems.
3. JCAHO Patient Safety Standards
4. National call to establish a safe healthcare environment
5. Easy accessibility and acceptance of the internet

Proposed Plan

Develop a national education strategy and implementation plan, to increase awareness and to promote widespread usage of FDA PSN

It is anticipated that:

- A one-time investment to raise awareness, with multiple component options, will achieve exponential use
- A staged roll out can be structured
- After initial investment in awareness strategy, on-going awareness will require minimal associated costs

1. On site educational sessions (inservices);
2. Utilize Healthtv survey participants - who have expressed interest in further participation - to give input on in-hospital messaging vehicles,
3. Create standardized print message that is re-purposable across multiple platforms.

Recommendation

2. Educate healthcare professionals on FDA's role and responsibilities.

Rationale

While 70% indicated that FDA was a credible source which would affect their decision to use FDA PSN, 60% felt other sources "carried more weight", had higher authority and greater responsibility for patient and product safety than FDA. 50% felt other sources had more current information. *Note: "Current" did not refer to frequency of broadcasts, but the perception that FDA has less immediacy than other sources (e.g. Pharma companies, product manufacturers)*

Proposed Plan

1. Couple education on FDA's role and responsibilities with PSN inservices
2. Use PSN to further increase awareness of FDA role and responsibilities

Recommendation

3. Format Modifications for a more Healthcare-Friendly Format

Rationale

'Group by specialty' achieved a mean score of 4.1 on a scale from 1- 5, with '5' being 'strongly agree'

The majority stated the service would be more effective if the stories were grouped by specialty. Examples put forward: by disease state and areas of practice – e.g. Oncology, Cardiology, and Pediatrics etc. Consistent reason: this would help to reduce time when searching for information to implement best practices and when quickly viewing service to select stories of immediate interest.

Proposed Plan

1. Group stories by specialty.

Recommendation

4. Gather additional data to serve as a benchmark for all further initiatives on educating professionals on medical errors and the root-cause to prevent similar errors occurring in the future.

Rationale

Research has supported direct costs saved by implementing a computerized medication order entry system, but more research is needed to estimate the effects of direct healthcare professional education and increased awareness of adverse and near missed events and their root causes.

98% stated they would use the information obtained from FDA PSD to increase awareness of messages and to promote change for improved safety system. Only 2% stated they would not use service.

Inservices sparked discussion about strategies to increase awareness and implementation of FDA PSN within their own institution.

Proposed Plan

1. A government-supported research project to evaluate FDA PSN's impact on reducing medical errors

Two hospitals will be selected to participate in a research project in which Healthtv™ will facilitate widespread implementation of FDA PSN. A subsequent evaluation will be undertaken to measure the impact of education on reducing medical errors and associated cost savings.

Recommendation

5. Provide reported information to healthcare professionals via FDA PSN. This will complete the circle of communication in a coordinated effort to reduce adverse and near missed events.

Rationale

In the Performance Goal for Fiscal -Year 2004, the FDA would like to expand its surveillance system to a wider reach of hospitals.

FDA PSN can be utilized to promote availability of and use of the surveillance system. This will greatly benefit hospitals that are mandated by JCAHO to implement safe practices and standards. While JCAHO provides standards and goals, it does not provide a method or action plan for implementation. Nor does JCAHO focus on specific medications and medical products. As a result, hospitals are working individually, on in-house reporting systems and internal communication vehicles. There is no coordinated national mechanism for the sharing of and learning from this collected information.

FDA PSN could be an effective educational tool to communicate to a large national population of healthcare professionals on a wide range of medication and product safety information collected by the FDA and other surveillance/reporting systems.

This will complete the circle of communication, in a coordinated effort to reduce medical errors.

Proposed Plan

1. Encourage an internal (FDA) communication mechanism to provide PSN with events reported by FDA surveillance systems. in turn, FDA PSN is the communication vehicle to disseminate this information - and solutions - to healthcare professionals.

Appendix 1

Findings Brief

Breakdown on the respondents:

68% RNs
10% MDs
13% Other
6% PharmD
2% RD

42% Nursing Practice/Policy Committee
18% Patient Safety Committee
21% Other
11% Pharmacy & Therapeutics Committee
9% Risk Mgt Committee

Assessing awareness and value of PSN among FDA desired target group:

- 83% were not aware of the FDA PSN prior to inservice.
- 98% will now use service as a resource for staff education and/ or promoting patient safety.

3.8 on a scale from 1-5, 5 being 'most effective' for FDA PSN in assisting with their role in hospital.

Top Reasons For Use Of Information:

- Present information at meetings
- Inform superiors
- Help implement safety information in their work areas.

Note: Usage concentrated into two groups: educating/increase awareness to other healthcare professionals; implementation for patient safety alerts/message
Increase awareness will net wider distribution of information presented on PSN to promote reduction in adverse events and medical errors. Messages and alerts Implemented into best practice directly impact the reduction of medical errors, adverse events and near misses.

Perception of FDA as an information source:

- 70% indicated that FDA being a credible source affects their decision to use FDA PSN
- 60% felt other sources carried more weight than FDA
- 50% felt other sources had more current information

The Health Television System Inc.

Note: "Current" does not refer to frequency of broadcasts, but the perception that FDA has less immediacy than other of sources (e.g. Pharma companies, product manufactures). There is a disconnect between FDA's regulatory role and how that guarantees the most accurate top-down information.

73% request receiving regular monthly notice

56% have opted in for a follow-up survey

69% of the healthcare professionals surveyed stated they would view the broadcast over the internet.

A wide range of accessibility was noted from nurse's station, department and in-patient hospital units, hospital office and at home.

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Appendix 2

Healthtv/ FDA Patient Safety News Final Survey Results: Winter 2004

Survey Items	Final Results (1/24/04) N= 104
Q1 Aware of FDA PSN	17% Yes 83% No
Q2 Which likely to do	69% View broadcasts 67% Read stories 17% Download 14% Watch on satellite 2% None
Q3 Where likely to access	38% Nurses' station 37% Dept/Unit computer 13% Hospital library 28% Your hospital office 53% At home 3% Other
Q4 How use the information	38% Print info 14% Email link 24% Present info at meeting 26% Inform your superiors 40% Help implement safety 24% Take action leading to change 14% Show PSN at orientation or inservices 3% Other 2% Probably wouldn't use it 17% All the above (except "not use it")
Q5 PSN from FDA—How would it affect your use	62% More likely to watch – FDA credible source 30% More likely to watch – FDA carry more weight 44% More likely to watch – Provides current info 5% Less likely to watch 7% No difference 2% All the above(except less likely & no difference)

The Health Television System Inc.

Q6 More likely to use FDA info (Scale 1-5)	3.6 (mean score)
Q7 Grouped by specialty (Scale 1-5)	4.1 (mean score)
Q8 Watch stories not related to specialty	83% Yes 17% No
Q9 Found presentation	69% Informative & appealing 28% Informative, but not appealing
Q10 Effectiveness of FDA's PSN (Scale 1-5)	3.8 (mean score)
Q11 Receive notification	73% Yes 27% No
Q12 Participate in follow-up survey	56% Yes 44% No

Notes

Items 2, 3, 4, & 5 allowed participants to select all items as appropriate, therefore, percentages were calculated from all possible items selected and divided by the total number of participants

Appendix 3

Chart 1

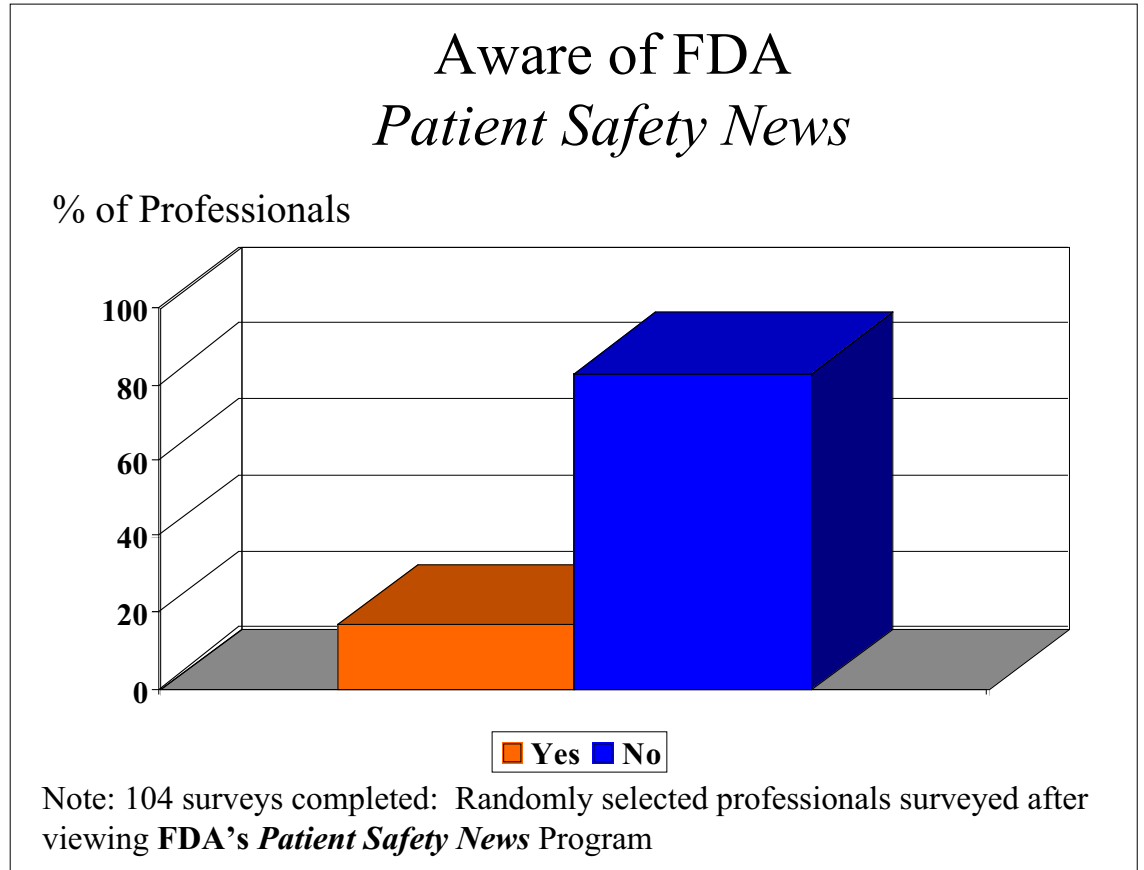


Chart 2

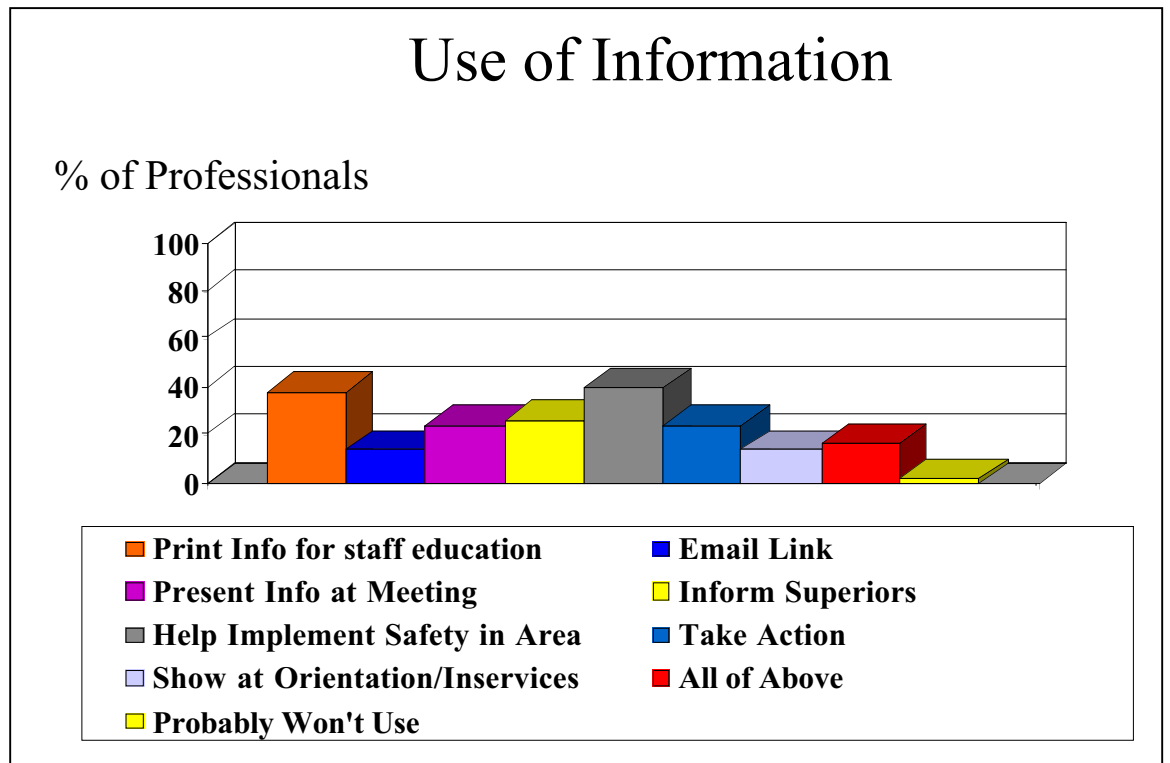


Chart 3

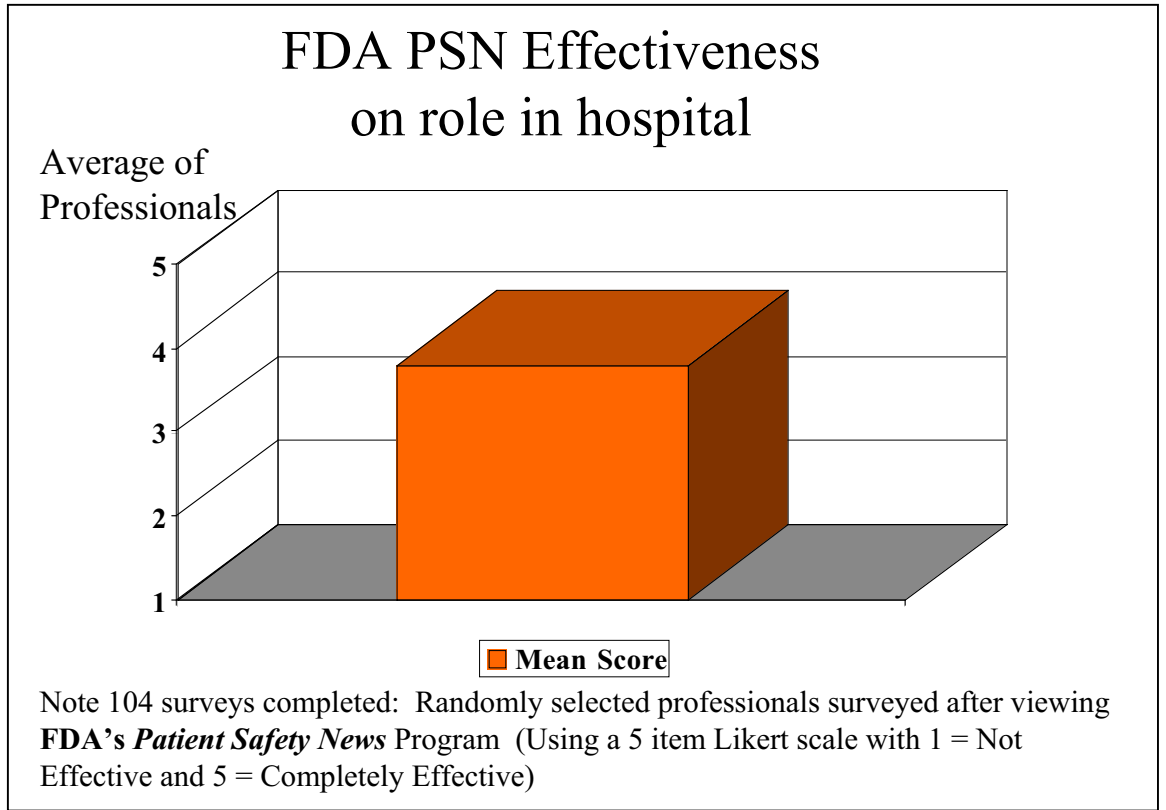


Chart 4

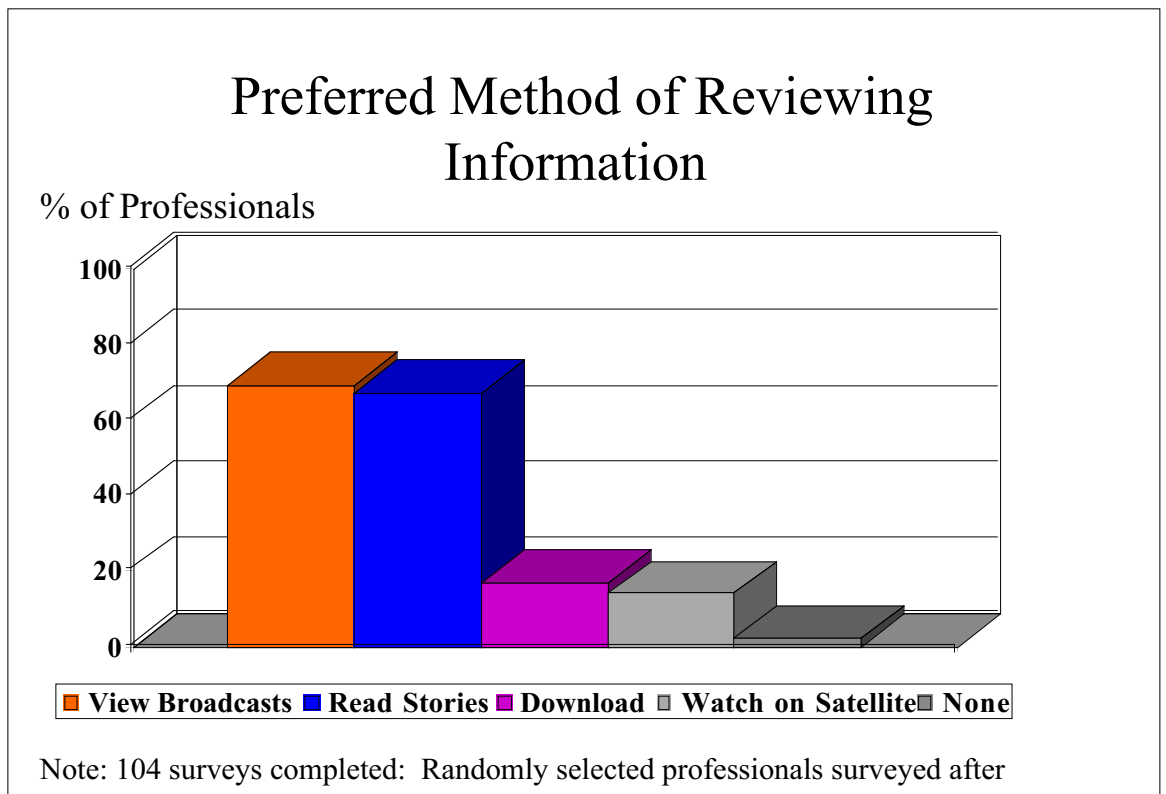


Chart 5

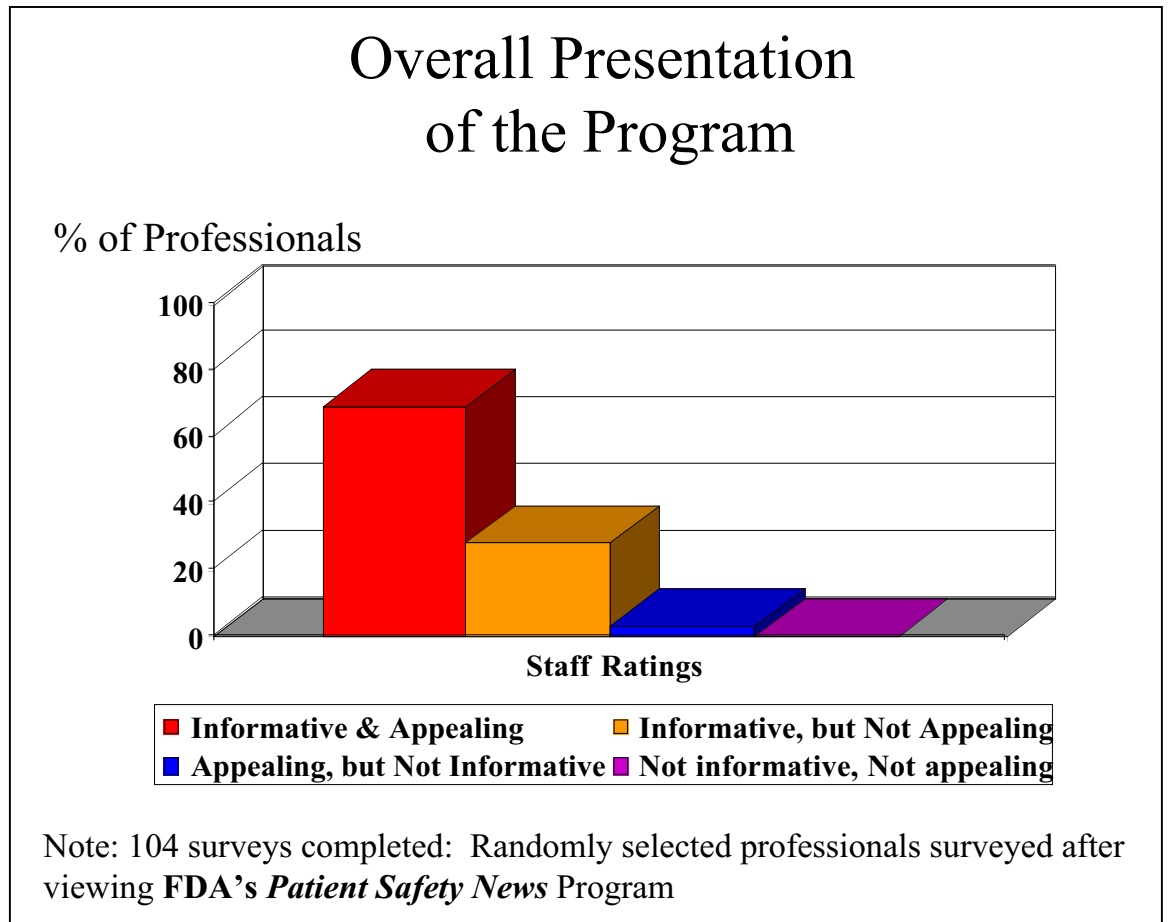


Chart 6

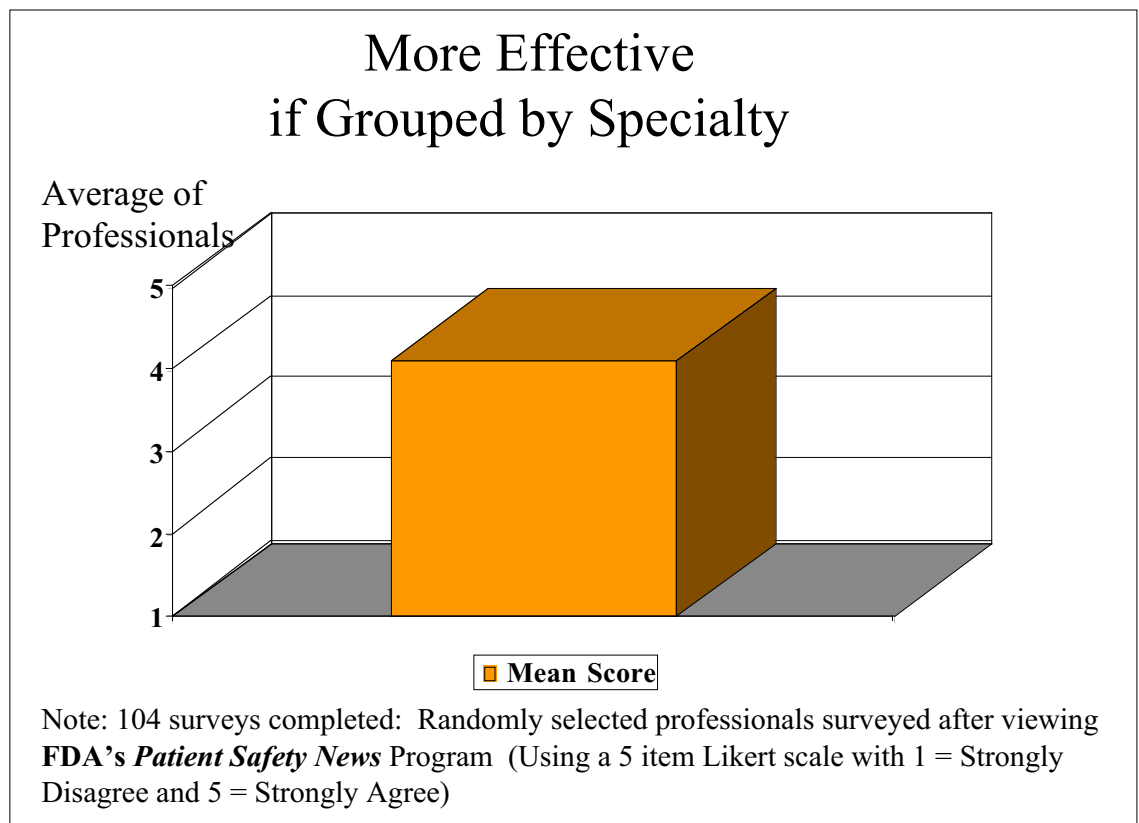


Chart 7

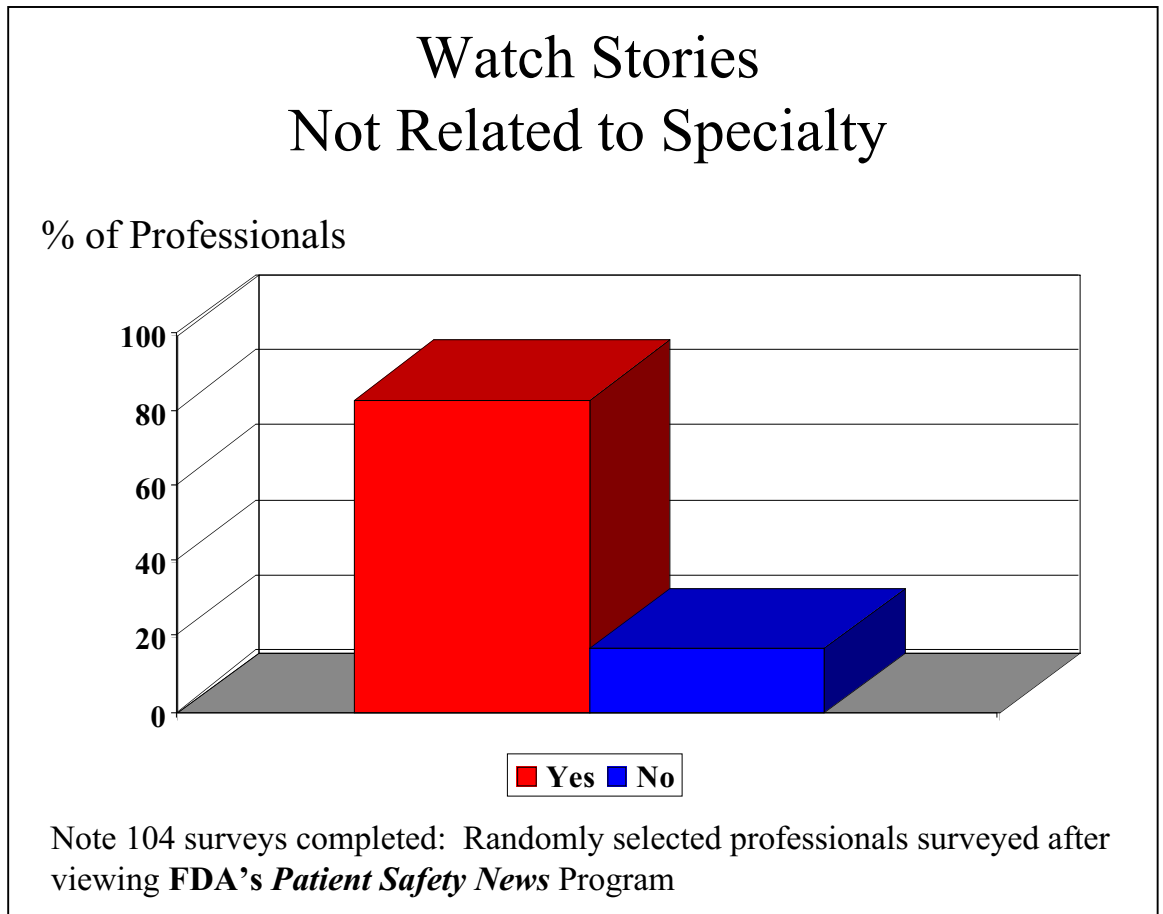


Chart 8

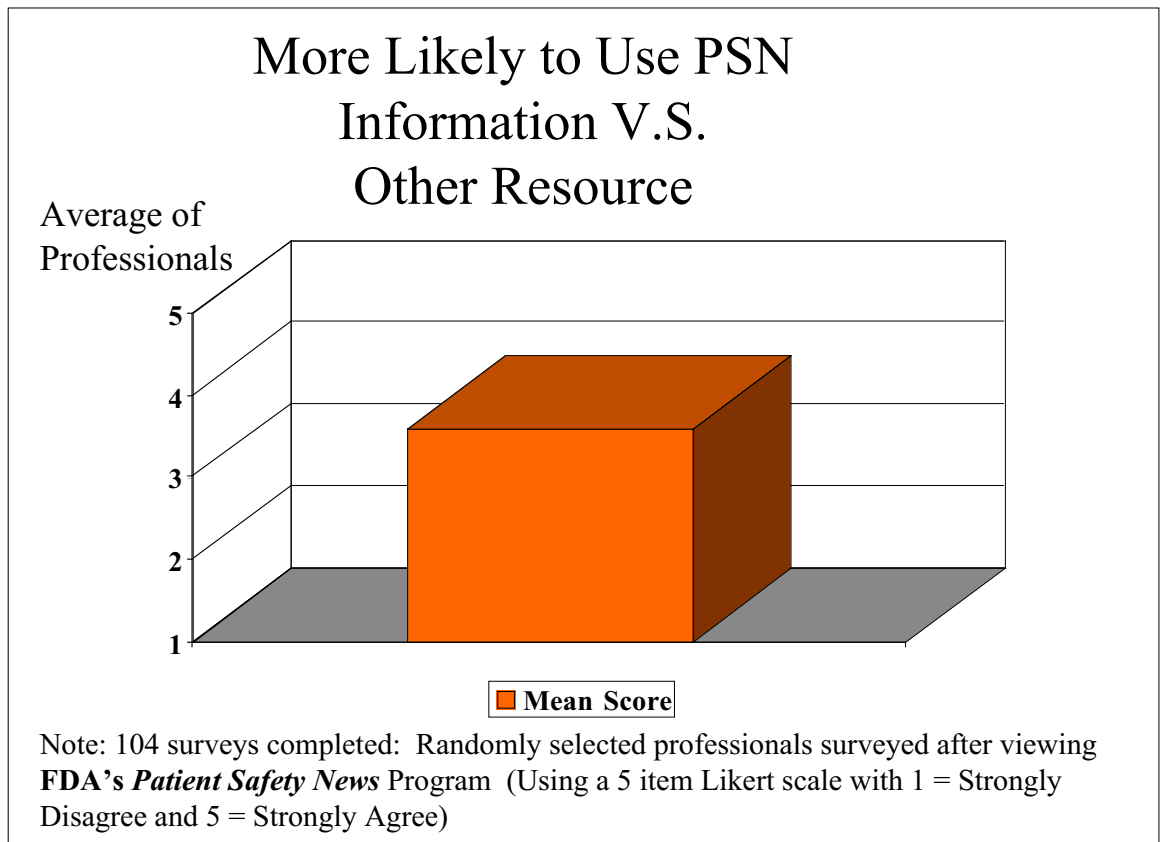
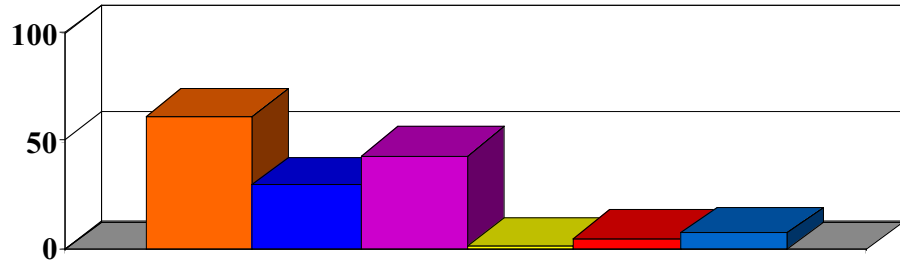


Chart 9

Assessment of FDA as an Information Source

% of Professionals



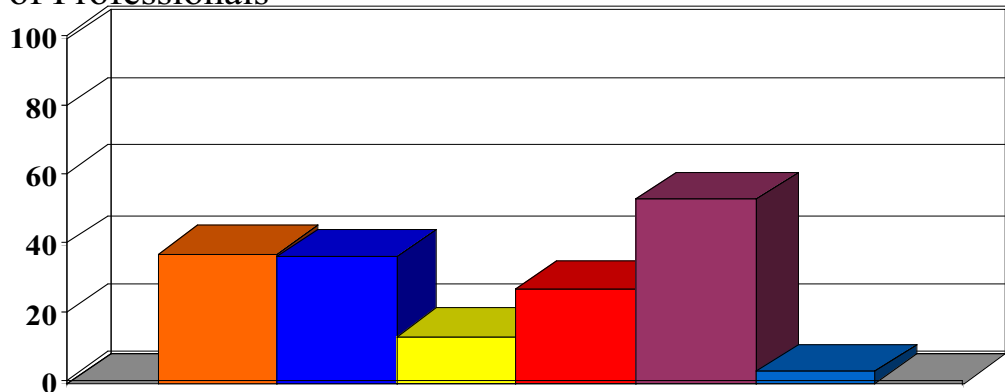
- More Likely to Watch - FDA Credible Source
- More Likely to Watch - FDA Carry More Weight
- More Likely to Watch - FDA Provides More Current Info
- All of Above
- Less Likely to Watch
- No Difference

Note: 104 surveys completed: Randomly selected professionals surveyed after viewing FDA's *Patient Safety News* Program

Chart 10

Where Likely to Access FDA PSN Website

% of Professionals



- Nurses' Station
- Dept/Unit Computer
- Hospital Library
- Your Hospital Office
- At Home
- Other

Note: 104 surveys completed: Randomly selected professionals surveyed after viewing FDA's *Patient Safety News* Program

Appendix 4

Questionnaire- Survey Tool



FDA Patient Safety News Survey

The FDA (Food and Drug Administration) regulates many products including: prescription and over-the counter medications, medical devices, vaccines, blood products, foods and cosmetics.

FDA Patient Safety News (PSN) is a video news show issued monthly by FDA for healthcare professionals. It features information on new drugs, biologics and medical devices approved by FDA, safety notifications and product recalls, and ways to protect patients when using medical products.

We would like your opinions on FDA Patient Safety News (PSN). Your participation is voluntary, and your responses will be confidential.

Please tell us about yourself:

- Hospital: _____ City _____ State _____
- Professional initials/healthcare professional title: MD RN PharmD Other _____
- Job Title: _____

- Committee member *Circle one or more of the following committees:*
Patient Safety Committee, Risk Management Team, Nursing
Practice/Policy/Procedures, Pharmacy & Therapeutics Team, Other: _____

- Your Department: *Circle one* - Nursing, Pharmacy, Risk Management, Quality
Management, Administration, Other: _____

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Please circle your responses:

1. Prior to this inservice, were you aware of FDA Patient Safety News? Y N

2. Now that you're aware of it, which of the following are you likely to do? (check all appropriate answers)
 - View broadcasts on the internet
 - Read stories on the internet
 - Download the broadcast from the internet to view later
 - Watch broadcasts on satellite network (if available)
 - None of the above

3. Where would you be likely to access FDA PSN ? (check all appropriate answers)
 - Nurses' station
 - Dept /Unit computer
 - Hospital library
 - Your hospital office
 - At home
 - Other

4. How might you use information obtained from FDA PSN? (check all appropriate answers)
 - Print written information and post for department staff
 - Email link for other staff members to view
 - Present information at committee meeting
 - Inform your superiors of the relevant alerts and information
 - Help implement safety messages on your unit, in your dept, at your hospital (i.e.- check expiry dates on medication within your dept.)
 - Take action leading to change in practices and policy
 - Show FDA PSN during staff orientation or staff inservices
 - Other
 - I probably wouldn't use it

5. Unlike other sources of information, FDA PSN comes directly from the FDA. Would this affect whether or not you'd watch it? (check all appropriate answers)
 - More likely to watch because FDA is a more credible source for this type of information
 - More likely to watch because FDA recommendations carry more weight than advice from other sources
 - More likely to watch because FDA PSN provides more current/up-to-date information
 - Less likely to watch because it presents just the FDA's viewpoint
 - No difference

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6. I am more likely to use the information in FDA PSN than similar information that I can get elsewhere.

Strongly Disagree Strongly Agree
1 2 3 4 5

7. FDA PSN would be more effective if stories were grouped by specialty (i.e. oncology, cardiology, general medicine, surgery).

Strongly Disagree Strongly Agree
1 2 3 4 5

8. Are you interested in watching stories on FDA PSN that are not directly related to your specialty?

Y N

9. Do you find the presentation of the broadcast? (check one answer)

- informative and appealing
- informative, but not appealing (needs change in format or presentation)
- appealing, but not informative
- not informative, not appealing

10. Please rate how effective you think FDA PSN will be for you in your role at the hospital.

Not Effective Completely Effective
1 2 3 4 5

11. Would you like to receive notification about new FDA PSN broadcasts? Y N

12. Would you like to participate in a follow up survey? Y N

Please add my name to the FDA PSN listserv to receive a monthly email, which provides a list of the latest stories and links to the FDA PSN website:

Name _____ **Institution** _____
Mailing address _____ **City** _____ **State** _____
Phone number _____ **Email address** _____