注意：作答請簡要並提出重點，每個題目以不超過一千字為原則。

一、請論述您對嚴重急性呼吸道症候群(SARS)的瞭解及看法，並闡述您衛生政策上的建議（25%）。

二、請描述一個您在臨床工作中面臨需作決策的情境，並以您所學過的理論背景探討當時決策的優缺點（25%）。

三、請論述您認為一個領導者最重要的三大特質（25%）。

四、請閱讀下頁所附文章並回答以下問題：

1. 簡述所選文章的重要論述及其對實務工作的建議（10%）。

2. 此文章激發你想探究哪些臨床行政議題（15%）。

LETTER TO THE EDITOR

Errors in Nursing

The nursing profession must debate issues surrounding the causes of medical error and accountability. Therefore, the insights provided by the authors of individual, practice, and system causes of errors in nursing[1] are welcome. Unfortunately, I believe they have perpetuated a myth that forestalls real progress: the notion that elimination of error requires individual flawlessness and practice perfection. While I applaud their attempt to quantify errors, their taxonomy measurement method will only maintain the punitive status quo culture of blame, shame, and train—a culture that continually places the safety of patients in jeopardy.

Researchers who study the relationships between human factors and human error acknowledge that the last failure in a system is usually that of a human mistake occurring in the automatic or problem-solving mode. They accept that all humans frequently err. But what experts in the safety movement also realize is that errors are caused not by individual flaws or practice failures. Rather, errors result from multi-factorial system-based failures that reside in healthcare organizations that fail to incorporate adequate safety system measures.

Latent failures in flawed systems frequently predestine nurses to commit errors that are often beyond their individual control. This was clearly demonstrated in the well-publicized Denver case where a nurse administered a tenfold overdose of penicillin G benzathine intravenously, resulting in the death of a newborn infant. One nurse, who was indicted on criminal negligent homicide, was found not guilty after a system analysis presented to the jury revealed over fifty latent failures in the organization that caused this tragic error. Had any one of these failures in the system not been present this error would not have occurred.[2]

System flaws are not just inherent in healthcare organizations but also reside in the educational process where nursing schools have not adopted a nonpunitive collaborate approach to patient safety. These flaws are also prevalent in regulatory oversight agencies and boards of nursing where patient safety continues to be a reactive force rather than proactive function.

It is easy and natural to blame individual nurses when errors occur and resort to traditional error reduction efforts such as disciplinary action to improve performance. But reliance on correcting human performance has been an unprofitable path in healthcare. The result of disciplining nurses can even be dangerous to patients because it creates an incentive for practitioners to conceal their errors for fear of losing their job or license. Worse, it focuses attention on the least manageable component of an error, the individual, rather than the most manageable component, the system.

Patient safety is best served when we recognize the inevitability of human error and begin to address system-based failures, which if remedied, can prevent the error from reaching the patient. We all must recognize that it is often the most caring and competent nurse who is involved in serious errors. Nursing leaders must come to accept the prevailing thinking—nurses are human and anyone of us has and will make errors. The acceptance of this notion is paramount if we are ever going to enhance safety by removing the jeopardy that our patients are now experiencing.

References

1. Benner P, Sheets V, Uris P, Malloch K, Schwed K, Jamison D. Individual, practice, and system causes of errors in nursing: a taxonomy. *J Nurs Admin.* 2002;32(10):509-523.
2. Cohen MR, Smetzer JL. Lesson from the Denver medication error/criminal negligence case: look beyond blaming individuals. *Hosp Pharm.* 1998;33:640-657.

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