PATIENT SAFETY BLOG

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Two Steps Forward, One Step Back for Patient Safety in Hospitals

January 9, 2012 by Patrick A. Malone

There's been a lot of good news lately about what hospitals are doing to protect patients: Many have improved their infection control practices, many are looking at the value of "hospitalists" (doctors who practice exclusively with inpatients) and many have embraced palliative care.

Yet for every two steps forward for patient safety, it appears as though many hospitals are taking at least one step back. As reported last week in The New York Times, a federal report concluded that hospital employees recognize and report only 1 in 7 errors, accidents and other events that harm Medicare patients.

An even more shocking revelation in the report by Department of Health and Human Services investigators is that once hospitals do investigate preventable injuries and infections, they seldom change their practices to thwart them from recurring. This despite the fact, as HHS Inspector General Daniel R. Levinson pointed out, that Medicare reimbursements to hospitals are contingent on them tracking such errors and adverse events, analyzing and addressing them.

"Adverse events" are those that cause significant harm experienced by patients as a result of medical care.

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As the Times reported, “Despite the existence of incident reporting systems,” Levinson said, “hospital staff did not report most events that harmed Medicare beneficiaries.” And, he said, some of the most serious problems, including some that caused patients to die, were not reported.

The report found that “hospitals made few changes to policies or practices” even after employees reported harm to patients. In many cases, hospital executives told federal investigators that the events did not signify any “systemic quality problems.”

Among the problems enumerated were:

- medication errors;
- severe bedsores;
- hospital-acquired infections;
- delirium caused by overuse of painkillers; and
- excessive bleeding linked to improper use of blood thinners.

Levinson estimated that more than 130,000 Medicare beneficiaries experienced one or more adverse events in hospitals in a single month, and that many hospital administrators knew that hospital staff were underreporting them.

Whereas once hospital employees were afraid to admit mistakes for fear of reprisal, that doesn’t seem to be the problem here. Rather, Levinson said, it’s that hospital employees don’t recognize “what constitutes patient harm,” nor do they realize that certain events harm patients and should be reported. And sometimes they just assume someone else will report the episode, they believe it to be so common as to be insignificant or they assume it is an isolated event unlikely to be repeated.

For more information about hospital errors, and what you can do about them, see this page on our website.

In response to the confusion described by the HHS report, Medicare officials said they would develop a list of “reportable events” hospital employees could use to eliminate questions about what’s required and what isn’t. In addition, the Medicare agency said, hospitals should give employees “detailed, unambiguous instructions on the types of events that should be reported.”

You mean they haven’t already done so?

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