amednews.com
AMERICAN MEDICAL NEWS

PROFESSION

Hospitals urged to end punitive responses to error reports

Doctors and nurses who share information about adverse events and unsafe conditions should not fear retribution, says a report from quality officials.

By KEVIN B. O'REILLY, amednews staff. *Posted Nov. 5, 2012.*

The leaders of U.S. hospitals need to spearhead changes to encourage physicians and other health professionals to report the quality and safety problems they witness, said a report released in October.

The "call to action" was issued by the National Assn. for Healthcare Quality, which represents more than 10,000 professionals worldwide who are charged with administering hospital quality measurement and adverse-event reporting programs.

"If individuals fail to report near misses and significant events, underlying systemic issues will remain unseen and unaddressed," said the report, which comes amid evidence casting doubt on the effectiveness of hospital error-reporting systems.

Hospital leaders need to make clear that quality and safety reporting systems should not be gamed, the NAHQ report said. Executives and clinical leaders also should protect health professionals who report problems from retribution or intimidation and respond to problems with timely, effective improvement plans. Doing all of this is key to creating a stronger "safety culture" in hospitals, the report said.

"The reason I think this is coming up now is not because things are necessarily getting worse, but they are getting more visible," said Cynthia Barnard, lead author of the report and director of quality strategies at Northwestern Memorial Hospital in Chicago. "As more and more payers link reimbursement to quality measures, there are higher stakes associated with quality data and quality reporting."

Nearly 90% of harmful inpatient adverse events are not captured by hospitals' incident-reporting systems, said a January report from the Dept. of Health and Human Services' Office of Inspector General. Of the 18 most serious events identified in the report — ones involving death or permanent disability — only two were reported, said the OIG's study of 780 randomly sampled Medicare patients' hospital stays.

Although the OIG did not name fear of retribution as a reason for failing to report adverse events, survey results released by the Agency for Healthcare Research and Quality in February suggest that many health professionals are concerned that reporting safety problems means asking for trouble. Of nearly 600,000 staffers surveyed at more than 1,100 hospitals nationwide, 54% said that when an adverse event is reported, "it feels like the person is being written up, not the problem."

Error reporting seen as ineffectual

Another contributor to nonreporting of near mistakes in hospitals is that it sometimes appears to have little impact. In the AHRQ survey, 39% of respondents said "hospital management seems interested in patient safety only after an adverse event happens." Thirty percent of the time, hospital administrators choose not to further investigate adverse events after they are reported, the OIG said.

That problem is addressed in the quality professionals' report. The NAHQ says health care leaders should "establish and enforce policies for responding to a quality or safety concern" and, "as appropriate, escalate the response to the issue along the organizational chain of responsibility."

The NAHQ's report contains solid suggestions, but putting them into action at the organizational level is the big challenge, said Sara J. Singer, PhD, assistant professor in the Dept. of Health Policy and Management at the Harvard School of Public Health.

"It's easier said than done," said Singer, who studies the relationship between hospitals' professional culture and medical-error reduction. "It's not simply a matter of creating a reporting system, but once you've created a reporting system, you have to do everything you possibly can to reinforce people's use of that reporting system to make them feel safe to do it and that doing it is worthwhile. What it takes to do that is different in different organizations."

AHRQ officials agreed that the quality professionals' report, while useful, could have benefited from offering more concrete suggestions to help hospitals overcome under-reporting. They also noted that the Patient Safety and Quality Improvement Act of 2005 protects analysis of quality information from legal discovery when it occurs under the auspices of a designated patient safety organization. There are 78 PSOs in 30 states and the District of Columbia, encompassing more than 1,600 hospitals, according to AHRQ.

The growing use of health information technology is likely to increase the proportion of adverse events and near misses that get reported and acted upon, said William B. Munier, MD, director of AHRQ's Center for Quality Improvement and Patient Safety.

"It's a consumer-oriented world, with the Internet and the focus on improving value," Dr. Munier said. "Electronically processed medical information that becomes more and more widely available is going to push us to better data and more transparency."

ADDITIONAL INFORMATION:

5 steps to a stronger "safety culture"

Many hospital adverse events go unreported because doctors and other health professionals are concerned that sharing information about safety problems would get them into trouble. A report by health care quality professionals says fixing the problem would require hospital leaders to:

- Create a focus on accountability for quality and safety as part of a strong and just culture.
- Help clinicians recognize their responsibility for quality and safety.
- Ensure that protective structures are in place to encourage reporting of quality and safety concerns.
- Ensure comprehensive, transparent, accurate data collection and reporting to internal and external oversight bodies.
- Ensure an effective response to quality and safety concerns.

Source: "Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems," National Assn. for Healthcare Quality, October (**www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf**)

WEBLINK

"Hospital Survey on Patient Safety Culture: 2012 User Comparative Database Report," Agency for Healthcare Research and Quality, February (**www.ahrq.gov/qual/hospsurvey12/**)

"Hospital Incident Reporting Systems Do Not Capture Most Patient Harm," Dept. of Health and Human Services Office of Inspector General, January (**oig.hhs.gov/oei/reports/oei-06-09-00091.asp**)

"Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems," National Assn. for Healthcare Quality, October (**www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf**)

RELATED CONTENT

» **Hectic pace pressures medical practices on quality** June 18
» **Celebrities make pitch for patient safety panel** May 14
» **Fear of punitive response to hospital errors lingers** Feb. 20
» **Clarity needed on how and when to report medical adverse events** Jan. 23
» **HHS sets rules for confidential medical error reporting system** Dec. 15, 2008