Hospitals Fall Short on Adverse Event Reporting

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Nearly all U.S. hospitals have a centralized system for reporting adverse events, but only about 20% are distributing and discussing the findings widely across their organization, according to national survey data.

The survey, conducted by the RAND Corporation and the Joint Commission from September 2005 to January 2006, also found that hospitals fell short in terms of how they collected adverse event reports. Only about a third (32%) of hospitals surveyed had established an environment that fostered reporting through confidentiality, and only 13% had broad staff involvement in reporting.

The survey included responses from 1,652 U.S. hospitals, about 63% of which were general medical-surgical hospitals. The survey and the analysis were funded by the Agency for Healthcare Research and Quality with the goal of establishing baseline data on internal adverse event reporting in U.S. hospitals (Qual. Saf. Health Care 2008;17:416-23). The researchers reported no conflicts of interest.

The investigators found strong agreement among hospitals about what elements should be included in adverse event reporting systems. For example, nearly all hospitals included information on patient demographics, personnel involved, follow-up treatment, and actions taken.

However, hospitals varied widely in terms of how information was used and who reported it. Only about 20% of hospitals surveyed reported that they distributed summary reports of adverse events broadly to nurses, physicians, and hospital administrators, and that the reports were discussed by the hospital board and medical executive committee. Hospitals with patient safety programs were more likely to discuss adverse events. In contrast, critical access hospitals, teaching hospitals, and hospitals with computer-only reporting systems were less likely to discuss adverse event findings within hospital board and medical executive committees.

It will take time for something as complex as adverse event reporting to become part of the culture, just as new medical therapies take 10-15 years to be adopted into routine clinical practice, said Dr. Peter Lindenauer, director of the Center for Quality and Safety Research at Baystate Medical Center in Springfield, Mass.; he was not involved in the analysis.

"Engaging physicians is difficult because they already feel stressed for time, and because they may not sense that there are direct benefits to them from reporting," said Dr. Lindenauer, who also is an associate professor of medicine at Tufts University in Boston.

A recent report from the Department of Health and Human Services Office of Inspector General found similar trends. Hospital staff may fail to report adverse events because they don't believe action will be taken, they lack time to complete documentation, they assume another staff member will report the incident, or they fear punitive action, the report said.

The key to making an adverse event reporting system successful is similar to making any other major organization change, Dr. Lindenauer said. Hospitals must establish a rationale for change, ensure readiness, and communicate a clear vision as to why the event reporting system is an improvement over the status quo. Hospital leaders must also promote participation and develop a clear and consistent communication plan, he said.

"Safety reporting represents one of the best ways for organizations to discover opportunities to enhance the safety and quality of care," he added. ■