Liability Jitters May Impede Patient Safety System

BY NELLIE BRISTOL
Contributing Writer

WASHINGTON — The patient safety system signed into law this summer by President Bush will likely take many months to implement—and is likely to demand some adjustment in physician attitudes about error reporting.

Under the new law, a "patient safety work product" of reported errors and near misses is privileged and cannot be used in legal or disciplinary actions. Data collected can be used in a criminal trial only after the court makes a determination that the evidence is "material to the proceeding" and "not reasonably available from another source," according to text of the Patient Safety and Quality Improvement Act of 2005.

The structure will allow providers to voluntarily submit information to patient safety organizations certified by the Department of Health and Human Services. Patient confidentiality must be maintained. The purpose of the system is to create a searchable database of medical errors that can be analyzed and used to develop new care systems and best practices that would avoid similar errors in the future.

The law authorizes federal funding for fiscal years 2006-2010. Implementation could begin as early as next year, said Gordon Wheeler, associate executive director for public affairs for the American College of Emergency Physicians, noting that for that to happen, the HHS "secretary's got a lot to do to set it up."

It may take physicians a while to trust the new system.

DR. FLEMING

HHS must coordinate databases nationwide into a single aggregated interactive resource for providers and patient safety organizations. It also must develop or adopt voluntary national standards to promote the electronic exchange of health care information.

HHS will also certify the organizations, which were described as "new animals," by Margaret VanAmringe, vice president for public policy and government relations at the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

There are several possible models for patient safety organizations, she said, including U.S. Pharmacopeia's MEDMARX system. For a subscription fee, hospitals and health care systems can access MEDMARX's database to track adverse drug reactions and medication errors. Ms. VanAmringe also said groups like JCAHO could develop patient safety organizations, as could medical specialty organizations looking to establish "niche PSOs" to track specific areas, such as anesthesiology.

For physicians, who have operated so long in an environment of liability fear, it may take a while to trust the new system, said Michael O. Fleming, M.D., board chair of the American Academy of Family Physicians.

"Physicians are going to have to get comfortable with this and realize that [documenting errors under the plan] is a thing that you can do now, and it's going to improve quality tremendously," said Dr. Fleming, adding that it may take physicians some time to lose their reporting inhibitions.

Doctors are concerned about reporting something going wrong, because someone will be at fault and liable for that situation, he said. "In medicine, unfortunately, too many times everybody—from staff to nurses to doctors—has been afraid to report things."

Dr. Fleming said the arrangement could help reveal weaknesses in medication dispensing and other systems. "This will give us an opportunity, when these errors occur, to report them without having to worry about the consequences of a liability threat," he noted.

Many patient safety organizations will likely be run by systems analysts and industrial engineers, "I'm hoping there are also going to be peers," Dr. Fleming said. "I think physicians are going to feel much more comfortable if we have peer evaluation."

Ms. VanAmringe said patient safety organizations will not only need to collect data but also have the ability to aggregate and analyze those data to provide institutions with "feedback on common problems." The PSOs will develop solutions and best practices by collating data from different institutions and then monitoring whether proposed interventions work.

"PSOs will play a fairly robust role in using the data that are reported to them," she said.

Federal PSOs will not preempt state laws, even those with mandatory reporting systems, but VanAmringe said many state arrangements are more narrowly focused and do not provide the data analysis expected from federal PSOs. The federal program will provide standardized reporting methods and more in-depth, comprehensive analysis and potentially will develop more solutions to common problems, she said. ■

Hospitals Urged to Develop Rapid-Response Teams

BY BRUCE DIXON
Chicago Bureau

CHICAGO — Expanded use of rapid-response teams should be a key element in efforts to reduce hospital mortality, speakers said at the annual meeting of the Society of Hospital Medicine.

"Few of us get good team training," said John Whittington, M.D., coordinator of clinical informatics and patient safety officer at OSF Healthcare System in Peoria, Ill. "A rapid-response team of clinicians brings critical care expertise to the bedside, where they can assess, stabilize, improve communication, educate, support and assist with patient transfer when necessary."

Development of rapid-response teams is a cornerstone of the systems-based approach advocated by the "100,000 Lives Campaign" of the Institute for Healthcare Improvement, Cambridge, Mass. Supported by the American Medical Association and other private and public sector health care organizations, the campaign aims to prevent 100,000 unintended deaths by June 2006.

Other goals of the 100,000 Lives Campaign include delivery of evidence-based care for patients with acute myocardial infarction, implementation of "medication reconciliation" to prevent prescribing errors, and use of science-based methods to prevent central-line infections, ventilator-associated pneumonia, and surgical-site infections.

More than 2,000 hospitals have joined the effort, Dr. Whittington said. "We decided that instead of a disease-specific focus, we'd go to a systems-specific focus to float the whole boat." By improving teamwork and communications, "you can improve the whole situation in a hospital."

"We can achieve a significant drop in all-cause mortality" by using these teams, he said. "You also see a significant drop in code rate per 1,000 discharges." By improving outcomes, relationships, and job satisfaction, rapid-response teams also may boost employee retention levels and reduce costs.

Dr. Whittington cited an Australian study showing that 76% of cardiac arrests followed more than 1 hour of ongoing instability (Med. J. Aust. 1999;171:22-5). This and other studies identifying missed warning signs show that there are "burning opportunities" for rapid-response teamwork in hospitals, he said.

Terri Simmonds, R.N., director of critical care and patient safety at the Institute for Healthcare Improvement, said that a rapid-response team might be staffed with a respiratory therapist, an intensivist, a hospitalist, a resident, and a physician assistant, depending on a hospital's situation and resources.

The clinicians assigned to the team must be ready to respond quickly, Ms. Simmonds said. "Many organizations set a minimum response time of 5-10 minutes, so that when the nurse on the floor activates the rapid-response team, she knows these individuals are going to show up in 5-10 minutes—and with smiles on their faces."

Members of the rapid-response team need access to proven protocols so that they can take immediate action, Ms. Simmonds added.

She and Dr. Whittington advocated the use of the SBAR (situation, background, assessment, and recommendation) technique, developed by a group at Kaiser Permanente of Colorado. SBAR improves patient care by providing a framework for communication between members of the health care team about a patient's condition. SBAR can encourage nurses to make recommendations that can improve the decision-making abilities of physicians who are willing to listen. ■

Hospitals Face Growing Public Impatience

Nearly 6 years after an alarming Institute of Medicine report on hospital mortality, public trust in the nation's hospitals remains shaky, a spokesman for the American Hospital Association said at the meeting.

In that much-debated 1999 document, the IOM estimated that 45,000-98,000 U.S. patients were dying each year due to preventable medical errors.

"A lot of money and effort are being poured into patient safety, a lot of advocacy groups are inside our institutions, and a lot of hospitals are trying to create cultures of safety and all the rest, yet we have no data. … We have nothing that can assure the public that we're any safer today than we were 5 years ago," Richard H. Wade said. The public "is going to begin to ask questions such as: 'How well are doctors doing at policing and overseeing each other so that the quality of care you put before us can be trusted?' "

In a 2004 poll of 2,012 adults, conducted by the Kaiser Family Foundation, 55% of those asked were dissatisfied with the quality of the care they received in the hospital, he said. Also, 70% of those polled said they would have greater confidence in a hospital that voluntarily reported errors. One-third of the participants said they or a family member had experienced a preventable medical error during a hospital stay; of that group, 70% said they were never told about being the victim of an error. Overall, 92% of those polled said there should be public reporting of medical errors.

None of this is lost on state and federal legislators who have drafted—or are drafting—legislation to make data on hospital medical errors open to public scrutiny, Mr. Wade noted.

"Why haven't hospitals taken the lead to do these things themselves? We're trying to accomplish these things, but it takes time," Mr. Wade said, pointing to the Hospital Quality Alliance sponsored by the AHA, the Association of American Medical Colleges, and the Federation of American Hospitals.

"We sat down 2 years ago and decided to begin to put data in front of the public," he said. The resulting Web site, www.hospitalcompare.com, offers data on hospital treatment of heart attack, heart failure, and pneumonia.