



Rx: Health Care FYI #20

Subject: *Reporting Errors Improves Patient Safety*
From: *Rep. Tim Murphy (PA-18)*

The problem: To address the over 195,000 preventable annual deaths due to medical errors¹, accurate numbers on infection rates and medical and medication errors are necessary for health care providers to improve patient safety.

- Pennsylvania found more than 11,000 patients acquired infections that resulted in 1,500 deaths and \$2 billion in additional charges last year.² These new numbers for **only one state** represent about half of the previous estimate for total nationwide infection costs.
- While the vast majority of hospitals disclose errors, only one-third actually have board-approved policies in place.³
- 69 percent of hospital CEOs believe that a mandatory system would discourage reporting of patient safety incidents to their hospital's own internal reporting system. 79 percent believe that it would encourage additional lawsuits.⁴
- Organizations currently collecting patient safety information need legal protections to share information to promote patient safety.

Disclosure improves patient safety:

- Hospitals encouraging staff to immediately report patient safety concerns without fear of reprimand significantly improves patient safety. For example, nurses at Allegheny General Hospital in Pennsylvania are empowered to bring medical treatments to a halt when they see the potential for infections or errors. This reporting has improved the administration of IV lines in intensive-care-units and resulted in a 90 percent decrease in infections and \$500,000 in annual savings.⁵
- Hospitals participating in CDC's National Nosocomial Infections Surveillance (NNIS) system reduced infections by up to 50 percent by implementing hygiene education training to employees for monitoring and preventing infections.⁶

¹ HealthGrades. Second Annual Patient Safety in American Hospitals Report. May 2005.

² Pennsylvania Health Care Cost Containment Council. Hospital-acquired Infections in Pennsylvania. July 2005.

³ Lamb RM, Studdert DM, Bohmer RMJ, et al. Hospital disclosure practices: results of a national survey. *Health Affairs* 2003;22(2):73-83.

⁴ Weissman, Joel. Error Reporting and Disclosure Systems. Views From Hospital Leaders. *JAMA*. 2005;293:1359-1366.

⁵ Ysocki, Bernard. To Fix Health Care, Hospitals Take Tips From Factory Floor. *Wall Street Journal*. April 2004.

⁶ Centers for Disease Control. Programs in Brief: Patient Safety. January 2004.

- Mercy Health Center in Oklahoma has performed 400 surgeries without any infections by tracking infections and administering antibiotics immediately to surgical patients.⁷

A step in the right direction: H.R. 3205, The Patient Safety and Quality Improvement Act:

- Provides legal protection for health care providers for information reported to patient safety organizations.
- Protects patient privacy by allowing providers to voluntarily disclose **non-identifiable information** for the creation of a National Patient Safety Database for purposes of improving safety and quality.
- Establishes a certification process for patient safety organizations independent of health care providers and insurers.
- Establishes voluntary standards for Health Information Technology (IT) and \$25 million in grants for Electronic Prescribing and Health IT systems to reduce errors to improve the quality of care.

The Federal Government's Role:

- HHS established Hospital Care, a website for consumers to compare quality on hospitals who voluntarily submit data on treatment for heart attack, heart failure, or pneumonia. Available at: <http://www.hospitalcompare.hhs.gov/>
- The CDC's NNIS system voluntarily monitors and prevents adverse healthcare events. Available at: <http://www.cdc.gov/ncidod/hip/Surveill/nnis.htm>
- HHS issued four Requests for Proposal on standards, certification and privacy for the creation of a National Health Information Network. Available at: <http://www.hhs.gov/healthit/contracts.html>

Recommendations:

- Empower employees to report errors without fear of retribution to improve patient safety.
- Strengthen confidentiality and monetary penalties for the unauthorized disclosure of a patient's personal health information.
- Establish standards for Health IT and the National Health Information Network to coordinate information with the National Patient Safety Database.
- Increase funding for private-public partnerships for patient safety organizations to improve health care quality.
- Pass H.R. 3205, The Patient Safety and Quality Improvement Act.

⁷ Bratzler, Dale. Use of Antimicrobial Prophylaxis for Major Surgery: Baseline Results From the National Surgical Infection Prevention Project. Archives of Surgery. 2005.