POLICY WATCH //

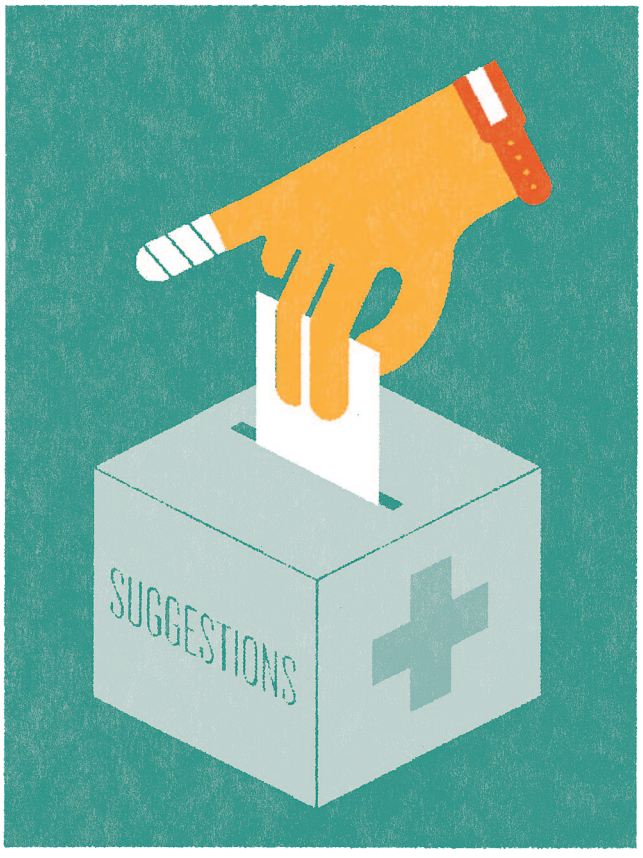
Errors From the Patient's View

BY JENNIFER USCHER

One night a patient got out of bed, fell and hit his head; the incident report that clinicians submitted through the hospital's patient safety reporting system simply stated that the fall occurred because he was feeling lightheaded. Yet the patient would tell a different story: He got up to go to the bathroom after discovering that the portable urinal that was supposed to be at the foot of his bed was missing, and staff didn't respond when he used the call bell.

"If we had planned safety interventions based on the clinicians' report alone, we wouldn't be targeting the right hazards," says Peter J. Pronovost, senior vice president for patient safety and quality at Johns Hopkins Medicine, who heard this story from a colleague who is a friend of the patient. "We're missing so many opportunities to improve safety because we don't have systematic ways of capturing what patients see."

Adverse events such as falls, medication errors and diagnostic mistakes affect hundreds of thousands of patients each year. A report from the Department of Health and Human Services Office of Inspector General estimated that 13.5% of hospitalized Medicare beneficiaries experienced adverse events during a single month in 2008.



JUDE BUFFUM

Though there's no centralized, national reporting system, 27 states and the District of Columbia have created regulations or passed legislation requiring hospitals to report adverse events as of May 2012, and hospitals that participate in the Medicare program are also required to track them. But most current systems accept reports only from health care providers—not patients or their families.

The federal Agency for Healthcare Research and Quality aims to address this gap. In a prototype program intended for use at the local level, the testing of which is expected to begin later this year, patients, consumers, family members and caregivers other than clinicians will be able to report health care "safety events" that resulted or nearly resulted in harm or injury by filling out a Web-based questionnaire or by calling a hotline. Patients will be able to submit reports on events not only in hospitals but also in nursing homes, pharmacies and other health care settings.

Many reporting efforts have focused on collecting data on adverse events but not on utilizing that data to improve patient safety, notes Pronovost, who has provided input on AHRQ's prototype reporting system. Ideally, he says, a reporting program would give providers data on safety risks identified at their facility and share resources that will help them implement interventions. AHRQ already has a number of programs that help health care organizations reduce hospital-acquired infections and improve teamwork and communication.

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"The more they can show they're improving safety and reducing preventable harm, the more successful they'll be," Pronovost says. "People will say this system works and they'll submit reports." ■

Will patients' medical error reports improve care?
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