

Progress Slow in Improving Patient Safety in U.S Hospitals

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By Graciela Flores

NEW YORK (Reuters Health) Dec 15 - Hospital patient safety systems in the U.S. have improved, but they still don't meet the Institute of Medicine (IOM) recommendations, according to study results published in the Journal of the American Medical Association for December 14.

In 1996, the IOM launched an effort focused on assessing and improving the nation's quality of care, and laid out a vision for how to fix the American Health Care System, Dr. Daniel R. Longo, from the University of Missouri-Columbia told Reuters Health.

"They estimated that between 44,000 and 98,000 people die in American hospitals each year because of medical errors," Dr. Longo said. "If you were to use medical errors as a cause of death in this country, it would be the eighth leading cause, more than AIDS and breast cancer," he added.

Dr. Longo and his colleagues looked at hospitals in two states, Missouri and Utah, which are representative of hospitals nationally. The team surveyed all acute care hospitals using a 91-item comprehensive questionnaire, in 2002 and 2004. Change over time was analyzed based on a subset of 107 hospitals that responded at both time points.

The seven variables constructed to assess patient safety included computerized physician order entry systems; computerized test results and assessment of adverse effects; specific patient safety policies; use of data in patient safety programs; drug storage, administration, and safety procedures; manner of handling adverse event/error reporting; prevention policies and root cause analysis.

The results of the survey showed that patient safety systems have improved, but that improvement was "modest at best," Dr. Longo said.

For example, while 74% of hospitals have implemented a written safety plan, nearly 9% still have no plan. The area of surgery has the highest level of patient safety systems, but other areas are disappointing. While most hospitals have medication safety systems, only 3% have fully implemented computerized physician order entry systems for medications. "We were very surprised; we expected to see more dramatic changes," Dr. Longo said.

"These results should act as a reminder to the hospital community and the public at large that the IOM report results have not been fully implemented," Dr. Longo said.

"Hospitals will be able to see where they need to make improvements because we have comprehensively listed all the safety systems that a hospital must have," he added. "This report calls attention to the fact that there are systematic problems. We are not talking about bad apples."

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