PATIENT SAFETY AUTHORITY ANNUAL REPORT 2005
ISSUED APRIL 28, 2006

Op-ed Piece
05/09/06

The Patient Safety Authority is required by statute to issue an Annual Report.

In 1999 the Institute of Medicine issued a study To Err is Human which estimated that up to 98,000 die in hospitals each year from preventable medical errors.

The tort reform fight in Pennsylvania in 2002 resulted in the creation of a Patient Safety Authority in return for considerable tort reform. Barriers to bring medical malpractice cases in Pennsylvania were first erected by the legislature in 1996 and in 2002 a further raising of that bar occurred.

The Patient Safety Authority has been active in the last year and the report is indicative of that. To the public, the safety of the medical care received is listed as the third greatest worry people have. 52.9% of people are very worried or somewhat worried about medical healthcare.

Almost a third (1/3) of people indicate that either they or a family member have been personally involved in a situation where a preventable medical error was made. Explanation of the cause of the error **did not** occur 74.8% of the time.

The Patient Safety Authority has had to encourage increased reporting by hospitals. Facilities were contacted to determine why they were not reporting at the expected volume. Unfortunately, the reporting of incidents and serious events is still based upon the voluntary goodwill of the facility involved.

Interpreting the data is not always easy and the Patient Safety Authority report contains many cautions and corollaries. The bottom line is that between January 1, 2005, and December 31, 2005, Pennsylvania facilities submitted 169,072 reports to PA-PSRS, the Pennsylvania Patient Safety Authority Reporting System. Approximately 5% of the submitted reports were labeled by the facilities as serious events. The number of serious events reported in 2005 average 625 per month, a 6% **increase** over 2004 reports submission levels.

Some members of the Board continue to believe that serious events are well underreported even though the numbers are still unacceptably high.

The north central part of the state shows a surprisingly low report of serious events, even after accounting for differences in the volume of healthcare provided in each region. The contractor for the Patient Safety Authority believes that the number of incidents and serious reports in North Central Pennsylvania was consistent with other regions, not withstanding the reported data.

The greatest mishap which occurred to patients statewide and in order are: medication errors; errors related to procedures/treatments/tests; falls; complications of procedures/treatments/tests; skin integrity; and “other/miscellaneous.”

As has been reported on the national level, older patients have the greatest risk in hospitals although in Pennsylvania, among the greatest category of reports covered the age group of 15-34.

Women are more likely than men to suffer incidents and serious events in

hospitals. The proportions of reports in each category from different size hospitals seem to be similar.

A high number of reports in one category may comprise serious events while in another category there may be more incidents. Incidents are usually defined as a near miss where there is not substantial patient harm. For example, while complications comprise 14% of reports overall in 2005, they comprise 36% of the reports of events involving harm and 61% of all reports of events resulting in or contributing to the patient's death. At the other end of the spectrum, while medication errors comprise 25% of reports from 2005, they only comprised 4% of events involving harm and 2% of events contributing to or resulting in death.

Conditions most likely to result in harm are complications of procedures/treatments/tests; falls; skin integrity issues; errors related to procedures/treatments/tests; and the miscellaneous category. Where death is involved, it usually relates to complications of procedures/treatments/tests, a very large number in the miscellaneous category; falls; and errors related to procedures. In the opinion of this board member, at least, the miscellaneous category is too large and needs to be examined as well.

In 2005 the Patient Safety Authority received events that may have contributed to or resulted in a patient's death at a rate of twice those received during the last seven months of 2004. This may be because of better reporting, but in any event it is quite alarming.

The Patient Safety Authority reporting system in Pennsylvania lists nearly 40 potential contributing factors that may have precipitated the event. Patient characteristics was said to be a contributing factor 27% of the time and "team factors" 26% of the time. Exactly what this means is not always clear, but staff communication was also most frequently cited "root cause" among reports submitted, mentioned in 25% of reports that contained this information.

Infections are a matter of great concern in Pennsylvania. Pennsylvania's patient safety reporting contractor noted that Pennsylvania's reporting system is clearly not capturing reports of all cases of infections that occur in Pennsylvania. A national estimate of healthcare associated infection occurring annually in the United States is 98 per 10,000 patient days. The largest number of such reports was submitted in the southwestern region.

The Pennsylvania Patient Safety Authority does not attempt to identify fault but simply gathers the information for educational purposes. Nevertheless, the Patient Safety Authority report does confirm what has been reported nationally; there is a crisis in healthcare safety which contributes significantly to the cost of healthcare in the United States. Without a professional aggressive approach to patient safety, akin to what the Federal Aviation Authority has done for the airline industry, the crisis will not abate.

The increase in patient safety problems is **not** accompanied by an increase in litigation. In Pennsylvania in 2005 there were approximately 1,500 lawsuits filed and it appears that relatively few of those ever resulted in payment to a patient for their losses. That represents a 37% drop in cases filed over five years. While barriers to recovery have been enhanced by tort reform, this has only hurt and not helped patient safety. Maybe it is time that the fox stopped guarding the hen house.

CAR/srb

Clifford A. Rieders, Esquire
Rieders, Travis, Humphrey, Harris,
Waters & Waffenschmidt
161 West Third Street
Williamsport, PA 17701
570-323-8711 (telephone)
570-323-4193 (facsimile)
crieders@riederstravis.com

Cliff Rieders, who practices law in Williamsport, is Past President of the Pennsylvania Trial Lawyers Association and a member of the Pennsylvania Patient Safety Authority.