

Are You Tracking Medication-Related Incidents?

Hospital managers rely on timely and complete incident reports to identify areas for performance improvement and to provide information that might be needed to defend their organizations in the event of litigation. While the severity of incidents range from sentinel events like wrong-side surgeries to housekeeping issues, incident reports should be completed whenever something is not as it should be. But how reliable are those reports, typically?

An analysis of incident reports from risk managers at 33 not-for-profit community hospitals disclosed that many organizations report far fewer incidents, in total, than other organizations (see Exhibit 1). In the study, which looked at eight months of paper incident reports, 28 hospitals reported recording fewer than three total incidents per month, and 26 hospitals reported two or fewer medication errors per month. Does this mean that four out of five U.S. hospitals have “crossed the quality chasm” and largely won the battle for patient safety?

Unfortunately, no. The study found that most of the hospitals grossly under-reported the occurrence of incidents. And often, when they did report an incident, essential information was missing, illegible, incomplete, or late.

Unreported incidents. During the study, 2,218 total incidents were reported—on average, nearly 8.5 per facility per month. Remarkably, however, two facilities accounted for about 30 percent of the total incidents reported, although these facilities did not markedly differ in bed size, patient volume, or other characteristics from the other participating facilities. A similar pattern of under-reporting was apparent when only medication-related incidents were analyzed.

Incident data quality. The study also found that critical data elements were often missing or illegible on paper incident reports. An average of only 60 percent of incident reports recorded notification of the patient’s physician after the report of a medication-related incident. The participating hospitals stated that the low rate of recorded physician notification did not necessarily mean that physicians are not usually notified of medication errors. But the fact that this crucial piece of data is often missing from incident reports raises the question of what other data elements are missing.

Timeliness of notification and review. Analysis of follow-up times disclosed that, on average, the lag time from incident report to review by a department head is nearly four days, yet department managers provided no new information on the vast majority of incident reports.

Moreover, the average lag time before a risk manager reviewed the reports was eight days. Although 51 percent of the incident reports recorded that a witness was present, risk managers often were unable to verify the presence of the witnesses because of delays in notification and review.

Given that “you can only improve what you measure,” lower-than-expected reporting rates for falls, medication errors, and other incidents should alert hospital leaders to look closely at the occurrence (and reporting) of incidents in their organizations. Failure to address incident data quantity, quality, or timeliness can severely undermine an organization’s ability to manage risk and maintain insurability.

The analysis for this article was conducted by Quantros, Inc. For additional information, contact Matt Quinn at mquinn@quantros.com. ■

EXHIBIT 1: DISTRIBUTION OF TOTAL REPORTED INCIDENTS AT 33 COMMUNITY HOSPITALS

