CALIFORNIA
HOSPITAL
ASSOCIATION

Providing Leadership in
Health Policy and Advocacy

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Adverse Events

California hospitals are on the front lines of our health care system, operating around-the-clock emergency rooms and treating millions of patients each year, regardless of their ability to pay. While hospitals strive every day to provide the safest care possible through the use of sophisticated systems, information technology and care protocols, human error can and does occur. When serious preventable adverse events do occur, information should be quickly and openly communicated to patients and their families.

A state law which took effect in July 2007 requires hospitals to report adverse events to the California Department of Public Health (CDPH). Adverse events were developed using the National Quality Forum (NQF) list of Serious Reportable Events. In the past these events were called 'never events', however the NQF has since changed the name because there is an acknowledgement that some serious reportable events are not preventable. The California Hospital Association (CHA) supported the legislation (SB 1301, Alquist) that mandated this new public reporting.

California hospitals support the public reporting of adverse events. We believe that public reporting will result in hospitals having an increased focus on patient safety and quality of care.

As time goes on, CHA expects to see the number of preventable adverse events being reported to the state to decline. Hospitals are becoming increasingly vigilant about ensuring the safety of all patients under our care.

Adverse events are lacking in specific definitions; therefore we believe reporting is inconsistent. For example, when does surgery end? When the incision is closed, when suturing begins? When the patient is moved to the recovery room? Without a precise definition, any of these definitions could be used. The vagueness of some aspects of the law are likely leading some hospitals to "over-report" and 'under-report' the number of adverse events.

Some adverse events may not be preventable. For example preventing a pressure ulcer for a patient with a serious spinal cord injury may conflict with the care needed to stabilize the spine. These patients are immobilized on a rigid, flat "backboard" until the spine can be stabilized. The very nature of the backboard can result in a pressure ulcer. However, it may be medically preferable to keep the patient immobilized and risk the patient developing a pressure ulcer rather than to cause paralysis by moving the patient to prevent the pressure ulcer.

Enhanced definitions and clarifications are needed to determine what exactly is considered to be a reportable preventable error. For example, clarification is needed in the law regarding foreign objects left in after surgery. For example, broken cardiac micro-needles are often left in during surgery rather than risking harm to the patient's heart to remove them. Currently under the law, this would be considered a reportable adverse event even though it is in the patient's best interest to leave in the micro-needle.

Existing law also requires hospitals to develop, implement and comply with patient safety plans. These plans address adverse events, health-care-associated infection as well as potential safety issues related to the misconnection of tubing. Hospitals perform a root cause analysis of these events to determine contributing factors and to prevent future events from occurring.

In 2000, Dr. Lucian Leape, a Harvard professor of health, testified before Congress on safety in healthcare. He stated to greatest impediment to error prevention in the medical industry is that 'we punish people for making mistakes.' He believes providers only report what they cannot hide. The problem is that doctors make mistakes, professional boards take licensing action, and newspapers demonize the dedicated professional who makes mistakes. Humans, who provide all of the care in hospitals, are fallible human beings. Hospitals enact systems to help those fallible human beings reduce the risk of making a mistake.

CHA is pleased to participate in the CDPH pre-meeting regarding regulation development for administrative penalties and adverse events. The importance of standardized definitions is very important to the validity and reliability of the data reported.

CHA believes hospitals should have an opportunity to review, and submit corrections for, the information to be made public. This is consistent with federal healthcare reform.