

Adult hospital deaths in England related to patient safety suggest areas for intervention

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In a study of all adult deaths occurring in hospitals in England from June 1, 2010, to October 31, 2012, and reported by National Health Service (NHS) staff as related to patient safety incidents, Liam J Donaldson, Institute of Global Health Innovation, Imperial College London, London, United Kingdom, and colleagues categorized the incidents and classified them into types of systemic failures. They sought to identify specific areas that, if addressed, potentially could help to save patient lives.

The authors categorized the total of 2,010 reported incidents into 18 incident types, such as failure to act on or recognize patient deterioration (23%), inpatient falls (10%), healthcare-associated infections (10%), unexpected peri-operative death (6%), and poor or inadequate handover (5%). They then categorized these incident types into 6 areas of systemic failure: mismanagement of deterioration (35%), failure of prevention (26%), deficient checking and oversight (11%), dysfunctional patient flow (10%), equipment-related errors (6%), and other (12%).

Falls and healthcare-associated infections were the most frequent incident types; combined they made up one in five of the reported deaths. Deficiencies in checking and oversight accounted for 11% of the incidents and included unexpected peri-operative death (6%), medication errors (3%), and misinterpretation or mishandling of test results (2%). Nine percent of deaths related to decisions and exchange of information on transfer between hospital departments, or from the hospital to the community. Failures in medical equipment, its misuse by practitioners, or its absence when urgently needed were associated with

6% of deaths. Temporary or sustained shortages of intensive care capacity were associated with 1% of deaths reported.

The authors acknowledge that incident reporting is subject to under-reporting, selective reporting, and incomplete reporting, but indicate that the study took place after reporting of incidents associated with death and severe harm became mandatory in the NHS. They did not aim to determine the absolute incidence of severe harm, but "to identify situations where frontline staff perceived their patient's care to have been unsafe and associated with death." They were not able to conduct root cause analysis, an approach that sets out to identify the underlying origins of the problems.

The authors state, "In our experience, incident reporting data cannot be used routinely to distinguish "avoidable" from "unavoidable" harm, although many reports, by the nature of the incidents, clearly fall into the former category. What is needed is recognition that when there is an accumulation of incidents in a particular area of care, this should trigger a response to ensure that patients are protected... For example, without standardised root cause analysis of each case, we cannot determine how many of the 2,010 deaths would have been avoided, but we can assume that the level of concern expressed by the staff making the reports has highlighted major problems." They recommend that "Use of a classification system, such as the one proposed in this study, would allow hospital boards and clinicians to identify and prioritise areas for greater scrutiny and intervention."

More information: Donaldson LJ, Panesar SS, Darzi A (2014) Patient-Safety-Related Hospital Deaths in England: Thematic Analysis of Incidents Reported to a National Database, 2010. *PLOS Med* 11(6): e1001667. [DOI: 10.1371/journal.pmed.1001667](https://doi.org/10.1371/journal.pmed.1001667)

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