INPATIENT PRACTICE

# Eliminating Errors in the Hospital

Since the Institute of Medicine released its report "To Err is Human: Building A Safer Health System" in 1999, inpatient medical errors have come under increased scrutiny. The report suggested that 44,000 patients to perhaps as many as 98,000 patients die in the hospital every year as a result of errors.

Because psychiatric hospitalization accounts for about one-quarter of hospital admissions, it's likely that errors occur on inpatient psychiatric units.

BENJAMIN C. GRASSO, M.D.

This month, CLINICAL PSYCHIATRY NEWS talks with Dr. Benjamin C. Grasso about medication errors in inpatient psychiatry. Dr. Grasso is the author of two reviews on medication errors and patient safety and is in private practice. The reviews were commissioned by the Institute of Medicine/National Academy of Sciences. Dr. Grasso and fellow Harvard Medical School associates Dr. David Bates and Dr. Miles Shore were among the first to call attention to the problem in inpatient psychiatry.

**CLINICAL PSYCHIATRY NEWS:** Are medication errors prevalent in inpatient psychiatry?

**Dr. Grasso:** It's reported that medical errors in medical-surgical hospitals may kill more patients than industrial accidents, but little is known about medication errors in inpatient psychiatry.

**CPN:** What do the data show?

**Dr. Grasso:** There are some hospital studies from the United Kingdom, the most recent of which found a fairly high rate of errors, with 77% being attributable to prescribing errors.

One of the few published studies of psychiatric hospitals is the one three colleagues and I published in 2003 (Jt. Comm. J. Qual. Saf. 2003;29:391-400). We reviewed the charts of 31 patients in a state psychiatric hospital over a 2-month period. The usual modality of self-reporting errors yielded 9 errors per 1,448 days; however, using an independent chart review, we found 2,194 errors per 1,448 days.

Our study supports the often-stated concern that self-reporting of errors results in substantial underreporting. We also found that 58% of the errors we detected had the potential to cause serious harm.

**CPN:** I understand that your study was conducted at the Augusta Mental Health Institute, a state psychiatric hospital in Maine. Would the situation likely be different in a private institution?

**Dr. Grasso:** There are no data to answer your question definitively. In a private hospital there may be more pressure to move patients quickly, which could make errors more likely.

On the other hand, in our study, 66% of the errors we picked up were errors of administration. But our study looked at the administration of medication by medication technicians, not registered nurses. Private hospitals may have more nurses and other resources that militate against such errors.

**CPN:** You mentioned the elderly. What did your review find about that patient population?

**Dr. Grasso:** According to our review of the published evidence, psychotropic drugs may account for 2%-3% of adverse drug events in hospital settings, but in nursing homes psychotropic drugs may be involved in as many as 35% of adverse drug events. It is well known that these medications may cause falls, delirium, and pseudodementia in the elderly. However, in our review, we found only two studies conducted in inpatient psychiatric settings.

**CPN:** What can be done to reduce the number of errors?

**Dr. Grasso:** First, medical staff members should know the reported medication error rate in their institution and should be familiar with the types of errors possible—prescribing, transcribing, dispensing, and administration errors. Of course, more studies are needed.

A nonpunitive environment—as well as encouragement of medication error reporting—is necessary to deter the understandable reluctance in reporting errors at all.

**CPN:** What other remedies have you identified?

**Dr. Grasso:** Computerized physician order entry, while not foolproof, has been shown to reduce prescribing and transcription errors.

We conducted a study of the use of personal digital assistants (PDAs) and found that for a minimal cost, we had the potential to reduce prescribing and transcription errors.

Our pharmacy interventions on prescriptions written increased by 60% during the first 6 months of PDA use, and medical staff requests for drug information declined by 45%, which suggested that they already had access to that information through the device.

Prescribers need access to the best-fit medications for their patients. Formulary restrictions, among both the privately insured and Medicaid and Medicare beneficiaries, pose a substantial risk for medication errors of omission.

Finally, and—to me, most importantly—all prescribers need sufficient time with patients as a basis for accurate assessment and diagnosis and to build sufficient rapport to support good medication adherence among patients.

External pressures by private insurers pose a potential risk by reinforcing less time with patients and by rationing care in general with little accountability and with a financial incentive to deny care. ■

DR. GRASSO *practices psychiatry in Falmouth, Maine.*

# Report Suicides to JCAHO

**Inpatient** *from page 1*

windows—are taken care of.

The family must be notified, he said, and clergy—if appropriate. A staff member should be designated as liaison for the family to help with the questions they are sure to have.

Hospital administrators and police must be called immediately. It is also important to note that the area in which the patient died is a crime scene, Dr. Rosenstein warned. Given that, the scene cannot be cleared until the police complete their investigation.

A final note should be put in the patient's medical record, he added, and then the chart should be sequestered: "There should not be any revision."

### Soon After the Event

During the first few days, clinicians should attend to the emotional needs of patients and staff, Dr. Rosenstein advised. He suggested formal and informal counseling sessions. The death at the Hatfield hospital was very public; as such, it even affected housekeepers and other staff members who did not know the patient. Their distress might have been overlooked, had counseling been limited to those who worked on the psychiatric unit.

Although the hospital is not required to notify the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Dr. Rosenstein recommended doing so. "They will get to you if someone else reports it," he said; inpatient suicide is a sentinel event.

The administration also should conduct a root-cause analysis of what happened and generate an action plan for quality improvements within the hospital.

While acknowledging the difficulty of maintaining calm under these circumstances, Dr. Rosenstein said it is important to try to minimize demonstrable expressions of guilt. Focus meetings instead on the assessment of and changes in policies and procedures.

### Formal Acknowledgment

Mark the event with a memorial service open to everyone who wants to attend, Dr. Rosenstein suggested.

He advised administrators to be prepared to show the JCAHO that the hospital is taking action.

Collect data, organize staff training sessions, and undertake some form of a "Failure Mode and Effects Analysis," a quality improvement initiative borrowed from engineering that helps identify where an organization is vulnerable.

"How can you create a culture where people anticipate dangers rather than responding after [they happen]?" Dr. Rosenstein asked.

### Lessons Learned

Psychiatrists should be prepared to hear "multiple narratives," in which people attempt to make sense of what happened. "Talking helps," Dr. Rosenstein said.

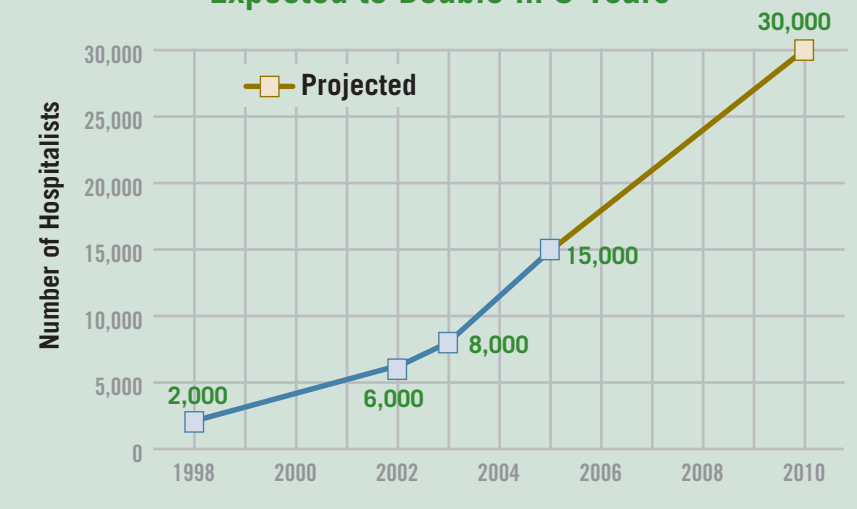
But be wary of blame and the damage such incidents can cause.

"Any fault lines in an institution are going to come out here. … These things can take on a life of their own," Dr. Rosenstein said.

Administrative overkill is another danger, Dr. Rosenstein concluded.

If suicide assessments become too frequent and too routine, for example, patients or staff may not always take them seriously. ■

DATA WATCH




Source: Society of Hospital Medicine

ELSEVIER GLOBAL MEDICAL NEWS