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Safe Patient Project

End secrecy, save lives.

Consumers Union

ACT NOW | TOPICS | BLOG | SHARE YOUR STORY | VIDEO | ESPAÑOL | ABOUT US

ACT NOW! Ten years later, and we're still dying!

When deadly medical errors are kept secret, the underlying problems that cause them don't get fixed. These errors, including hospital infections, kill more than 100,000 Americans each year, and cost us at least $45 billion each year. Yet they aren't required to be tracked or made public. **By bringing medical errors to light, effective action can be taken to prevent them.**

It's time we got serious about stopping preventable medical errors. **Help us get 50,000 signatures on our petition** to make error rates public so we know what to do to prevent them in the first place.

TOPICS WE COVER:

Doctor Accountability

When physicians provide poor quality care, their patients are typically the last to know. Some physician backgrounds may be available in your state, but can you tell which ones have the most complaints, malpractice claims or disciplinary actions? Knowing the background information on your doctor could save your life.

RECENTLY ADDED:

- To Err is Human - To Delay is Deadly
- Rhode Island hospital ordered to have camera's in operating room.
- Film explores broken health care system

Drug Safety

Americans have suffered and lost their lives because they are not given ALL information about risks by either manufacturers or the FDA. Pharmaceutical companies should be accountable for safety problems, and not keep drug risks hidden from the public. Medical device companies should respond to malfunctioning implants.

RECENTLY ADDED:

- To Err is Human - To Delay is Deadly
- Film explores broken health care system
- Money-Driven Medicine Watch-In!

Hospital Acquired Infections

Hospital acquired infections are a leading cause of death in the U.S. Consumers Union supports public disclosure of infection rates so that you can choose the safest hospital and hospitals will have an incentive to improve.

SUBTOPICS:

- MRSA

RECENTLY ADDED:

- CU Summary State Hospital Infection Disclosure Laws
- Spies to monitor hand washing in hospitals
- England: C.diff cases may be twice as high as tests miss infection

Medical Errors

Wrong surgery, wrong medication, serious bedsores... Unsafe practices and poor quality care kill 98,000 patients each year and waste billions of dollars every year. What information do you have about the safety of your hospital? What protections do you have if the hospital makes a mistake with you?

RECENTLY ADDED:

- To Err is Human - To Delay is Deadly
- Delaying Is Deadly--Join Our Patient Safety Webcast on November 17
- Rep. Braley (IA) stands up for patients

Hospital Infection campaign
Public disclosure of infection rates

- 2003 - 1 state reporting law (IL); 1 state initiating regulations (PA)
- 2010 - 27 state reporting laws+DC; 20 public reports issued so far
- 5 states require MRSA screening and reporting (PA, IL, NJ, CA, WA)
- National reporting to begin in 2011

Facility-specific (MVP)
Mandatory, Validated, Public reporting

Imagine if Consumer Reports rated a group of cars and said some of them performed well, some not so well -- and we are not going to tell you which one was a “best buy” or which one was “not recommended.”

Why publicly report? Benefit to consumers

- Patients' right to know
- Patient informed choices – evidence-based medicine
- Stimulate conversations between doctors and patients about quality and safety
- Inform policymakers about the financial and human costs of these preventable injuries
- Dynamic process: public awareness of performance can stimulate pressure from community (media, conversations among providers; doctors might pressure hospital improvement)

Why publicly report?
Benefit to health care system

- Inform hospitals and providers how they compare
- Stimulate change within the hospital
    - Cultural attitudes
    - Active identification when infections and errors occur creates a change in behavior more than assessing performance after the fact through analyzing billing data
- Stimulate conversations among professionals
- Improve awareness of prevention strategies – they don't necessarily know how to improve care (IHI and Pronovost campaigns are examples of "helpers")
- Creates early innovators speaking out about their results

CDC on public reporting

- May 2005: HICPAC guidance
- National Nosocomial Infection Surveillance System⇒National Healthcare Safety Network (NHSN)
- Feb 2010:
  - "The Centers for Disease Control and Prevention (CDC) believes public reporting of healthcare-associated infections (HAIs) is an important component of national HAI elimination efforts. Research shows that when healthcare facilities are aware of their infection issues and implement concrete strategies to prevent them, rates of certain hospital infections can be decreased by more than 70 percent."

Use of the NHSN for Mandatory HAI Reporting in 22 States and the District of Columbia

Central line-associated bloodstream infections (CLABSIs)	AL, CA, CO, CT, DC, DE, IL, MA, MD, NH, NJ, NV, NY, OK, OR, PA, SC, TN,TX, VA, VT, WA, WV
Surgical site infections (SSIs)	AL, CO, IL, MA, NH, NJ, NV, NY, OR, PA, SC, TN, TX, VT, WA
Multidrug-resistant organisms (MDRO) and *Clostridium difficile* associated disease (CDAD)	CA, DC, NJ, NV, NY, TN and other states considering its use
Ventilator-associated pneumonias (VAPs)	OK, PA, WA
Catheter-associated urinary tract infections (CAUTIs)	AL, NJ, PA
Central line insertion practices (CLIP)	CA, NH
Dialysis events	CO

NHSN-National Reporting

- Jan 2011: hospitals to report CLABSI in ICU
- Aug 2011: first quarter due to NHSN
- Dec 2011: public report on CLABSI in ICU
- Jan 2012: hospitals to report Surgical site infections
- FY 2013 (begins Oct 2012): payment adjustments for lowest quartile in CLABSI
- FY 2014 (begins Oct 2013): payment adjustments for lowest quartile in SSIs

Hospital-acquired conditions

- Medicare payment policy; health reform extends to Medicaid; some private insurers mirroring policy
- Includes preventable harm and some hospital infections: CLABSIs, CAUTI, certain SSIs
- will be publicly reported sometime in the next few months
- Present on Admission = a problem
  - 57% foreign objects
  - >90% falls and trauma

Hospital-acquired conditions-cont'd

1. objects left in patients' bodies following surgery;
2. urinary tract infections associated with catheters;
3. bloodstream infections associated with central lines (vascular catheter associated)
4. certain surgical site infections – mediastinitis (sternum?) after coronary artery bypass graft (CABG), certain weight loss surgery (bariatric-laparoscopic gastric restrictive surgery, gastroeneterostomoy), and orthopedic procedures (spine, neck, shoulder, elbow);
5. air embolism
6. blood incompatibility;
7. serious bed sores (stage III and IV pressure ulcers)
8. Falls and trauma (fracture, dislocation, intercranial injury, curshing injury, burn, electric shock)
9. deep vein thrombosis/pulmonary embolism (formation/movement of a blood clot) following total knee and hip replacement;
10. extreme blood sugar derangement (poor glycemic control)

Data must be used

- We must make this important information more visible, usable, and available
  - USA Today CMS readmissions data
  - Hearst Dead By Mistake: medical errors
  - ProPublica: California nurses; Pharmaceutical gifts to doctors
  - Consumer Reports Health: SCIP (CMS data); bloodstream infections - state and Leapfrog data
  - Local: Las Vegas Sun, Seattle PI, Seattle Times

MDRO infections- superbugs

- Antibiotic resistance: new antibiotics needed BUT must change use in health care and food supply
- Clostridium difficile infection growing problem: 500,000 cases per year, 15,000 deaths (CDC)
  - Use of antibiotics and PPIs (meta-analysis: 65% increase of these infections among PPI users)
- NDM1(New Delhi Matallo-beta-lactamase)
- Gram-negative bacteria infections carbapenem-resistant Enterobacteriaceae (CRE)
  - produce an enzyme (called Klebsiella pneumoniae carbapenamase, KPC) that is resistant to carbapenem antibiotics, “antibiotics of last resort.”
  - reported to the CDC by hospitals in about 35 states; fatal in 30% to 60% of cases.

MRSA screening
“active surveillance cultures”

- swab the nose of patients, isolate colonized patients; strict hand hygiene, barrier precautions (gowns/gloves/masks)
- often focus on ICU and “high risk” patients but compelling reasons to screen all patients (CA-MRSA)
- Consumers Union supports screening - tier 2 at CDC
- 5 states require hospitals to screen high risk (PA, IL, NJ, CA, WA); many hospitals voluntarily screening

Veterans Admin MRSA

- The VA has been screening all patients for more than two years.
- Most recent data on their results:
  - ICU MRSA infection rates declined 76% (from1.62/1 ,000 Bed Days of Care in October 2007 to 0.39/1,000 bed days in June 2009)
  - non-ICU setting MRSA infection rates declined 28% (from 0.46/1 ,000 bed days in October 2007 to 0.33/1,000 bed days in June 2009)
- Other private hospitals are seeing similar results.

MRSA screening studies

Robicsek, Ari et al, "Universal Surveillance for Methicillin-Resistant Staphylococcus aureus in 3 Affiliated Hospitals," Annals of Internal Medicine, March 18, 2008, p. 416.

Evanston, IL – 3 hospital system

- Conclusion: "universal screening" significantly reduced infections
- Hospital-wide effect measured
- Over 50% reduction in MRSA infections using universal screening in the hospital system
  - 70% reduction during course of their study
- Targeted screening did not significantly reduce infections

A lot going on

- Still, just scratching the surface on assessing and addressing the problem
- Awareness is growing - improvement is happening; collaboratives
- Investment (public and private) to combat problem must meet the scope of the problem

Culture is changing

- HHS Action Plan
- State action plans
- Federal funding to states via ARRA
- CDC - HAIs among its top 6 priorities
- Goal of zero

HHS-OIG report

- New report released this week on medical harm to Medicare patients
- Demonstrates the scope of the problem is much greater than current accounting by hospitals
- Details…

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Consumers Union

Tell Us Your Story!

We want to hear from you. Your willingness to share your stories helps us pass laws to protect you and your family.

Hospital Acquired Infections

Have you or a loved one contracted a hospital infection when you went in for surgery or other illness? We would like to hear your story, or any other comment you may have about your hospital experience. SHARE »

Read Hospital Acquired Infections stories »

Doctor Accountability

Have you or a loved one had tests, surgeries, procedures or medications that you thought were unnecessary? If so, we would like to hear your story. SHARE »

Have you or a loved one been harmed by a doctor or medical staff person when seeking medical treatment? We would like to hear your story, or any other comment you may have about the experience.

Drug Safety

Have you or a loved one had trouble with or had a problem with prescription drugs? Have you experienced harmful side effects from medications or been misled by a drug company advertisement? We would like to hear your story, or any other comment you may have about your experience with prescription medicines. SHARE »

Read Drug Safety stories »

Medical Errors

Have you or a loved one been harmed by a medical error at a hospital or doctor's office? We would like to hear your story. SHARE »

Were you ever given the wrong drug or wrong dosage? Did your doctor fail to inform you about side effects? Share your story. SHARE »

Read Medical Errors stories »

RECENTLY ADDED STORIES

Browse the most recently published stories from consumers like you.

MICHAEL SKOLNIK OF COLORADO

After Michael Skolnik passed out in September 2001, his neurosurgeon told his parents that Michael needed to have brain surgery within two days. The three hour operation lasted six hours with no cyst ever being found. This marked the beginning of a 32-month nightmare of brain surgeries, infections, and more than $4,000,000 in medical bills.
Read more Doctor Accountability stories »

MY HOSPITAL INFECTION NIGHTMARE

In November 2006, following a medical procedure, I came down with a 104 fever with an extreme headache. Informing the doctor of my symptoms, I was told I had probably caught a â€˜flu bugâ€™ and to wait it out until my post-op appointment two weeks later.
Read more Hospital Acquired Infections stories »

BROTHER BLED TO DEATH FROM CENTRAL LINE MEDICAL ERROR

Over 3000 stories
have put a human face on medical harm


Hospital-acquired infections
kill 99,000
Americans
each year
Safe Patient
Project.org
That's the equivalent of a
jumbo jet full of passengers
crashing every other day