Surgical patient safety: analysis and interventions

de Vries, E.N.

Citation for published version (APA):
de Vries, E. N. (2010). Surgical patient safety: analysis and interventions

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.
The incidence and nature of in-hospital adverse events: a systematic review

Quality and Safety in Health Care, 2008;17:216-223

Eefje N. de Vries1
Maya A. Ramrattan2
Susanne M. Smorenburg2
Dirk J. Gouma1
Marja A. Boermeester1

Departments of Surgery1 and Pharmacy2
Academic Medical Centre, Amsterdam, the Netherlands
ABSTRACT

Introduction
Adverse events in hospitals constitute a serious problem with grave consequences. Many studies have been conducted to gain an insight into this problem, but a general overview of the data is lacking. We performed a systematic review of the literature on in-hospital adverse events.

Methods
A formal search of Embase, Cochrane and Medline was performed. Studies were reviewed independently for methodology, inclusion and exclusion criteria and endpoints. Primary endpoints were incidence of in-hospital adverse events and percentage of preventability. Secondary endpoints were adverse event outcome and subdivision by provider of care, location and type of event.

Results
Eight studies including a total of 74,485 patient records were selected. The median overall incidence of in-hospital adverse events was 9.2%, with a median percentage of preventability of 43.5%. More than half (56.3%) of patients experienced no or minor disability, whereas 7.4% of events were lethal. Operation- (39.6%) and medication-related (15.1%) events constituted the majority. We present a summary of evidence-based interventions aimed at these categories of events.

Conclusions
Adverse events during hospital admission affect nearly one out of ten patients. A substantial part of these events are preventable. Since a large proportion of the in-hospital events are operation- or drug-related, interventions aimed at preventing these events have the potential to make a substantial difference.
INTRODUCTION

Adverse events (AEs) in hospitals are now widely agreed to be a serious problem, annually killing more people than breast cancer or AIDS\(^1\). An AE is usually defined as an unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge or death and caused by health care management rather than by the patient’s underlying disease process\(^2\)\(^-\)\(^3\). Aside from the direct harm to the patient, AEs are a considerable financial burden to the health care system. In 1999, it was estimated that the total costs of preventable AEs in the USA lie between $17 billion and $29 billion annually\(^4\).

In recent years, the focus in thinking about AEs has shifted from the person approach -blaming individuals for errors- to the systems approach. The systems approach assumes that people will make mistakes, and that the system that surrounds them should provide a safety net for these mistakes. Therefore, efforts to eliminate AEs should be directed towards a particular system\(^5\). This new approach has shifted the focus of the debate on AEs from the legal consequences associated with personal responsibility, to a more constructive point of view, clearing the way for thinking about solutions.

In the aftermath of the 1999 Institute of Medicine report ‘To err is human’\(^1\), many large studies have been performed concerning AEs, some of them nationwide. Although many of these studies used similar methods, they report substantially different incidences. A general overview of data on in-hospital AEs is lacking. To make the important step towards solutions, it is necessary to gain a more detailed understanding of this problem: what percentage of events is preventable, where do the majority of events happen and which type of event is the most frequent? This will enable identification of categories of AEs that are most susceptible to interventions to improve patient safety.

To gain an insight into the overall incidence, preventability, outcome and subdivision by location, provider and type of in-hospital AEs and the evidence related to relevant patient safety interventions, we conducted a systematic review of available data from the literature.
METHODS

Literature search
Two authors (ENV, MAB) independently performed a formal computer-assisted search of the medical databases Medline (January 1966 to February 2007), Cochrane and Embase (January 1980 to February 2007). Keywords used were “adverse events”, and “preventable”. Clinical studies published in peer-reviewed journals in the English language were identified. A manual cross-reference search of the eligible papers was performed to identify additional relevant articles.

Selection
In order to be able to reliably compare the data, we defined an AE as follows: an unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge or death and caused by health care management rather than by the patient’s underlying disease process. All studies that used this or a similar definition to evaluate the incidence of AEs in adult hospital patients and that included a minimum of 1,000 patient records were eligible for inclusion. Studies that evaluated errors without linking them to outcomes and studies relying only on
computerized screening data were excluded. Studies that evaluated specific types of AEs only (for example, adverse drug events only) and studies that evaluated specific populations (for example, ICU patients only) were excluded. No abstract publications without subsequent full-text published data were used. Disagreements about inclusion were resolved in a consensus meeting.

**Validity assessment**

Two authors (ENV, MAB) independently assessed selected studies for methodology and endpoints. Information was extracted on the methods of data collection (prospective or retrospective), record selection and review, the time frame of included AEs and recorded interobserver variability. Primary endpoints were the incidence of AEs and the percentage of preventability. Secondary endpoints were adverse event outcome and subdivision by provider of care, location and type of event.

**Data collection**

Data on incidence of AEs, preventability, outcome, location, provider of care and type of event were extracted. Whenever possible, raw data were used, and percentages were calculated. Extrapolations to state or country levels were not reproduced. Data on outcome, provider of care, location and type of event were grouped into common categories that the majority of articles used.

**Interventions**

After analysis of the data yielded the categories of events that were responsible for the majority of adverse events, a computer-assisted search of Medline was performed to identify interventions relating to these categories of events. Only studies with a level of evidence of 1 or 2 were included.

**Statistical analysis**

Medians and interquartile ranges (IQR) of incidence, preventability, and the different categories of outcome, location, provider of care and type of event were calculated using Statistical Package for the Social Sciences version 12.0 (SPSS, Chicago).

**RESULTS**

**Article retrieval**

The initial search yielded 257 articles (figure 1). After reviewing the titles and abstracts, 228 articles were excluded. These articles included reviews, studies on
specific types of AEs only, for example adverse drug events, and studies in specific populations, for example children or ICU patients. Of the remaining 29 studies, another 17 were excluded after reviewing the full article. Three of these studies applied a different definition of an AE; one study used an observational approach and recorded only errors without linking them to outcomes; the other two studies used a computer-assisted approach to screen a large number of patient records for certain codes denoting complications. Three studies were excluded because of an insufficient number of patient records; one of these studies used retrospective record review; the other studies would otherwise have been excluded due to methodological designs that differed from the large record review studies. Five studies presented data of patient populations already included in other publications and six studies presented insufficient data on the primary endpoint.

### Included studies

We included 12 articles in the review. Of these articles, four reported additional data of patient populations that were already included. In this review, these articles were considered as one study together with the article first published, resulting in eight reviewed studies.

### Study characteristics

Characteristics of included studies are presented in tables 1 and 2. A total of 74,485 patient records were derived from the included studies. The number of hospitals per study ranged from 1 to 51 and the median number of patient records reviewed...
Table 2. Study characteristics

<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>Method of record selection</th>
<th>Method of review</th>
<th>More than 1 AE per patient?</th>
<th>Time frame of included events</th>
<th>Kappa value for interobserver agreement</th>
<th>Endpoints</th>
</tr>
</thead>
</table>
| 1. Brennan et al. 
(2016) | Adult acute hospital patients (no psychiatric or day care) | Random sample of hospitalizations from 51 hospitals | Two-stage record review: first, screening for 1 of 10 criteria by trained nurses; second, review by two medical officers | not specified | Occurred before and during and detected during index admission | 0.61 | Incidence, negligence, outcome, location, type of event |
| 2. O’Her et al. 
(2018) | Hospital patients | All admissions to the medical service of one hospital over a four-month period | Two-stage record review: first, screening for 1 of 10 criteria by medical record analysts; second, review by medical officers 2. Reviewing reported incidents | no | not specified | 0.57 | Incidence, preventability |
| 3. Miller et al. 
(2019) | Adult acute hospital patients (no psychiatric or day care) | Random sample of discharges from 25 hospitals | Two-stage record review: first, screening for 1 of 10 criteria by trained nurses; second, review by two medical officers | no | Occurred before and during and detected during or after index admission | 0.44 | Incidence, preventability, outcome, provider of care, location, type of event |
| 4. Thomas et al. 
(2020) | Hospital patients (in psychiatric, rehabilitation or drug and alcohol treatment) | Random sample of discharges from 25 hospitals | Two-stage record review: first, screening for 1 of 10 criteria by trained nurses; second, review by physician | no | Occurred before and during and detected during index admission | 0.42 | Incidence, preventability, outcome, provider of care, location, type of event |
| 5. Vernet et al. 
(2021) | Adult hospital patients (general medicine, general surgery, orthopaedic surgery, obstetrics) | Records randomly drawn from 2 hospitals | Two-stage record review: first, screening for 1 of 10 criteria by trained nurses; second, review by physician | yes | not specified | 0.58 | Incidence, preventability, outcome, provider of care, location, type of event |
| 6. Davie et al. 
(2022) | Hospital patients (in psychiatric, day care or rehabilitation) | Random sample of admissions from 15 hospitals | Two-stage record review: first, screening for 1 of 10 criteria by trained nurses; second, review by medical officer | not specified | Occurred before and during index admission | 0.47 | Incidence, preventability, outcome, provider of care, location, type of event |
| 7. Baker et al. 
(2023) | Adult hospital patients (in psychiatric, obstetric or alcohol abuse) | Random sample of admissions from 25 hospitals | Two-stage record review: first, screening for 1 of 10 criteria by trained nurses; second, review by physician | yes | Occurred before and during and detected during or after index admission | 0.45 | Incidence, preventability, outcome, provider of care, location, type of event |
| 8. Salk et al. 
(2024) | Hospital patients (surgery, general medicine, accident and emergency, orthopaedics, urology, oncology, ENT, ophthalmology) | Random sample of admissions in one hospital | Two-stage record review: first, screening for 1 of 10 criteria by trained nurses; second, review by physician 2. Reviewing reported incidents | yes | not specified | 0.76 | Incidence |

1. Only included if partly responsible for index admission
2. Only included if occurred was detected during a hospital admission
3. Kappa values for interobserver agreement of judgement on injury causation, preventability

The incidence and nature of in-hospital adverse events: a systematic review.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Brennan et al(^2)</th>
<th>O’Neill et al(^3) (^5)</th>
<th>Wilson et al(^2)</th>
<th>Thomas et al(^2)</th>
<th>Vincent et al(^3)</th>
<th>Davies et al(^2, 10)</th>
<th>Baker et al(^4)</th>
<th>Sari et al(^6)</th>
<th>Median percentage (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of records</td>
<td>30,121</td>
<td>3,141</td>
<td>14,179</td>
<td>14,700</td>
<td>1,014</td>
<td>6,579</td>
<td>3,745</td>
<td>1,006</td>
<td>-</td>
</tr>
<tr>
<td>Number of patients with at least one adverse event</td>
<td>1,133 (3.8)</td>
<td>237 (7.5)</td>
<td>2,353 (16.6)</td>
<td>475 (3.2)</td>
<td>110 (10.8)</td>
<td>850 (12.9)</td>
<td>255 (6.8)</td>
<td>110 (10.9)</td>
<td>9.2 (4.6-12.4)</td>
</tr>
<tr>
<td>Number of adverse events (if &gt;1 adverse event per patient)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Number of preventable adverse events</td>
<td>- (43.5)</td>
<td>103 (51.2)</td>
<td>1,205 (53.3)</td>
<td>- (37.1)</td>
<td>57 (41.6)</td>
<td>315 (61.6)</td>
<td>106 (41.6)</td>
<td>- (39.4-49.6)</td>
<td>-</td>
</tr>
</tbody>
</table>

**Outcome**

<table>
<thead>
<tr>
<th>No or minor disability(^1)</th>
<th>644 (56.8)</th>
<th>1,073 (45.6)</th>
<th>253 (53.3)</th>
<th>73 (66.4)</th>
<th>524 (61.6)</th>
<th>161 (55.7)</th>
<th>- (51.6-62.8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary disability(^2)</td>
<td>187 (16.5)</td>
<td>702 (29.8)</td>
<td>150 (316)</td>
<td>21 (19.1)</td>
<td>162 (19.0)</td>
<td>36 (12.5)</td>
<td>- (15.5-30.3)</td>
</tr>
<tr>
<td>Permanent disability(^3)</td>
<td>74 (6.5)</td>
<td>315 (13.4)</td>
<td>40 (8.4)</td>
<td>7 (6.4)</td>
<td>87 (10.2)</td>
<td>15 (5.2)</td>
<td>- (6.1-11.9)</td>
</tr>
<tr>
<td>Death</td>
<td>154 (13.6)</td>
<td>112 (4.8)</td>
<td>31 (6.6)</td>
<td>9 (8.2)</td>
<td>38 (4.5)</td>
<td>46 (15.9)</td>
<td>- (4.7-14.2)</td>
</tr>
<tr>
<td>Unknown</td>
<td>75 (6.6)</td>
<td>151 (6.4)</td>
<td>- (6.4)</td>
<td>- (4.7)</td>
<td>31 (10.7)</td>
<td>- (5.1-9.7)</td>
<td>-</td>
</tr>
</tbody>
</table>

Numbers (percentages) in each column.  
IQR: Inter Quartile Range = 25th to 75th percentile.  
The numbers and percentages given here represent the mean of the combined results from the publication by O’Neill et al and the results by Bates et al for the preventability numbers.  
\(^1\): No disability or disability resolved within 1 month contains Thomas’ categories of ‘mild’, ‘moderate’ and ‘minor temporary’ and Baker’s categories of ‘none’ and ‘mild’.  
\(^2\): Contains Thomas’ categories of ‘mild’ disability resolved within 1-6 months and within 6-12 months.  
\(^3\): Contains Thomas’ categories of ‘minor permanent’, ‘significant permanent’, ‘major permanent’ and ‘grave’.  
\(^4\): Contains Thomas’ categories of ‘minor permanent’, ‘significant permanent’, ‘major permanent’ and ‘grave’.  
\(^5\): Contains Thomas’ categories of ‘minor permanent’, ‘significant permanent’, ‘major permanent’ and ‘grave’.  
\(^6\): Contains Thomas’ categories of ‘minor permanent’, ‘significant permanent’, ‘major permanent’ and ‘grave’.
per study was 5,162 (IQR 1,542-14,569). All studies used a two-stage retrospective record review technique. Records were first screened by trained nurses; when positive for certain trigger criteria (for example an unplanned readmission, an adverse drug reaction or a hospital-acquired infection), the records were then reviewed by a physician to determine whether or not an AE had occurred. In two studies, the data from this approach were compared with voluntary reporting data. Whether or not an event was caused by healthcare management (causality judgement) was measured on a six-point scale in six studies; a score of ≥2 or ≥2 was considered positive. The other two studies did not specify the details of the causality judgement. Of the six studies that gave a judgement on preventability, four used a similar six-point scale; a score of ≥4 was considered preventable. The other two studies did not specify the details of the preventability judgement.

Incidence, preventability and outcome

The data on incidence, preventability and outcome of case record review studies are shown in table 3. The median incidence of AEs was 9.2% (IQR 4.6-12.4%). The median percentage of AEs that was judged preventable was 43.5% (IQR 39.4-49.6%). Two studies judged negligence instead of preventability, which was defined as AEs caused by a failure to meet standards reasonably expected of the average physician or institution. Negligence data were not considered in the calculation of the median percentage of preventability.

Outcome data were divided into five categories: no or minor disability (resolved within one month), temporary disability (resolved within one year), permanent disability, death and unknown. The median percentage of AEs that led to no or minor

Legend to Table 3

Legend to Table 3

- Brennan: Number of records, number of AEs and percentages of outcomes were given. Percentage of AEs and numbers of outcomes were calculated. No number or percentage was given for preventability. Numbers of AEs with negligence (failures to meet standards reasonably to be expected) were 250 (24%).
- O’Neill: Two different strategies were used. Number of records, number and percentage of AEs per strategy and percentage of preventability per strategy were given. Total number and percentage of AEs and total number and percentage of preventable AEs were calculated.
- Baker: Number of records, number of AEs and percentage of AEs were given.
- Wilson: Number of records, number and percentage of AEs, percentage of preventability and numbers were given. Number of preventable AEs and percentages of outcomes were calculated.
- Thomas: Number of records, number of AEs and percentages of outcomes were given. Percentage of AEs and numbers of outcomes were calculated. No number or percentage was given for preventability. Percentage of AEs with negligence (failures to meet standards reasonably to be expected) was 30.6 for Utah and 27.6 for Colorado.
- Vincent: Number of records, number and percentage of AEs, percentage of preventability and numbers and percentages of outcomes were given.
- Davis: Number of records, number and percentage of AEs, number and percentage of preventability and percentages of outcomes were given. Numbers of outcomes were calculated.
- Baker: Number of records, number of AEs, number and percentage of preventability and numbers and percentages of outcomes were given. Percentage of AEs was calculated.
- Sari: Two different strategies were used, numbers and percentages in table are combined results. Number of records and number of AEs were given. Percentage of AEs was calculated.
disability was 56.3% (IQR 51.4-62.8%). Permanent disability was found in 7.0% (IQR 6.1-11.0%) of patients experiencing an AE, while 7.4% (IQR 4.7-14.2%) of AEs caused the death of the patient.

**Providers of care**

Providers of care were divided into three groups (table 4): ‘surgical’, containing all surgical professions, anaesthesiology, gynaecology and obstetrics; ‘medicine’, containing all internal specialties and paediatrics; and ‘other’, containing for example family practice, nursing and emergency medicine. The median proportion of AEs associated with surgical providers was 58.4% (IQR 54.5-70.9%) versus 24.1% (IQR 18.7-40.4%) for medical providers.

---

Table 4. Adverse events classified by providers of care

<table>
<thead>
<tr>
<th>Reference</th>
<th>Wilson et al4</th>
<th>Thomas et al3</th>
<th>Vincent et al2</th>
<th>Davis et al3</th>
<th>Baker et al2</th>
<th>Median percentage (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of adverse events / total no of records</td>
<td>2,535 (14,179)</td>
<td>479 (14,700)</td>
<td>116 (1,014)</td>
<td>850 (6,579)</td>
<td>209 (3,745)</td>
<td>-</td>
</tr>
</tbody>
</table>

**Surgical**

- 219 (46.4) - 48 (70.3) - 40 (38.6) - 7 (5.9) - 14 (51.4) - 59.4 (58.7-60.1)

**Orthopaedic surgery**

- 317 (13.5) - 47 (39.5) - 4 (2.4) - 25.5 (13.5-39.5)

**Obstetrics**

- 140 (5.9) - 44 (9.2) - 7 (5.9) - - - 5.9 (5.0-6.2)

**Gynaecology**

- 134 (5.7) - 32 (17.7) - - - 6.2 (5.7-6.7)

**Urology**

- 99 (3.7) - - - - -

**Cardiac surgery**

- 77 (3.5) - - - - -

**Vascular surgery**

- 71 (3.0) - - - - -

**Oncotraumatology**

- 59 (2.5) - - - - -

**Neurosurgery**

- 57 (2.4) - - - - -

**Colon/rectal surgery**

- 53 (2.3) - - - - -

**Plastic surgery**

- 49 (2.1) - - - - -

**Anaesthesiology**

- 47 (2.0) - 3 (0.7) - - - 1.6 (0.7-2.9)

**Medicine**

- 385 (16.4) - 114 (24.1) - 25 (21.0) - 303 (35.7) - 130 (45.0) - 24.1 (13.7-45.4)

**Internal medicine**

- 105 (4.4) - 110 (23.2) - - - 14.8 (6.6-23.2)

**Cardiology**

- 113 (5.0) - - - - -

**Paediatrics**

- 49 (2.1) - 4 (0.9) - - - 1.5 (0.9-2.1)

**Gastroenterology**

- 43 (1.8) - - - - -

**Medical oncology**

- 25 (1.1) - - - - -

**Other**

- 542 (23.0) - 57 (11.9) - 58 (9.9) - 10 (2.6) - 5.4 (4.4-10.2)

**Nursing**

- 147 (6.0) - 21 (4.4) - - - 5.3 (4.6-6.2)

**Emergency medicine**

- 55 (3.6) - 8 (1.7) - - - 2.7 (1.7-3.6)

**Ophthalmology**

- 34 (1.1) - 8 (1.7) - - - 1.6 (1.1-1.7)

**Oncology**

- 28 (1.2) - - - - -

**Radiology**

- - - 5 (0.1) - - -

**Other**

- 246 (10.5) - 15 (3.1) - - - 6.8 (3.1-16.5)

**Unknown**

- 81 (2.0) - - - - -

Numbers (percentages) except last column. IQR: Interquartile Range = 25th to 75th percentile.

Wilson: Numbers and percentages were given. Thomas: Percentages were given, numbers were calculated.

Vincent: Numbers were given, percentages were calculated. Davis: Numbers and percentages were given.

Baker: Numbers were given in a cross-table with type of event. Because AEs could be attributed to more than one type of event, the total was 360. Numbers and percentages in this table were calculated as a percentage of the total number of AEs.
The incidence and nature of in-hospital adverse events: a systematic review

Table 5. Adverse events classified by location

<table>
<thead>
<tr>
<th>Reference</th>
<th>Brennan et al.</th>
<th>Wilson et al.</th>
<th>Thomas et al.</th>
<th>Davis et al.</th>
<th>Median percentage (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of adverse events/total no. of records</td>
<td>1,133/10,121</td>
<td>2,983/14,179</td>
<td>474/14,700</td>
<td>850/6,579</td>
<td>-</td>
</tr>
<tr>
<td>In hospital</td>
<td>920 (81.2)</td>
<td>1,741 (74.0)</td>
<td>398 (83.8)</td>
<td>603 (80.4)</td>
<td>80.8 (75.6-83.2)</td>
</tr>
<tr>
<td>Operating room</td>
<td>485 (41.0)</td>
<td>1,077 (49.8)</td>
<td>188 (39.5)</td>
<td>-</td>
<td>41.0 (39.5-45.8)</td>
</tr>
<tr>
<td>Patient’s room</td>
<td>300 (26.5)</td>
<td>577 (24.5)</td>
<td>103 (21.6)</td>
<td>-</td>
<td>24.5 (21.6-26.5)</td>
</tr>
<tr>
<td>Emergency room</td>
<td>33 (2.9)</td>
<td>-</td>
<td>14 (3.0)</td>
<td>-</td>
<td>3.0 (2.0-3.0)</td>
</tr>
<tr>
<td>Labor and delivery room</td>
<td>32 (2.8)</td>
<td>87 (3.7)</td>
<td>31 (6.5)</td>
<td>-</td>
<td>3.7 (2.0-6.5)</td>
</tr>
<tr>
<td>Intensive care unit</td>
<td>31 (2.7)</td>
<td>-</td>
<td>17 (3.5)</td>
<td>-</td>
<td>3.5 (2.7-5.5)</td>
</tr>
<tr>
<td>Radiology</td>
<td>23 (2.0)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cardiac catheterization laboratory</td>
<td>10 (0.9)</td>
<td>-</td>
<td>20 (4.2)</td>
<td>-</td>
<td>2.6 (0.8-4.2)</td>
</tr>
<tr>
<td>Ambulatory care unit</td>
<td>9 (0.8)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Procedure room</td>
<td>-</td>
<td>-</td>
<td>16 (3.4)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>19 (1.7)</td>
<td>-</td>
<td>10 (2.2)</td>
<td>-</td>
<td>2.0 (1.7-2.2)</td>
</tr>
<tr>
<td>Out of hospital</td>
<td>156 (13.8)</td>
<td>297 (12.6)</td>
<td>76 (16.6)</td>
<td>167 (19.6)</td>
<td>14.6 (12.9-18.7)</td>
</tr>
<tr>
<td>Physician’s office</td>
<td>87 (7.7)</td>
<td>200 (8.5)</td>
<td>33 (7.0)</td>
<td>54 (6.4)</td>
<td>7.4 (6.6-8.3)</td>
</tr>
<tr>
<td>Patient’s home</td>
<td>31 (2.7)</td>
<td>56 (2.4)</td>
<td>16 (3.4)</td>
<td>45 (5.3)</td>
<td>3.1 (2.5-4.8)</td>
</tr>
<tr>
<td>Ambulatory care unit</td>
<td>16 (1.4)</td>
<td>-</td>
<td>11 (2.3)</td>
<td>-</td>
<td>1.4 (1.3-1.4)</td>
</tr>
<tr>
<td>Nursing home</td>
<td>10 (0.9)</td>
<td>41 (1.7)</td>
<td>3 (0.6)</td>
<td>32 (3.8)</td>
<td>1.3 (0.7-3.3)</td>
</tr>
<tr>
<td>Day surgery</td>
<td>-</td>
<td>-</td>
<td>8 (1.2)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Private hospital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17 (2.0)</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>12 (1.1)</td>
<td>-</td>
<td>18 (3.8)</td>
<td>8 (0.9)</td>
<td>1.1 (0.8-3.8)</td>
</tr>
<tr>
<td>Unknown</td>
<td>58 (5.1)</td>
<td>315 (13.4)</td>
<td>1 (0.3)</td>
<td>-</td>
<td>0.1 (0.3-13.4)</td>
</tr>
</tbody>
</table>

Numbers (percentages) except last column. IQR: Interquartile Range = 25th to 75th percentile.
Brennan: Percentages were given, numbers were calculated. Wilson: Numbers and percentages were given.
Thomas: Percentages were given, numbers were calculated. Davis: Percentages were given, numbers were calculated.

Locations
Table 5 shows the various locations where AEs took place. For all AEs, 80.8% (IQR 75.6-83.2%) were encountered in hospital, versus 14.9% (IQR 12.9-18.7%) out of hospital before admission or after discharge. The majority of events were seen in the operating room (41.0% (IQR 39.5-45.8%)) or the patient’s room (24.5% (IQR 21.6-26.5%)). By contrast, only 3.1% (IQR 2.7-3.5%) of AEs were located in the complex environment of the intensive care unit. The emergency room accounted for 3.0% (IQR 2.9-3.0%) of AEs.

Type of event
Finally, the AEs were classified according to type of event (table 6). In three studies, an AE could be attributed to more than one category13,24,31, whereas in the other studies, the types of events were mutually exclusive. Importantly, approximately 50% of AEs are operation- or drug-related: 39.6% (IQR 31.5-50.2%) and 15.1% (11.9-20.4%).
Chapter 1

DISCUSSION

Baker: Numbers were given, percentages were calculated. Vincent: Numbers were given, percentages were calculated. Davis: Numbers and percentages were given.

Table 6. Adverse events classified by type of event

<table>
<thead>
<tr>
<th>Reference</th>
<th>Brennan et al11</th>
<th>Wilson et al1</th>
<th>Thomas et al3</th>
<th>Vincent et al26</th>
<th>Davis et al24</th>
<th>Baker et al31</th>
<th>Mean percentage (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of adverse events</td>
<td>1,130-1,213</td>
<td>2,562-14,579</td>
<td>476-14,700</td>
<td>112-1,014</td>
<td>1,000-5,570</td>
<td>360-1,740</td>
<td>39.8 (31.5-50.2)</td>
</tr>
<tr>
<td>Operation-related</td>
<td>588 (52.6)</td>
<td>1,189 (46.3)</td>
<td>213 (44.9)</td>
<td>40 (33.8)</td>
<td>258 (24.2)</td>
<td>133 (34.1)</td>
<td>39.8 (31.5-50.2)</td>
</tr>
<tr>
<td>Drug-related</td>
<td>176 (15.3)</td>
<td>240 (10.6)</td>
<td>52 (10.3)</td>
<td>17 (14.4)</td>
<td>130 (12.3)</td>
<td>85 (23.6)</td>
<td>35.1 (11.9-20.4)</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>79 (7.0)</td>
<td>314 (13.3)</td>
<td>33 (6.5)</td>
<td>4 (4.2)</td>
<td>85 (6.0)</td>
<td>38 (10.6)</td>
<td>7.5 (6.2-11.3)</td>
</tr>
<tr>
<td>Therapeutic</td>
<td>82 (5.5)</td>
<td>210 (11.7)</td>
<td>21 (4.3)</td>
<td>-</td>
<td>80 (6.0)</td>
<td>-</td>
<td>7.8 (4.7-10.9)</td>
</tr>
<tr>
<td>Procedure†</td>
<td>88 (7.6)</td>
<td>107 (4.6)</td>
<td>64 (13.5)</td>
<td>6 (5.1)</td>
<td>82 (7.7)</td>
<td>26 (7.2)</td>
<td>7.8 (5.4-7.7)</td>
</tr>
<tr>
<td>Fall fracture</td>
<td>36 (3.4)</td>
<td>102 (8.2)</td>
<td>8 (1.7)</td>
<td>-</td>
<td>8 (2.2)</td>
<td>2.6 (1.0-3.9)</td>
<td></td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>18 (1.6)</td>
<td>52 (5.4)</td>
<td>17 (3.6)</td>
<td>-</td>
<td>1 (0.3)</td>
<td>2.6 (0.6-5.8)</td>
<td></td>
</tr>
<tr>
<td>Anaesthesia-related</td>
<td>13 (1.1)</td>
<td>51 (2.2)</td>
<td>6 (1.3)</td>
<td>0 (0.0)</td>
<td>7 (2.3)</td>
<td>2.8 (1.2-7.1)</td>
<td></td>
</tr>
<tr>
<td>Neonatal</td>
<td>29 (3.0)</td>
<td>30 (1.3)</td>
<td>16 (3.1)</td>
<td>-</td>
<td>-</td>
<td>2.0 (1.3-3.1)</td>
<td></td>
</tr>
<tr>
<td>System/other</td>
<td>39 (3.5)</td>
<td>358 (16.3)</td>
<td>71 (15.3)</td>
<td>476 (30.3)</td>
<td>29 (8.1)</td>
<td>81.3 (22.3-27.3)</td>
<td></td>
</tr>
<tr>
<td>Ward management</td>
<td>-</td>
<td>-</td>
<td>30 (25.4)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Discharge</td>
<td>-</td>
<td>-</td>
<td>14 (11.9)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Clinical management</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>43 (11.5)</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Numbers (percentages) except last column. IQR: Interquartile Range = 25th to 75th percentile
Medical procedure such as coronary angiography or endoscopy.
† Contains: defective equipment or supplies, inadequate reporting or communication, inadequate staffing, training or supervision, no protocol failure to implement protocol.

Brennan: Numbers were given, percentages were calculated. Wilson: Numbers and percentages were given. Thomas: Percentages were given, numbers were calculated. Vincent: Numbers were given, percentages were calculated. Davis: Numbers and percentages were given. Baker: Numbers were given, percentages were calculated.

respectively. By contrast, anaesthesia-related events formed only 2.0% (IQR 1.2-3.7%) of AEs.

Patient safety interventions

Table 7 gives an overview of the top level (level of evidence 1 and 2) of evidence-based interventions directed towards the major types of adverse events: operation- and medication-related events. The operation-related interventions include a number of medical interventions such as perioperative beta-blockade and antibiotic prophylaxis. In addition, interventions such as training programs for laparoscopy and a medical emergency team are mentioned. The medication-related practices include bar code technology and computerized physician order entry systems.

DISCUSSION

We conducted a systematic review to gain an insight into the overall incidence, preventability and outcome of adverse events and added information about location, provider and type of events. Despite the enormous amount of recent attention for
Table 7: Interventions related to operation- and drug-related events

<table>
<thead>
<tr>
<th>Type of event</th>
<th>Intervention</th>
<th>Highest level study example</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operation-related</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localizing care to high-volume units</td>
<td>Perineal patient care</td>
<td>ätt et al. (volume related to outcome in health care: A systematic review and methodology critique of the literature. Ann Intern Med 2002)</td>
<td>2A</td>
</tr>
<tr>
<td>Training programs for laparoscopic procedures</td>
<td>Surgical training programs improve resident operative performance.</td>
<td>ätt et al. (volume related to outcome in health care: A systematic review and methodology critique of the literature. Ann Intern Med 2002)</td>
<td>2B</td>
</tr>
<tr>
<td><strong>Drug-related</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention of surgical site infections:</td>
<td>Perioperative normothermia</td>
<td>ätt et al. (Perioperative normothermia to reduce the incidence of surgical wound infection and shunt occlusion. J Am Coll Surg 2006)</td>
<td>1B</td>
</tr>
<tr>
<td>Supplemental oxygen</td>
<td>ätt et al. (Supplemental oxygen to reduce the incidence of surgical wound infection. J Vasc Surg 1997)</td>
<td>1B</td>
<td></td>
</tr>
<tr>
<td>Glucose control in diabetics</td>
<td>ätt et al. (Clinical effects of hyperglycemia in the cardiac surgery population: the Portland diabetic project. J Am Coll Surg 2000)</td>
<td>2B</td>
<td></td>
</tr>
<tr>
<td>Perioperative beta blockers</td>
<td>ätt et al. (The evidence for the use of perioperative beta blockers. Uncontrolled surge? Systematic review and meta-analysis of randomized controlled trials. BMJ 2007)</td>
<td>1A</td>
<td></td>
</tr>
<tr>
<td>Computerized Physician Order Entry (CPOE) and Clinical Decision Support System (CDSS)</td>
<td>att et al. (A randomized trial of “prompt order” to prevent errors of omission. J Am Med Inform Assoc 1997)</td>
<td>1B</td>
<td></td>
</tr>
<tr>
<td>Clinical pharmacist consultation services</td>
<td>ätt et al. (Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. JAMA 1999)</td>
<td>1B</td>
<td></td>
</tr>
<tr>
<td>Bar code technology in pharmacy</td>
<td>ätt et al. (Medication dispensing errors, and potential adverse drug events before and after implementing bar code technology in the pharmacy. Ann Intern Med 2000)</td>
<td>2B</td>
<td></td>
</tr>
<tr>
<td>Patient self-management of anticoagulation</td>
<td>ätt et al. (Outcomes of post-discharge management of anticoagulation by a specialist anticoagulation clinic: a randomized cross-over comparison. Lancet 2000)</td>
<td>1B</td>
<td></td>
</tr>
</tbody>
</table>
patient safety, such systematic compiling of all available evidence on the subject is lacking to date.

This systematic review included eight studies from the USA, Canada, the UK, Australia and New Zealand. The median overall incidence of adverse events was 9.2%, and almost half of these events were regarded as preventable. The majority of events were associated with a surgical care provider, and more than half of events were operation- or drug-related.

Although all included studies used the same definition, incidences of adverse events varied considerably. In 2000, a comparison was made between the Utah/Colorado study (incidence 3.2%) and the Australian study (incidence 16.6%), and a number of possible reasons for this difference were provided. There were a number of methodological differences between the studies, such as a lower threshold for defining causation in the Australian study and inclusion of some types of events in one study that were excluded in the other. Aside from these differences, the authors suggest that the disparity might be due to differences in quantity and methods of documentation between Australia and the USA, and different perspectives of the two studies (medicolegal versus quality-improvement). These considerations may also apply to the other studies included in this review. For example, both studies that were performed from a medicolegal point of view reported considerably lower incidences than the other studies, performed from a quality-improvement point of view.

Furthermore, not all studies employed the same time frame for included events. Out of hospital events were included in only a few studies. Some studies only recorded one adverse event per patient record, whereas others did not enforce this restriction. These methodological differences may well, at least in part, account for the difference between the recorded incidences.

Retrospective record review has been criticized for a number of reasons. As it relies heavily on patient records, it is dependent on the quality of documentation. If adverse events are not documented properly, they will not be detected by this method. Furthermore, only those adverse events are detected that result in one of the trigger criteria of the review method. Finally, in retrospective record review, the interobserver variability is very high, especially with regard to the judgments on causality and preventability. The studies included in this review show moderate interobserver agreement scores, illustrating this drawback of retrospective record review.

Aside from the fact that the conclusions from this review are based solely on retrospective record review studies, and as such, most likely represent an underestimation of the problem, there are a number of other limitations of this systematic review, the most important one being the heterogeneity of the included
Although most studies used roughly the same methods, the details differed considerably. For example, the studies from Australia and New Zealand applied a lower threshold for causation than the other studies. The time frame of included events also differed between studies: the studies from the United States did not include events discovered after discharge, whereas the other included studies did. Because differences in methodology and perspective may lead to different numbers of recorded AEs, we must proceed with caution when drawing conclusions from the combined data from these studies. Apart from differences in methodology between the included studies, our strict inclusion criteria potentially may have caused us to exclude interesting studies. The three studies we excluded because of an insufficient number of patient records evaluated, when combined, 1,607 records, amounting to 2% of all records included in this systematic review (more than 74,000 records). The two excluded studies that used a computer-assisted approach reported incidences of adverse events that were slightly lower (8.3% and 6.9%) than the median incidence of the studies included in the present review. This approach is much less time-consuming than the retrospective record review, but a drawback is that it cannot make judgments on causation or preventability.

Much attention is being devoted to finding solutions to improve patient safety. In 2005, the authors of some of the largest adverse event studies advocated the implementation of selected evidence-based practices that have a potential for large impact. When looking at the classification of events as demonstrated in this review, operation-related and drug-related events together comprise the majority. It would thus be logical to concentrate funds and efforts on evidence-based interventions aimed at reducing these events. In addition to the evidence-based interventions reviewed here, there are a number of other interventions that seem promising but warrant further research to prove their value. This includes interventions derived from the aviation industry, such as crew resource management and the use of checklists in the operating room.

In conclusion, adverse events during hospital admission are a serious problem, occurring in approximately 9% of all admitted patients and leading to a lethal outcome in 7% of cases. Since a large portion of the adverse events are operation- or drug-related, and almost half of these events are preventable, funds and efforts should be concentrated on interventions aimed at reducing these types of events.
REFERENCES

1. Kohn LT. To err is human: building a safer health care system. Institute of Medicine. 1999


21. Thorndow DK, Stukkenborg GJ. The association between hospital characteristics and rates of preventable complications and adverse events. Med Care 2006;44(3):265-269.


25. Leape LL, Brennan TA, Laird N et al. The nature of adverse events in hospitalized patients. Results of
The incidence and nature of in-hospital adverse events: a systematic review