

'Global Trigger Tool' Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured

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[The purpose of this study is to document the best method of estimating the incidence of adverse events in hospitals so that patient safety outcomes against such events can be optimized. Nonetheless, their efforts discovered some very disturbing trends].

KEY POINTS FROM THIS STUDY:

- 1) The authors compared three methods to detect adverse events in hospitalized patients, using the same patient sample set from three leading US hospitals.
- 2) They found that the adverse event detection methods commonly used to track patient safety in the United States today—voluntary reporting and the Agency for Healthcare Research and Quality's Patient Safety Indicators—fared very poorly compared to other methods and missed 90 percent of the adverse events.
- 3) The Institute for Healthcare Improvement's Global Trigger Tool found at least ten times more confirmed, serious events than these other methods.
- 4) Overall, adverse events occurred in one-third of hospital admissions. Because some admissions suffered from more than one adverse event, the rate of adverse events rose to essentially half of admissions.
- 5) Voluntary reporting and the Patient Safety Indicators produce misleading conclusions about the current safety of care in the US health care system.
- 6) The most practical and less labor-intensive approach to assessing patient safety is the Institute for Healthcare Improvement developed the Global Trigger Tool. "This new method has been increasingly used by hospitals in the United States and the United Kingdom."
- 7) These authors evaluated the incidence of adverse events for inpatients at three hospitals, using several methods of detecting adverse events: (1) retrospective record review (working backward from patients' medical charts) using the Institute for Healthcare Improvement's Global Trigger Tool; (2) each hospital's voluntary sentinel event or other incident or event reporting system; (3) and screening with the Agency for Healthcare Research and Quality's Patient Safety Indicators.

- 8) “All three hospitals were major tertiary (specialized) referral centers with significant local market share and were teaching hospitals for their respective medical schools.”
- 9) “The hospitals selected for this review represented hospitals that had developed extensive patient safety programs, and they might not represent average hospitals across the country.”
- 10) “A total of 795 patient records were reviewed from the three hospitals in the study. Among the 795 patient records reviewed, 393 adverse events were detected by all three methods combined. The Global Trigger Tool methodology detected 354 adverse events (90.1 percent of the total), the local hospital reporting systems detected 4 adverse events (1.0 percent), and the Patient Safety Indicators detected 35 adverse events (8.99 percent).”
- 11) “Overall, adverse events occurred in 33.2 percent of hospital admissions, or 91 events per 1,000 patient days.”
- 12) Because some patients experienced more than one adverse event, the overall rate was 49 events per 100 admissions (range: 43–56). **[essentially half]**
- 13) Drugs, surgery, procedures, and nosocomial (hospital-associated) infections were the most common cause of adverse events.
- 14) “Our study suggests that despite sizable investments and aggressive promotional efforts by local hospitals, these reporting systems fail to detect most adverse events.”
- 15) “Our study also detected far more adverse events in hospitalized patients than have been found in prior studies.”
- 16) “Despite more than a decade of focus on improving patient safety in the United States, the current rates of adverse events among inpatients at three leading hospitals are still quite high at 33.2 percent of hospital admissions for adults.” “The true rates are likely to be higher still, given the consistent finding that direct observational studies reveal higher rates of adverse events than retrospective studies because not all adverse events are documented in the patient record.”
- 17) “Our findings indicate that two methods commonly used by most care delivery organizations and supported by policy makers to measure the safety of care—enhanced voluntary reporting systems and the use of the Agency for Healthcare Research and Quality’s Patient Safety Indicators—fail to detect more than 90 percent of the adverse events that occur among hospitalized patients.”
- 18) “Despite almost ten years since the Institute of Medicine report on patient safety, rates of adverse events in hospital patients are still high.”