

Policy-makers, service commissioners, service providers and assessors should be aware of these potential difficulties, and undertake measures to reduce them. Formal training in cultural sensitivity and competence is required for those involved in the application of the MCA. Professional interpreters involved with the MCA require formal training on the core concepts of the MCA. In the absence of a central mechanism or requirement to collect data on language, ethnicity and religion of subjects who have an assessment of DMC, individual health care providers, local authorities, and independent sector care homes should collect this data. This will allow monitoring of any disproportionate use of the MCA, auditing of any difficulties and identification of examples of good practice. This should be supplemented by high quality research examining the assessment of DMC and the application of the MCA in BME groups. Unless these steps are taken, BME elders may be disadvantaged by the practical application of some of the MCA's requirements. Many of the issues pertaining to the MCA with regard to BME elders may be relevant to developing countries because such countries, particularly from the Commonwealth, often make legislative changes after such changes are enacted in the United Kingdom.

### Conflict of interest

None

Professor Heginbotham is also Chief Executive of the Mental Health Act Commission.

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## How safe are our hospitals?

Safety is at the heart of the health-care agenda with hospitals needing to make substantial service improvements to avoid the adverse events currently affecting one in ten people admitted. Elderly people with multiple complex

co-morbidities, in particular, those with poor renal, hepatic and cardiac function, may be particularly at risk. Known or hidden cognitive impairment in an older patient may be associated with adverse events due to poor compliance with

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interventions, together with an inability to recognise that a problem exists, or call for help in situations where younger adults would take early action. Cascade iatrogenesis, with serial development of multiple medical complications, may also contribute as well as an increased exposure of older people to medical interventions in general [1].

In this issue, Sari *et al.* [2] identified significantly more adverse events in elderly patients aged over 75 years (13.5%) admitted to eight different specialties in a single large UK hospital, compared to patients aged less than 75 years (6.2%). The risk of adverse events increased by 3% every year though there was no evidence that adverse events in older patients are more preventable or associated with disability or death more frequently. The commonest adverse events were hospital acquired, i.e. post-operative infections, drug interactions, pressure sores and falls. This study complements another paper by the same authors [3], possibly using the same patient cohort, which reported that 15% of all adverse events led to impairment or disability lasting more than 6 months, and another 10% contributed to patient death. All events led to a mean increase in length of stay of 8 days.

The results are similar to another study from the United Kingdom that found 11% of inpatients experienced an adverse effect of which half were preventable, and a third were associated with disability or death [4]. Similarly, an Australian study demonstrated that 51% of hospital adverse events were preventable [5]. One study from the USA showed greater numbers of adverse events in the elderly [6] with a greater proportion of elderly patients tending to experience permanent disability or death though results were not statistically significant [7]. In the latter study, preventable adverse events were particularly related to complex medical procedures and falls, whereas age per se was not an independent predictor of adverse events [7]. Length of hospital stay, with greater exposure to interventions and infection, may confound the relationship between adverse events and older patients, and it is also possible that adverse outcomes may be under-reported because they are assumed to be the result of the ageing process, or as a consequence of multiple co-morbidities.

Despite hospital safety having a high profile, problems remain with clinical engagement in quality and safety issues at ward level. Identified solutions include the establishment of effective systems and interventions to reduce risk, prompt attention to identified errors and risks to prevent recurrence, and support for safety-conscious frontline staff to generate the right environment [8]. The need to address deep-seated attitudes and assumptions in order to overcome these barriers has been highlighted [9]. An important challenge is to minimise risk without promoting blame, while recognising that errors in medicine occur more due to systems failures. Excellent governance systems are associated with safer hospitals, whereas blame alone does not change the system, and there is a chance that an error will recur. A hospital culture where health-care professionals are reluctant to admit mistakes due to fear of disapproval or punishment, particularly where there are differences in clinical practice

between wards and poor incident reporting, is a barrier to reducing errors [10].

The reporting of errors, grave and minor, is important to learn where systems need to be improved. Incident reports are usually short, fragmented, and do not offer information on how they can be prevented. Deciphering incident reports requires clinical expertise together with an understanding of the factors that contribute to the error [11]. However, incident reporting is a reactive approach that will only pick a proportion of problems—other approaches are needed, since in one study only half the major incidents were reported by hospital staff [12].

As in the present study, medical record reviews have been found to be accurate at detecting adverse events [3] but are sensitive to the degree of consensus among reviewers [13]. A major drawback is poor inter-rater reliability, and computerised systems may have advantages [14]. Peer-implicit record review relies upon quality judgements by experts to evaluate quality of care from medical record analyses, whereas explicit review is undertaken by data collectors. Although explicit review typically has higher inter-rater reliability than implicit review, structured implicit review, in which the key aspects of care and data sources for review are specified, usually produces good between-reviewers reliability. Single-structured implicit review is effective for conditions that have a good evidence base, such as hypertension and diabetes, but should be employed cautiously for illnesses where the evidence base is less well developed, such as COPD and acute short-course illnesses [14]. Implicit review by peers, of the care of frail older adults can, however, play an important role in characterising the quality of care for complex patients with multiple interrelated conditions though the reliability may be poor [15].

Promoting safety is a priority. Parallels from aviation have commonly been drawn, which emphasise workflow management, prevention of stress and fatigue, teamwork and an individual responsibility to safety. A multi-disciplinary team approach of total quality management embracing incident reporting, pharmacist surveillance and record review, may help in reducing errors in respect of the elderly [16]. Although structured case note reviews are time consuming and require training, they are an important method of educating health-care professionals about the quality of care their patients receive, as well as identifying adverse events, and could be widely employed to make hospitals a safer place for patients of all ages.

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