

Detecting adverse events in surgery: comparing events detected by the Veterans Health Administration Surgical Quality Improvement Program and the Patient Safety Indicators.

June 4, 2014

Mull HJ, Borzecki A, Loveland S, et al. Detecting adverse events in surgery: comparing events detected by the Veterans Health Administration Surgical Quality Improvement Program and the Patient Safety Indicators. Am J Surg. 2014;207(4):584-95. doi:10.1016/j.amjsurg.2013.08.031.

<https://psnet.ahrq.gov/issue/detecting-adverse-events-surgery-comparing-events-detected-veterans-health-administration>

There is consensus that [multiple methods](#) must be used in order to [detect adverse events](#) during hospitalization. This study found that the AHRQ [Patient Safety Indicators](#) had poor sensitivity for identifying preventable harm in surgical patients when compared directly to the [National Surgical Quality Improvement Program](#) methodology.