Patient Safety Monitor Journal

Closing accountability gaps to improve patient safety in hospitals

by Dom Nicastro

Hospitalists sit at the center of inpatient care, often managing patients across multiple roles while coordinating with specialists, nurses, and care teams. That positioning creates both opportunity and risk.

In her guidance on patient safety strategies for hospitalists, **Kathleen Stillwell, MPA/HSA, RN,** senior patient safety risk manager at The Doctors Company, emphasizes that breakdowns in communication, unclear ownership, and missed follow-up remain among the most common drivers of preventable harm in hospitals.

For patient safety leaders, those risks show up in delayed diagnoses, missed test results, and confusion during transitions of care. Stillwell highlights that inpatient environments are inherently complex, with frequent handoffs, competing priorities, and fragmented information flows. Without clear systems to define accountability and ensure continuity, critical steps in care can easily fall through the cracks.

One of the most persistent vulnerabilities is ambiguity around who “owns” the patient at any given moment. Hospitalists may act as attending physicians, consultants, or co-managers, but without explicit role clarity, responsibility for follow-up actions—reviewing labs, ordering studies, or responding to clinical changes—can diffuse.

That ambiguity increases the likelihood that no one takes action when it matters most.

Equally concerning are gaps in communication during handoffs. Stillwell says that even when structured tools exist, their effectiveness depends on consistent use and a shared understanding of patient status, clinical reasoning, and next steps. When that context is missing, incoming clinicians are left to interpret incomplete information, increasing the risk of error.

For patient safety leaders, the takeaway is that improving safety in inpatient care depends less on adding new policies and more on strengthening execution around accountability, communication, and follow-up. Systems must be designed to make the right actions clear, visible, and unavoidable.

That perspective aligns closely with what **Peter Kolbert,** a legal and patient safety expert at Healthcare Risk Advisors, sees in malpractice claims and risk reviews across hospital settings.

Role clarity is the foundation of safe inpatient care

In complex inpatient environments, multiple clinicians often participate in a patient’s care. But shared involvement does not eliminate the need for clear accountability.

Kolbert says hospitals must explicitly define who is responsible for each aspect of care at any given time. Without that clarity, essential actions, such as following up on test results or monitoring changes in condition, can be delayed or missed.

Ambiguity is particularly common when terms like “co-manager” are used without clear operational definitions. While these labels are intended to reflect collaboration, they can end up obscuring responsibility rather than clarifying it.

“The safest approach is ensuring the care team shares a common understanding of responsibilities and communicates directly about who is responsible for the next step in care,” says Kolbert.

Early warning signs often appear before harm occurs

Breakdowns in accountability rarely happen without warning. Patient safety leaders can often identify early signals that risk is building.

One of the clearest indicators is when no one is clearly responsible for the next step in a patient’s care. This is especially common during transitions, as responsibility can become fragmented.

“When practitioners assume someone else will follow up on a test, order a study, or monitor a change in condition, important steps can be missed,” says Kolbert. “This often occurs during transfers between units or when several specialists are involved and accountability becomes unclear. Diagnostic error is often attributed to individual judgment.”

Missed follow-up remains a major source of patient harm

Failures to follow up on tests, consults, and imaging results continue to drive adverse outcomes in hospitals.

Kolbert notes that these failures appear in a meaningful percentage of malpractice cases. In many instances, the issue is not that a test wasn’t ordered, but that abnormal findings were not reviewed or addressed before discharge.

This type of breakdown is particularly dangerous because it often becomes visible only in hindsight, after harm has occurred.

System-level tools can reduce diagnostic and follow-up gaps

While diagnostic errors are often attributed to individual clinicians, Kolbert emphasizes the need for system-level safeguards.

Technologies such as artificial intelligence and natural language processing can help identify unresolved issues within patient records. These tools can flag abnormal lab results, highlight incomplete follow-up, and surface inconsistencies between clinical documentation and discharge plans.

For patient safety leaders, the value lies in creating redundancy—systems that catch what busy clinicians might miss.

Communication tools only work when they are part of the culture

Many hospitals have implemented structured communication frameworks such as SBAR (situation, background, assessment, recommendation), but their effectiveness varies widely.

Kolbert points to culture as the differentiating factor. In organizations where these tools are embedded into daily practice, they reduce variability and improve consistency. In others, they exist primarily as documentation requirements.

For patient safety leaders, the challenge is not adoption, but integration—ensuring that communication tools are used consistently and meaningfully in real-time care.

Documentation gaps undermine continuity during handoffs

Shift changes and handoffs remain among the highest-risk moments in inpatient care.

One of the most common documentation gaps is the absence of clinical reasoning.

“Charts may contain lab results or diagnostic findings but not clearly explain why those results supported a particular decision, were concerning, or were reassuring, such as maintaining the current level of care,” says Kolbert. “Without that context, the next clinician may not fully understand the patient’s trajectory or the rationale behind prior decisions.”

In addition, incoming clinicians must quickly absorb large volumes of information, often under time pressure. If critical details are not clearly communicated, even diligent providers can miss important information.

Kolbert notes that systems designed to flag anomalies and highlight key issues can help reduce these risks, particularly during high-volume transitions.

Escalation pathways must account for human factors

Patient safety systems must account for real-world conditions, including fatigue, workload, and interruptions.

Kolbert recommends designing escalation pathways around objective criteria rather than subjective judgment. Tools such as Modified Early Warning Scores can trigger escalation protocols, ensuring that deteriorating patients receive timely attention.

This approach reduces variability and helps ensure that critical decisions are not delayed.

Governance must reflect real-world workflows

Audits, peer review, and performance dashboards are essential for monitoring compliance with handoff protocols. But governance alone is not enough.

Kolbert stresses that processes must be designed with input from frontline clinicians. Policies that do not align with workflow realities are unlikely to be followed consistently.

A “just culture” approach can also improve adoption by reinforcing that these tools are intended to support staff, not punish them.

“Involving clinicians who deliver care in the design of these processes helps ensure they are practical and sustainable,” says Kolbert.

Three system-level priorities for patient safety leaders

For patient safety officers looking to reduce risk related to handoffs and transitions, Kolbert highlights the following priorities:

- Implementing technology that identifies unresolved clinical issues
- Strengthening communication and teamwork across disciplines
- Evaluating workflows to remove barriers to effective handoffs

These interventions focus on closing gaps that occur not because of lack of knowledge, but because of breakdowns in execution.