

## PROFESSION

### Clarity needed on how and when to report medical adverse events

A new study shows that 86% of inpatient harm cases are not sent to hospital administrators for investigation.

By **KEVIN B. O'REILLY**, *amednews* staff. *Posted Jan. 23, 2012.*

Physicians, nurses and other health professionals who work in hospitals soon may be getting a one-size-fits-all list of what adverse events they should report to improve patient safety.

That is the principal recommendation of a report released in January by the Dept. of Health and Human Services' Office of Inspector General. The Agency for Healthcare Research and Quality and the Centers for Medicare & Medicaid Services already have pledged to deliver such a must-report adverse events list.

The OIG's study found that 86% of harmful inpatient adverse events are not captured by hospitals' incident-reporting systems, with physicians and other health professionals often choosing not to report the patient harm cases because they did not believe they were supposed to. Health professionals reported only two of the 18 most serious events identified -- those that involved permanent disability or death, the study said.

"In the absence of clear reporting requirements for events, it is difficult for staff to determine hospital expectations for reporting incidents," said Inspector General Daniel R. Levinson. "Although administrators indicated that they want staff to report all instances of harm, when asked about specific events, administrators conceded that staff may often be confused about what constitutes harm and is, therefore, reportable."

For example, in 12% of the adverse events identified, health professionals said they did not report them because they were "not caused by a perceptible error." Eleven percent of the time, staffers said they avoided reporting incidents because they "caused little harm" to the patient. Fear of retribution was not named as a reason for failing to report. When adverse events were reported, hospital administrators chose not to further investigate them 30% of the time.

The OIG determined the rate of nonreporting by following up on a November 2010 report that examined a random sample of 780 Medicare patients' experience with hospital care. Medical coders, nurses and physicians reviewed the patients' medical records and found that nearly 30% of them experienced some adverse event in the hospital, with half the events being temporary and relatively minor.

In all, the reviewers identified 128 adverse events that were on the National Quality Forum's list of serious reportable events, CMS' no-pay hospital-acquired conditions, or resulted in extra time in the hospital. They also identified 174 "temporary harm" events.

Researchers then surveyed administrators at the 195 hospitals where the adverse events occurred and asked, using the patients' names, whether the cases had been reported to them using their incident-capture system. If the events were not reported, administrators were asked to find out why.

#### Miscounting patient harm

The findings should not come as news to patient safety experts, who have widely documented how voluntary hospital reporting systems' tend to undercount adverse events. An April 2011 *Health Affairs* study of 795 patient records at three hospitals identified 354 instances of patient harm that required some medical intervention to address. Only four of the 354 events were captured by the hospitals' reporting systems, the study said. Four patient deaths went unreported.

"As patient safety experts from any industry have told us for many years, when you ask for individuals to report things, you don't get 100% participation," said Nancy Foster, vice president for quality and patient safety policy at the American Hospital Assn. "It's not surprising that at this point in our evolution of safety efforts that we're not yet getting an even more robust number of reports."

The intent of hospital incident-reporting systems is to collect actionable information that will lead to systemic improvements, she said. Creating yet another reportable-events list is unlikely to aid in preventing patient harm.

"We're very effectively using what we're getting to drive safety," Foster said. "That's the real question -- are we driving safety or not?"

Hospitals that want to get paid by Medicare must track and analyze adverse events. In response to the report, AHRQ and CMS said they will work to create a single list of reportable events for hospitals. CMS also will push hospital accreditation bodies such as the Joint Commission to examine how well the facilities' incident-reporting systems are functioning and whether they adhere to the AHRQ-CMS reportable events list. The OIG did not propose directly punishing doctors or other health professionals who do not report adverse events.

## ADDITIONAL INFORMATION:

**Why adverse events don't get reported**

Only 14% of patient harm is captured using hospital incident-reporting systems. About a quarter of the time, physicians and other health professionals did not report the cases even though such adverse events usually get reported at their hospitals. Here's why events went unreported the rest of the time.

**12%:** Not caused by a perceptible error

**12%:** Expected outcome or side effect

**11%:** Caused little harm or harm was ameliorated

**9%:** Not on hospital's mandatory reporting list

**8%:** Event occurs frequently in hospitals

**5%:** Symptoms became apparent after discharge

**4%:** Occurred in patient with history of similar events

**2%:** No reason given

Source: "Hospital Incident Reporting Systems Do Not Capture Most Patient Harm," Dept. of Health and Human Services Office of Inspector General, January ([oig.hhs.gov/oei/reports/oei-06-09-00091.asp](http://oig.hhs.gov/oei/reports/oei-06-09-00091.asp))

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"Hospital Incident Reporting Systems Do Not Capture Most Patient Harm," Dept. of Health and Human Services Office of Inspector General, January ([oig.hhs.gov/oei/reports/oei-06-09-00091.asp](http://oig.hhs.gov/oei/reports/oei-06-09-00091.asp))

"Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries," Dept. of Health and Human Services Offices of Inspector General, November 2010 ([oig.hhs.gov/oei/reports/oei-06-09-00090.pdf](http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf))

"'Global Trigger Tool' Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured," *Health Affairs*, April 2011 ([content.healthaffairs.org/content/30/4/581](http://content.healthaffairs.org/content/30/4/581))

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