

PROFESSION

Most hospital adverse events not reported to state systems

An OIG report says the incidents go undisclosed because hospital officials are unaware of them.

By **KEVIN B. O'REILLY**, *amednews staff*. *Posted Aug. 8, 2012.*

Hospitals reported only 8% of the adverse events that they were required to share with state authorities, said a July study from the Dept. of Health and Human Services' Office of Inspector General.

Twenty-five states and the District of Columbia have adverse-event reporting systems, although the reporting requirements vary by state. Of 35 adverse events the OIG had identified previously in these states, only three were submitted to a state reporting system. The OIG found that only one Maryland hospital had internal reporting of an adverse event — excessive bleeding that prolonged a patient's hospital stay — and did not report it when required.

"For the remaining 31 events, hospitals had no record indicating that staff recognized the event had occurred," the OIG report said. "This suggests that the low rate of reporting to state adverse-event reporting systems is due largely to hospital staff not identifying incidents of harm as reportable events."

Yet many of these adverse events were serious enough that they should have been reported, the OIG said. For example, six of the 32 events contributed to patient death. One death was the result of acute renal failure caused by the hospital's failure to recognize bacteremia, said the report (oig.hhs.gov/oei/reports/oei-06-09-00092.pdf).

"Many hospitals are taking big steps to reduce patient harm," said Ruth Ann Dorrill, deputy regional inspector general in the OIG's Office of Evaluation and Inspections. "And this includes changing hospital systems to reduce the odds of human error and adopting practices that are known to provide better care with less risk of harm. And in many cases, we found, hospital staff acted very quickly to address problems to avoid more serious harm. But many of the hospitals don't know when harm occurs within their walls."

Fear, lack of clarity impede reporting

The report builds on previous OIG research. A January study found that 86% of adverse events causing serious harm were not captured by hospitals' incident reporting systems. The study was based on a random sample of 780 Medicare patients' experiences with hospital care in 2008. Their records were reviewed by medical coders, nurses and physicians, who determined that nearly 14% of the patients experienced adverse events during their hospitalization. The OIG then surveyed officials at the 195 hospitals and asked whether the events had been reported internally.

A big reason for the lack of reporting is a dearth of clarity about what adverse outcomes are supposed to be shared through incident-reporting systems, the OIG's earlier report said. Another reason for poor reporting is lingering fear among health professionals that they will be punished.

Of the nearly 600,000 health care workers surveyed at more than 1,100 hospitals, 54% said that when an adverse event is reported, "it feels like the person is being written up, not the problem," said an Agency for Healthcare Research and Quality report released in February. Half of the survey respondents said they believe their mistakes are held against them.

The OIG plans to spread its investigation of adverse events to the nursing home setting, Dorrill said.

"This is very complex work and an ever-changing target," she said.

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