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Hospital Incident Reporting Systems Do Not Capture Most Patient Harm.

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Incident reporting systems are ubiquitous, but their effectiveness as a means of monitoring for patient safety problems is unclear. In a prior report, the Office of the Inspector General (OIG) found that 13.5% of Medicare beneficiaries suffered an adverse event while hospitalized. This follow-up analysis found that incident reports were not filed for the vast majority of these adverse events. Moreover, hospital personnel did not voluntarily report any of the never events identified in the earlier study. The reasons for this lack of reporting likely include confusion about which types of errors needed to be reported, as well as other issues documented in prior studies such as lack of reporting by physicians. Based on these findings, the OIG recommends that the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services (CMS) create a uniform list of potentially reportable events for dissemination to hospitals, and that CMS should assist accrediting agencies in assessing the adequacy of hospitals' error reporting systems.