

A comprehensive overview of medical error in hospitals using incident-reporting systems, patient complaints and chart review of inpatient deaths.

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Patient safety professionals and directors of health care organizations must be able to prioritize among safety initiatives, which requires knowing which safety problems are most prevalent within an institution. However, as this cohort study conducted at a Dutch hospital shows, single error detection methods are unable to provide a comprehensive picture of patient safety. Comparing adverse events detected by the hospital's [voluntary incident reporting system](#), retrospective chart review, and [patient complaints](#), this study found that the type and severity of safety issues varied between detection methods, with little overlap of identified incidents. Similar findings were noted in a [prior study](#) conducted at an American tertiary care hospital, and an [editorial](#) that accompanied that study provides a comprehensive overview of the strengths and weaknesses of different types of error detection systems.