NYSTLA CIVIL JUSTICE BRIEF

New U.S. study finds most hospital medical errors go unreported.

Even when "adverse events" are reported, remedial action is rarely taken.

Hospitals are required to track medical errors and other adverse patient events, analyze their causes and take action to improve care. But are they meeting this basic obligation? According to a new report by the Inspector General of the U.S. Department of Health and Human Services, hospitals are doing an unacceptable job of tracking adverse events and are doing just as bad when it comes to taking remedial action.

The report, *Hospital Incident Reporting Systems Do Not Capture Most Patient Harm*, found:[1]

> *"Hospital incident reporting systems captured only an estimated 14 percent of the patient harm events experienced by Medicare beneficiaries. Hospitals investigated those reported events that they considered most likely to lead to quality and safety improvements and made few policy or practice changes as a result of reported events."*

This report was a follow-up to 2010 HHS report that found that "**13.5% of hospitalized Medicare beneficiaries experienced adverse events [defined as harm caused by patient care] during their hospital stays that resulted in prolonged hospitalization, required life sustaining intervention, caused permanent disability, or resulted in death."**[2]

To lower healthcare costs and improve patient care, hospitals *must* crack down on epidemic levels of medical mistakes.

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[1] U.S. Department of Health and Human Services, Office of Inspector General, *Hospital Incident Reporting Systems Do Not Capture Most Patient Harm,* January 2012, 0EI-06-09-00091.

[2] U.S. Department of Health and Human Services, Office of Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries*, November 2012, 06-09-00090.