

The underbelly of hospital error reporting has been exposed, and it is ugly. According to a recent study from Daniel R. Levinson, the inspector general of the Department of Health and Human Services, it is unlikely that employees will report adverse events that happen to hospitalized Medicare patients.

In a report of the study issued in January 2012, Levinson details findings following an in-depth review of nearly 300 cases in which Medicare beneficiaries had been harmed while in hospitals. Only 14 percent of cases were reported to hospital managers and just over half of those were investigated by hospitals. Worse, only five cases resulted in changes to hospital policies and protocols.

The Levinson report states that hospital employees are remiss in their duties to recognize hospital errors such as medication errors, severe bedsores, infections acquired in hospitals and drug-induced states of delirium. In fact, only one out of seven harmful events is reported. Levinson concludes employees, in general, do not seem to realize that particular activities caused harm to patients or that they should report the incidents. In some cases, employees assumed someone else would report the issue, so they did not take action.

As a condition for being paid, Medicare requires hospitals to track and analyze medical and surgical errors and make adjustments to improve care. Yet, even with existing reporting systems in place, employees fail to use them and hospital administrators fail to recognize problems with systemic quality.

To clarify expectations and encourage reporting, Medicare officials will now develop a detailed list of reportable events for hospital and employee reference. Medicare is also urging hospitals to provide detailed direction for employees about the types of events to be reported and the anticipation of follow through.

In addition to Medicare's requirements, the Obama administration has made reducing medical and surgical errors a priority. Further, more than half of the states have passed legislation requiring medical facilities to publicly report certain errors such as infections developed in hospitals.

**Source:** "Report Finds Most Errors at Hospitals Go Unreported," New York Times, 1/6/12