White Paper

# OIG Reports "Hospital Incident Reporting Systems Do Not Capture Most Patient Harm"

## *A Call to Action for Healthcare Providers and a Positive Push for PSOs*

*The statistic reported by the OIG in its survey of 189 hospitals, who reported using an incident reporting system, is that true patient harm experienced by Medicare beneficiaries is captured only an estimated 14% of the time.*

The recent report from the Department of Health and Human Services Office of the Inspector General (OIG) titled "Hospital Incident Reporting Systems Do Not Capture Most Patient Harm" raises a significant issue for healthcare providers by its very title. The statistic reported by the OIG in its survey of 189 hospitals, who reported using an incident reporting system, is that true patient harm experienced by Medicare beneficiaries is captured only an estimated 14% of the time.[1] If we extrapolate that number to all patients served, we estimate an even lower percent, and similar studies have shown that capturing patient harm with incident reporting systems can be as low as 6%.[2] This begs a broader question than just understanding what data is captured by incident reporting systems, and that is…*what is the expectation of such systems in capturing incidents of harm and how can these systems be improved to truly drive positive changes in patient safety?*

Incident reporting systems are required as a Condition of Participation (CoP) for Medicare reimbursement and are required by many accrediting programs. They are also at least noted in the insurance submission packages for hospital medical malpractice insurance coverage. In addition, many states have mandatory state reporting requirements for adverse events which often require such systems. This is indicative of the fact that regulatory bodies, insurers and healthcare consumers want to be assured that healthcare providers know when adverse events are taking place and that the providers are aware of the potential areas of patient harm and are taking the appropriate actions to maintain the highest levels of quality and patient safety.



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*…if the incident reporting system has been implemented only to meet regulatory or accreditation requirements, the system grossly fails as a way to drive organizational strategies in harm prevention and does not become an integrated patient safety tool.*

Although Medicare and other agencies have the "stick" to forcibly motivate hospitals to use incident reporting systems, the largely unrealized benefits of these systems (the "carrot") remain buried. Incident reporting systems, also known as occurrence reporting systems, have long been the domain of the Risk Management Department in a hospital. As a department function, it can be difficult to (1) raise awareness regarding the types of adverse events that the staff need to report and (2) assess how these systems and the reported events can be used and incorporated into a larger organizational strategy on the management of patient safety. Additionally, if the incident reporting system has been implemented only to meet regulatory or accreditation requirements, the system grossly fails as a way to drive organizational strategies in harm prevention and does not become an integrated patient safety tool. Even when departments or staff are assigned to conduct analysis and/or generate reports from these incident reporting systems, department heads and senior leadership may not view the data as germane in preventing harm … merely a report card on what has happened, not a signal for what can be prevented or how the situation can be improved. Further, in an even more damaging assessment, some professionals argue that the time spent following up on incident reports is very costly and takes time away from truly investigating the issues that lead to harm prevention, calling into question their value at all.[3] So then how do we dig up the "carrot" of potential?

*…we need to change our mental model and redefine our expectations of incident reporting systems as a way to truly change how we collect, respond and analyze events across our organizations.*

As with most things in healthcare today, and borrowing from the work of Peter Senge, we need to change our mental model and redefine our expectations of incident reporting systems as a way to truly change how we collect, respond and analyze events across our organizations. According to Mr. Senge, "Mental models are deeply held internal images of how the world works, images that limit us to familiar ways of thinking and acting. Very often, we are not consciously aware of our mental models or the effects they have on our behavior."[4] To begin, in many ways the incident reporting system is the "tail wagging the dog." That is, the organization has not made the transformational leap to understand that *internal transparency is the first step to external*



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*transparency.* Simply collecting data for the sake of collecting data will never create needed change, but collecting data within the context of a true culture of safety is a whole new construct upon which major change can happen.

Healthcare organizations need to start with these basic questions:

- What do we really believe constitutes 'patient safety' and its inverse, 'patient harm'?
- How do we educate our staff so that they recognize which events might lead to harm and which events are harmful and must be reported?
- What will we do after the event is reported?
- How will we change based on what we find?

Once these questions are seriously contemplated, answered and consensus is obtained, you can then determine (1) what data needs to be collected; (2) how it will be processed; and (3) what kind of system you might need to accomplish these tasks.

*To begin identifying a better and standard event reporting process, the OIG report references the use of the Agency for Healthcare Research and Quality (AHRQ) Common Formats as a way to nationally assist organizations in defining what types of events hospitals should focus on collecting in their reporting systems.*

As cited in the OIG Report, 62% of adverse events were not captured by incident reporting systems because "staff did not perceive the event as reportable." To begin identifying a better and standard event reporting process, the OIG report references the use of the Agency for Healthcare Research and Quality (AHRQ) Common Formats as a way to nationally assist organizations in defining what types of events hospitals should focus on collecting in their reporting systems. AHRQ and other agencies have done a considerable amount of work in establishing these reporting standards, templates and guidelines in the collection of adverse events. Through their work in the implementation of the Patient Safety and Quality Improvement Act of 2005 (the Patient Safety Act), they created the AHRQ Common Formats.[5] The current Common Formats take into account multiple incident reporting and quality indicator systems, including the work of the National Quality Forum, Department of Defense, Office of Civil Rights, Veterans Affairs and others. These groups have compiled an evidence-based data set that provides the information needed to intimately understand



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an event and gather intelligence on how the systems at play might need to be changed or altered to prevent future events. Had these guidelines been a part of the incident reporting systems reviewed in the OIG report, it is likely that the capture of patient harm events would have been much higher than 14%.

*The PSO creates a learning laboratory which encourages the reporting of events and unsafe conditions. The PSO also creates a new 'comfort' for healthcare providers because data reported to a PSO is afforded strong federal protections from discovery under the Patient Safety Act.*

The AHRQ Common Formats are an integral part of forward-thinking healthcare providers who are working with a Patient Safety Organization (PSO). Under the Patient Safety Act, healthcare providers who elect to work with a PSO gain several advantages in collecting data in the AHRQ Common Formats and reporting that data to their PSO, where they can join others in shared learning. The PSO creates a learning laboratory which encourages the reporting of events and unsafe conditions. The PSO also creates a new 'comfort' for healthcare providers because data reported to a PSO is afforded strong federal protections from discovery under the Patient Safety Act.

*Healthcare providers have a tremendous opportunity here on many fronts.*

Healthcare providers have a tremendous opportunity here on many fronts. By changing their mental model from managing incident reports to an effective and integrated event management system that supports a total organizational commitment to patient safety and healthcare quality, they can create a dynamic system of awareness and positive change driven by accurate and actionable data that becomes the cornerstone of collaborative discussions. As part of a PSO, all of this can be done without the fear of these incidents and reports being discoverable in a court of law. The Patient Safety Act, by way of the work between providers and PSOs (and the use of AHRQ's Common Formats), was designed to foster progress towards better reporting of incidents and more effectively changing delivery processes that have not yet been attained in the area of patient safety.

The OIG report is a call to action for healthcare providers and creates a positive push for working with a PSO. Healthcare providers have an opportunity to review, as part of their patient safety organizational strategy, how to best use an event management system to support their goals for creating a Healthcare



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Safety Zone for their patients, visitors and staff. The combination of selecting an event reporting system that supports a true culture of safety and joining a PSO raises the bar of patient safety to a whole new level because it, among other benefits, engages the entire organization in the dialogue and makes each staff person a change agent for safety.

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As we enter the new healthcare age of Coordinated Care, Value Based Reimbursement and Accountable Care Organizations, it is time to destroy the mental model of 'incident reporting' and recreate the model of Risk-Quality-Safety Event Management for healthcare across the continuum of care from inpatient to skilled nursing to outpatient areas to home health. A system that fulfills this goal is no longer isolated as a departmental function. Rather, it becomes the tool that drives internal transparency and the organizational glue that is needed to foster true and lasting change system-wide. Organizations that work with a PSO and use event management systems that incorporate AHRQ Common Formats have a tremendous opportunity. They will redefine the expectation of value in the collection of adverse events from one of compliance (the "stick") to one of enabling real change. Moreover, they may also uncover far greater potential (the "carrot") that helps minimize harm, foster a culture of safety and improve the patient outcomes in healthcare delivery.


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Clarity PSO is an operating Division of Clarity Group, Inc.

For more information on Risk-Quality-Safety Event Management Systems and PSOs, please visit the Clarity Group, Inc. website at www.claritygrp.com





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**Additional Information:**

Healthcare *SafetyZone®* Portal

Checklist for Evaluating a Risk-Quality-Safety Event Management System

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**Resource Links:**

The Patient Safety and Quality Improvement Act of 2005

AHRQ Common Formats

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