REPORT HIGHLIGHTS

July 2025 | OEI-06-18-00401

Hospitals Did Not Capture Half of Patient Harm Events, Limiting Information Needed to Make Care Safer

Why OIG Did This Review

- Over nearly 20 years, OIG has identified persistently high patient harm rates nationwide in hospitals, nursing homes, and other health care settings.
- Key to improving patient safety is identifying, or capturing, patient harm events; investigating their cause; and making system-wide improvements to prevent future harm.
- For this report, we traced harm events identified in a 2022 report on the incidence of harm in hospitals to examine whether hospitals captured those events in their incident reporting or other surveillance systems and to understand what actions they took in response.

What OIG Found

Hospitals did not capture all OIG-identified patient harm events, nor investigate all harm events they did capture, limiting hospitals' ability to make improvements for patient safety.

Hospitals did not capture half of patient harm events that occurred among hospitalized Medicare patients. In many cases, staff did not consider these events to be harm or explained that it was not standard practice to capture them. This was often because hospitals applied narrow definitions of harm.

Of the patient harm events that hospitals captured, few were investigated, and even fewer led to hospitals making improvements for patient safety. Some of the improvement actions hospitals took in response to the harm events included training staff and enhancing monitoring for similar events.

What OIG Recommends

HHS leads national efforts to promote patient safety. Our findings demonstrate that more Federal leadership is needed to drive and sustain progress. We recommend that AHRQ and CMS work with Federal partners and other organizations to align harm event definitions and create a taxonomy of patient harm to drive a more comprehensive capture rate of harm events. We also recommend that CMS ensure that surveyors prioritize the Medicare Quality Assurance and Performance Improvement (QAPI) requirement to hold hospitals accountable for patient harm. The QAPI requirement is intended to ensure that hospitals deliver safe, quality care and prevent patient harm. Finally, we recommend that CMS instruct Quality Improvement Organizations to use information about harm events to assist hospitals in identifying weaknesses in their incident reporting or other surveillance systems. AHRQ and CMS concurred with the first recommendation directed to both agencies. For the two recommendations directed to CMS, the agency neither concurred nor nonconcurred with the second recommendation and concurred with the third recommendation.