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How event reporting by US hospitals has changed from 2005 to 2009.

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Farley DO, Haviland AM, Haas A, et al. How event reporting by US hospitals has changed from 2005 to 2009. BMJ Qual Saf. 2011;21(1). doi:10.1136/bmjqs-2011-000114.
https://psnet.ahrq.gov/issue/how-event-reporting-us-hospitals-has-changed-2005-2009

All hospitals are required to maintain a voluntary error reporting system, and such systems serve an important role in detecting safety problems. However, prior research has extensively documented the limitations of such systems. The success of a reporting system rests on four key components, including a supportive safety culture and an effective mechanism for acting on reported issues. This AHRQ-funded survey of risk managers found that most hospitals' systems did not meet these effectiveness criteria, although some improvement had taken place between 2005 and 2009. Proposals for improving the utility of error reporting systems are advanced in a recent AHRQ WebM&M perspective and interview.