

## **Under-reporting of surgical errors: State perceptions and responses**

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**Abstract:** Objective: Under-reporting of surgical errors inhibits development of knowledge and strategies that can lead to lower error rates. Mandatory error reporting programs have proliferated among states as one means of reducing the incidence of errors. Evidence suggests that errors are under-reported. Little is known of the perceptions of states regarding the risk of under-reporting, their responses to it and the ways they use reported data to improve patient safety. A qualitative study was conducted to assess the perceptions of state managers regarding the risk of under-reporting and the role of enforcement, analysis and feedback in current and ideal error reporting programs.

Methods: 24 state medical error reporting programs were surveyed for characteristics and perceptions of surgical error reporting compliance. A key informant sample of 11 states explored perceptions of barriers and facilitators to reporting, and current and ideal strategies for enforcement and data use. Qualitative data were coded for themes and key findings. A plan for change responds to the conclusions.

Results: 52% of states had discovered surgical errors through means other than required reporting by health care institutions. 76% of states reported that it was impossible to know whether all required reports were made. Some managers did not have adequate resources to enforce reporting, analyze data or engage the health care industry to improve patient safety. State managers understood most of the same reasons given by the health care industry in the literature for failure to report, except lack of program usefulness and feedback. Most managers valued using error data analysis in collaboration with the health care industry to reduce the incidence of surgical errors, but only 37.5% of states use data this way.

Conclusion: Most state managers do not know whether their programs receive all required surgical error reports, and most do not have the resources to use data the way they would like to. Managers did not understand lack of program value and feedback as an important barrier. A plan for change provides education to states and recommendations that include standardization of reporting requirements, data sharing, and new requirements for error reporting.

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