

# Nurses Experience in Reporting Patient Safety Incident in Aceh General Hospital: A Phenomenological Study

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**Abstract:** *This study aims to explore nurses' experience in reporting patient safety incidents in inpatient rooms. This research was a qualitative method with a phenomenological approach. Data were collected through interviews with nine nurses as an informant was selected with purposive sampling technique. The study found eleven themes that describe nurses' experience in reporting patient safety incidents: (1) accidental, unexpected, and injury - causing patient incidents; (2) prioritizing first aid; (3) report on working days and holidays; (4) get a reward from reporting; (5) get a warning from the report; (6) difficulty on writing reports; (7) difficulty reporting on holidays; (8) afraid to report; (9) calm after reporting; (10) blaming culture; (11) less responsive and caring.*

**Keywords:** Nurses, Experience, Reporting, Incident

## 1. Introduction

Safety is a principle that must be applied to ensure the patient's safety, visitors, and staff in the hospital [1]. Patient safety principles seek to prevent incidents that cause physical and psychological injury intentionally or unintentionally when officers provide patient care. It is known as a Patient Safety Incident (PSI) [2]. If patient incidents occur when providing nursing care, it will affect nurses' perceptions, decisions, and interpersonal actions in patient action (reaction). Incidents related to Patient Safety should communicate with the team and supervisor to analyze processes from both internal and external hospital units so that incidents can be controlled and do not happen again. According to King, this process is called the goal attainment model responsible for the hospital's patient safety incident [3].

Implementing the PSI reporting system is one of the hospital's efforts as a form of responsibility in monitoring patient safety. The reporting system monitors functioned to record errors when officers serve patients, and it becomes lessons learned so that the same incident does not happen again. If reporting is ignored, it can create unsafe services for patients, visitors, and staff to reduce the quality of hospital services. Reporting can be done by anyone who finds a patient safety incident that has occurred, has potential, or is close to happening [4].

According to the Network of Patient Safety Database (NPS) data reported by the Agency for Healthcare Research and Quality (AHRQ) in 2020 in the United States, there were 1.7 million PSI cases where the reported incidence increased 0.9% from the number of incidents in the previous year. Based on the National Patient Safety Incident Reports (NRLS) survey conducted by the National Health Service (NHS) in the UK, there were 504, 593 incidents from September 2019 to September 2020, where reported incidents increased by 3.6% from the previous year. [5]. In following up on PSI reporting from officers and patients

exposed to PSI, hospitals must focus on finding solutions and fixing them, not looking for who is at fault [6].

In the context of PSI reporting, studies in 316 nurses in Turkey found that 13.6% were exposed to IK, but 88% of nurses did not document the incident. Another study of nurses in Korea also reported that 72.1% of nurses did not report PSI. For Indonesia, there were 688 incidents in 2016, an increase from 132 incidents in 2013. However, most nurses only report incidents if they have caused trauma/injury [7]. Aceh government Hospital Committee stated that the results of the PSI reporting recap in 2018 obtained 238 incidents in inpatient rooms. In 2019 PSI reports in hospitalization increased to 6, 029 incidents. From January to June 2020, there were 6, 332 incidents reported [4].

Some studies found several reasons why health workers did not report PSI, which is a limited time to report PSI and excessive workload [8]. Several other barriers that cause low PSI reporting are blaming others (blame culture), wrong perceptions about PSI, benefits, and reporting procedures [9]. Hewitt et al., in their study, also reported that most health workers choose to "fix and forget" when PSI occurs. Nurses try to correct errors or incidents that arise from their mistakes and then ignore them rather than report them back to their superiors. For that, the barriers to reporting PSI needs to be identified to find solutions as a preventive effort to improve hospital patient safety [10], [11]. Therefore, this study aims to explore the experience of implementing nurses in reporting Patient Safety Incidents in the inpatient wards of the Aceh Government General Hospital.

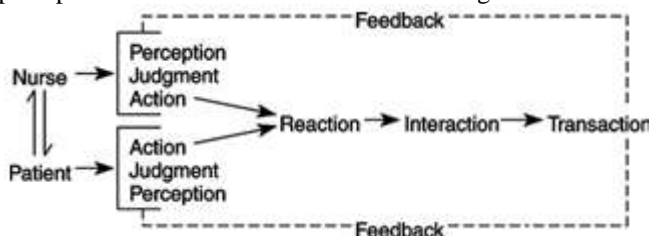
## 2. Literature Review

Riehle et al., in their study, stated there were obstacles in the implementation of patient safety incident reporting. The obstacles are that the benefits of reporting are unclear, sense of failure, fear of being blamed, fear of medical risks, and must be resolved legally. The benefits of reporting are unclear what is meant here is a lack of acknowledgment and

feedback from reported incidents, or it can be interpreted that the nurse does not see positive results after reporting PSI. So, the nurse feels to spend more time filling out forms than treating patients [12].

Some other barriers to reporting PSI, namely PSI, are considered something that does not affect or have direct feedback to nurses, so this reporting is seen as unimportant and time - consuming. Furthermore, the lack of resources is the lack of staff involved to handle the work, lack of time for reporting and filling out forms, and lack of costs for developing solutions. Difficulties in reporting, for example, involve reporting detailed information across multiple systems for different types of incidents [7].

Many methods are used to identify risks related to patient safety incidents, and one way is to develop a reporting system and incident analysis system. The reporting system invites everyone to care about patients' dangers/potential hazards. Reporting is also essential to monitor efforts to prevent errors from occurring so that it is expected to encourage further investments [4]. King, in his theory, views humans and life as having an influence and relationship to the environment, health, nursing, individuals, and the interactions that occur around them. Goal achievement theory focuses on the interactions between humans and their environment in achieving an ability to function or play a role in the social environment [3]. According to King, Nursing is a behavior that must help other individuals function and play an essential role in achieving goals. The process of achieving this goal involves action, reaction, interaction, and transaction. In addition, the nurse's perception also has an interpersonal influence in achieving the expected goals [13]. King describes the interaction process caused by actions and perceptions in a transaction model in the image below:



**Figure 1:** King's Destination Achievement Transaction Model [3]

Based on the figure above, King underlines several essential concepts in the interconnected transaction model in nursing, including:

- 1) Perception is defined as a person's picture of reality and relates to one's experience.
- 2) A decision is defined as a step a person takes to do something.
- 3) Action is defined as a set of behaviors expected of a social system. Action is the initial relationship between two individuals in behaving and understanding situations or conditions to achieve goals.

- 4) The reaction is defined as an action that occurs due to action and is an individual response.
- 5) Interaction is a form of cooperation that influences each other and is manifested in the form of communication.
- 6) Transactions are defined as conditions that occur because of an agreement in a plan to take action.

Interaction between individuals or social groups is carried out to achieve the hospital's goals in building an incident reporting system for patient safety and hospital quality. This interaction can be formed from the delivery of information related to incident reporting that can affect individuals and groups. It becomes the basis for deciding whether the incident reporting system is implemented, especially for nurses who find PSI. In this case, it is the achievement of a hospital's goal to implement the PSI reporting system.

### 3. Method

This research design uses a qualitative study with a phenomenological approach. Informants in this study consisted of key informants and associate informants. The key informant is the implementing nurse in the inpatient room, while the associate informant is the head of the inpatient room and was selected through the purposive sampling technique.

The study was conducted in the inpatient room of the Aceh Government General Hospital. The data collection method used in - depth interview techniques, throughout digging in - depth information related to the experience of implementing nurses in reporting patient safety incidents. Interviews were conducted in a semi - structured manner. The researcher asked open or unrestricted questions but had a clear theme and flow of conversation in the interview guidelines to avoid unnecessary discussions. The interview guide is based on King's theoretical foundation and related literature studies. This research has received ethical approval on June 10, 2021, with the number 138/EA/FK - RSUDZA/2021. Data analysis uses the steps of Colaizzi (1978), which have been systematically arranged [14].

### 4. Results and Discussion

The informants involved in this study were nurses who worked in the inpatient room and aged 27 - 35 years. Some nurses work as implementing nurses with more employment status working as civil servants. Most informants have higher education (undergraduate) with a 2 - 7 years working period. The study's results identified eleven themes experienced by nurses in reporting patient safety incidents in the inpatient ward of the Aceh Government General Hospital. The following eleven themes have been identified following King's Goal Attainment Model perspective on the figure below:

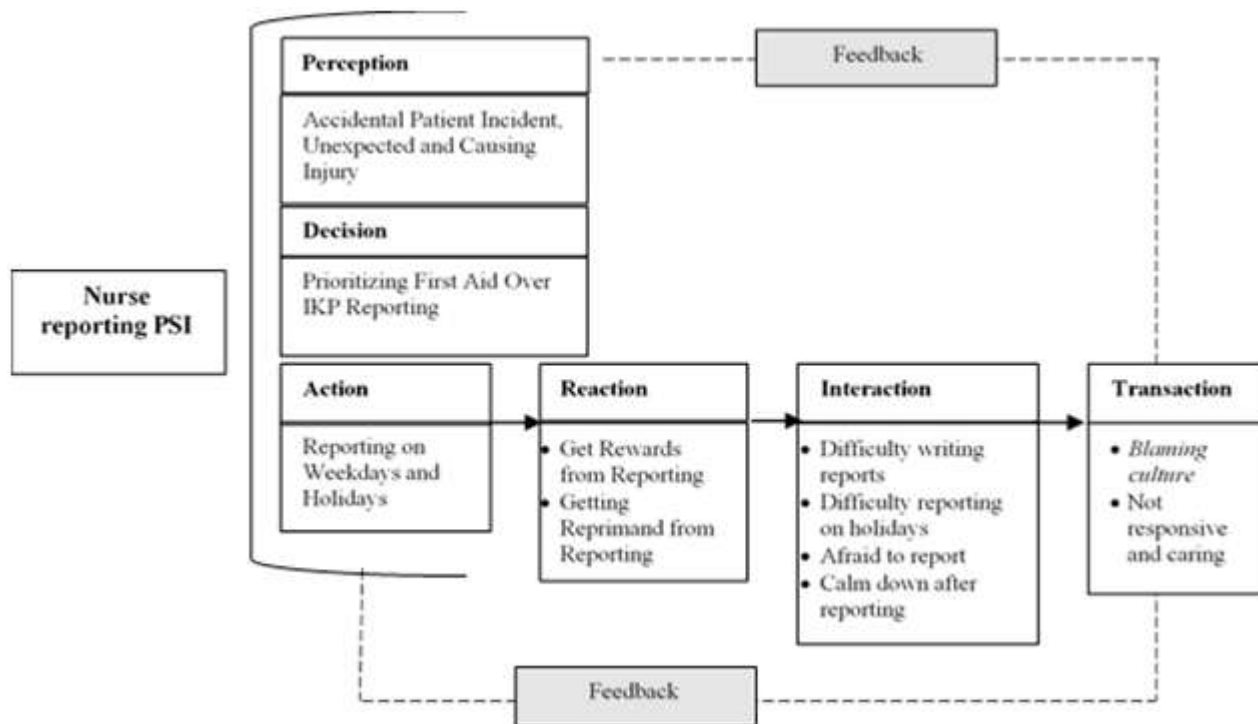


Figure 2: Result

Based on Figure 2, the study results can be described, illustrating how nurses' experience reporting PSI in the inpatient room is seen from nurses King's Goal Attainment Model. The results as shown above, will be discussed in the following points.

#### Accidental Patient Incident, Unexpected and Caused Injury

Based on the nurse's experience, a patient safety incident is perceived as a condition that causes the patient's injury from unintentional and unexpected actions. The unintentional action intends that the nurse takes an action that results in injury due to an accident, or there is no intent and purpose to injure the Patient. At the same time, it is not expected that the nurse performs an action that causes injury because the nurse does not take action according to the procedure. According to Hospital Patient Safety Committee, a patient safety incident (PSI) is an event or situation that results in or has the potential to cause harm (injury, disability, illness, death, and others) that should not have occurred. An incident is defined as an unintentional occurrence as a result of a preventable error. These errors result in or can cause the patient's injury and must be reported to the supervisor immediately. Some studies also stated that a patient safety incident is an adverse condition that can cause unexpected events when providing services and cause injury to patients [16], [17].

Nurses describe reporting as essential when an incident occurs either in a potential injury event, an unexpected event, or even an incident that causes serious injury (sentinel). Non - injury incidents and near misses must also be reported by the nurse who discovered the incident. As in interviews conducted by researchers with the associate informants, sometimes nurses consider incidents normal because they often occur or are considered lucky so that incidents do not occur. These reasons or assumptions are

some of the reasons for nurses not to report incidents. For this reason, the hospital must have an active role in carrying out routine socialization so that nurses have the correct perception regarding patient safety incident reporting. [18]. According to King, perception is essential to describe the nurse's decision to take action when an incident occurs. Suppose nurses have wrong perceptions, such as assuming incidents are common and often occur. In that case, it will have a negative impact on the incident reporting process, such as the absence of PSI data reported so that the same incident can happen again in the future because it is not used as a lesson from incidents that have happened previously or may lead to a sentinel event (injury has a severe impact on the Patient). Good perceptions of nurses can be formed through scientific activities through providing understanding and increasing nurses' knowledge regarding reporting in the form of training, scientific studies,

#### Prioritizing First Aid Over PSI Reporting

Based on the nurse's experience, if an incident causes injury or is fatal to the Patient's condition, the nurse immediately provides first aid to the Patient by handling it first according to the injury that impacts the Patient. After that, the nurse reported the incident to the supervisor. Patient safety is essential to provide immediate assistance to patients after an incident, especially if the incident caused a severe injury [19]. Other studies also stated where patient care is prioritized immediately after the incident, especially if the incident causes serious injury (sentinel) [20], [21]. The nurse's decision to provide immediate help to patients is one of the goals of patient safety that must be considered. For this reason, the need for direction (supervision) from the head of the room in directing his staff to make the right decisions when an incident occurs by handling the incident according to the injury caused so that the impact will not be fatal.

### Reporting PSI on Weekdays and Holidays

Based on the nurse's experience, the nurse decides to report incidents that occur on holidays or working days when an incident occurs. On weekdays nurses can directly report incidents to the head of the room or superiors. After that, the report will be forwarded to the unit that has been given the responsibility for carrying out the patient safety program, namely the Quality and Patient Safety Committee. Reporting PSI on weekdays and holidays is one form of action taken by nurses. If the incident occurs on holiday, the nurse reports the PSI by meeting the supervisor assigned to work. Next, the nurse tells the chronology of the incident and conducts a simple investigation of the impact on the Patient. So that the handling of patients due to injuries can be handled and monitored by supervisors to control incidents, considering that patient safety is a top priority in achieving an entire hospital. This condition In line with Anderson et al. 's studies that stated where incidents must be immediately reported to anyone and at any time, considering that incident reports must be analyzed immediately as learning material so that the same incident does not occur in the future [22].

Incidents must be reported immediately both on weekdays and on leave, and reporting must be done less than two days from the time the incident occurred [23]. Suppose incidents are reported as soon as possible. In that case, it can positively impact the incident reporting system where problems can be addressed immediately for patient safety and prevent severe impacts or injuries if treatment is given too long [24]. Hospital leaders need to facilitate nurses in reporting patient safety incidents, especially in type A hospitals as Aceh Government Hospital, if the incident occurs on holidays, such as adding staff responsible for reporting incidents and adding staff in units that play a role in handling hospital facilities.

### Get Rewards from Reporting

Based on the nurse's experience, a supervisor's response after getting reported a patient safety incident is in the form of rewards such as praise (verbal). There is also added value in the form of scores from superiors to nurses during the evaluation of staff performance assessments to report patient safety incidents. Based on interviews with associated informants, it was found that rewards can be an alternative to increasing staff motivation in reporting incidents.

The results of this study are supported by other studies where awards given to nurses can increase staff motivation in reporting patient safety incidents that occur in hospitals. [6], [25]. A study conducted by El - Aziz et al. indicating that awards in the incident reporting system can be given in the form of material (financial) or non - material (compliment). Rewards given to nurses who have reported incidents can be one solution in increasing and maintaining staff motivation in reporting patient safety incidents [26]. Rewards can be given to staff who report incidents and superiors and units which frequently report incidents. It is intended that the unit's leadership is also motivated to invite and direct their staff to report all forms of incidents that occur

### Getting Reprimand from Reporting

Based on nurses' experience, nurses also get other responses after reporting incidents in rewards and getting reprimands or warnings. Even this condition makes nurses feel worried if the incident occurs for the second time, nurses feel threatened not to work in the hospital again (expelled). The anxiety felt by nurses after receiving a warning will undoubtedly have a negative impact on nurses. Moreover, this was revealed by the head of the room, namely an undirected reprimand or sanctions that did not could be a reason for all nurses not to report incidents. Some hospitals give nurses warnings or sanctions after reporting unexpected events, [20], [27]. The motivation of nurses in reporting low patient safety incidents can have a negative impact on the low number of reports. The low number of PSI reporting can signify the low implementation of patient safety in hospitals.

This condition must be avoided considering that reporting is necessary to obtain learning materials for hospitals in carrying out patient safety programs. It can be followed by providing understanding and socialization for leaders to follow up on reporting wisely and not using sanctions and reprimands when staff makes mistakes in reporting PSI. Errors that occur should be a lesson for the hospital. A detailed analysis of the problem by the leadership and unit responsible for PSI reporting through a root cause analysis (RCA) will result in recommendations for improvement, looking at errors from the staff perspective and the facilities and hospital environment.

### Difficulty Writing Reports

Based on the experience of nurses, there are difficulties experienced by nurses when reporting incidents. It is challenging to write or type the PSI report, which must be reported no later than 2x24 hours after the incident occurred to the Quality and Patient Safety Committee. The report submitted by the nurse in the room will be typed on the computer. This condition is difficult for nurses because they have to provide free time to type PSI reports during their service. Some studies show that several reasons make it difficult for health workers not to report PSI. One of the reasons is the limited time to report and explain PSI to superiors in the form of PSI form [8]. Studies conducted by Carljford et al., was found that the high workload could cause the limited time for nurses to report incidents in the room that was not proportional to the number of staff available in the room [7].

This study attempts to link the concept of King in achieving PSI reporting objectives. In the context of this theme, namely the difficulty of writing PSI reports, researchers classify it as one of the nurse interaction processes in reporting PSI. According to King, nurses' perceptions, decisions, and actions influence the interaction process. The more positive the interaction process in nurses, the better the transaction process that impacts the existence of nurse feedback that will occur in achieving PSI's reporting objectives, namely reporting all forms of patient safety incidents. Nurses need free time typing incident reports to the Quality and Patient Safety Committee online or in writing manually. So this condition is not an excuse for nurses not to report incidents. An in - depth analysis is needed of the causes of the limited time for nurses to write

reports. If it is constrained in a bit of time due to the high workload, the leadership can re - analyze the workload to adjust the number of staff on duty.

### **Difficulty Reporting on Holidays**

Based on the nurse's experience, in addition to difficulties in writing or typing PSI reports, Another difficulty experienced by nurses is when incidents occur on holidays. The difficulty of communicating via telephone or directly with the supervising nurse assigned on holidays is felt by nurses when PSI occurs on holidays such as Saturdays, Sundays, and days of joint or national leave. It is in line with research conducted by Kusumawati et al., where PSI reporting procedures during leave and holidays become barriers to PSI reporting [9]. Also, in their study, Alfiani et al. stated that the reporting system that made it difficult for nurses, conflicts or collaboration between departments or sections, and long reporting responses were also some of the obstacles that hindered PSI reporting for nurses [27].

Another study conducted by Dhamanti et al. revealed that obstacles to PSI reporting, such as the difficulty of reporting on holidays, must be addressed both at the unit level and between units so that the motivation of nurses in reporting PSI continues to increase and be maintained [25]. The need for additional staff who work on holidays, especially staff involved in incident reporting, and the use of technology that can be used to communicate so that information related to incident reporting can be continuously monitored even on holidays.

### **Afraid to Report**

Based on the nurse's experience, nurses feel fear after reporting a patient safety incident, especially if the reported incident is fatal or seriously injured. The feeling of sadness after being blamed for an unintentional act makes nurses feel afraid of being responsible for the consequences of the incident. An interview with the head of the room also revealed that a nurse is still afraid to report incidents. This condition is in line with research conducted by Stavropoulou et al., where nurses are afraid to report incidents because of the consequences of losing their jobs and other administrative sanctions such as not getting rewards [28].

Silpasuwan, in his research, also shows that being afraid to report incidents, especially unexpected events or those that have resulted in injury, in the end, nurses only report incidents with near - injury events [29]. Riehle, Braun, and Hafiz also revealed that the reason for not reporting incidents was the fear of being blamed, being punished, and losing their job and other risks [12]. Punishment cannot be a solution in an incident reporting system because patient safety directs the hospital to find solutions to problems in the incident reporting system and not to find out who is at fault. Hospitals can use risk management to analyze problems that arise from various aspects, where errors are seen from the human point of view (human error) and other aspects such as hospital facilities and infrastructure.

### **Calm After Reporting**

Based on the nurse's experience, there is a feeling of relief or calm after reporting the incident found to the supervisor. Nurses feel relieved because they have contributed to patient

safety so that the same incident does not happen again or serious injuries will not arise in the future. Hewitt et al., in their study, stated that several reasons that can increase the motivation of nurses in reporting incidents are incidents can be a lesson for staff and other rooms, improve patient safety and prevent more serious incidents from happening in the future. Other studies about the factors that influence nurses in reporting incidents also provide consistent results. One of the reasons nurses decide to report incidents is to protect safety so that injuries do not occur that endanger both the Patient and family. The feeling of relief that arises in nurses after reporting an incident is a positive response that needs to be maintained. Given the incident reporting culture that has been established in hospitals, it is not easy to achieve [30], [31]. The hospital must commit to continuing to maintain nurses' motivation and enthusiasm in reporting incidents through routine activities such as meetings and morning apples with all staff to keep voicing patient safety as something that cannot be ignored and becomes a top priority in providing services (safety first) and reporting culture have decreased.

### **Blaming Culture**

Based on nurses' experience, there is still a culture of blame after reporting a patient safety incident. The existence of blaming actions carried out by superiors is also one of the reasons for nurses not to report incidents they find in the future. It was also conveyed by the head of the ward that patient safety directs the hospital not to look for who is at fault, so it is essential for the hospital to promote a no - blame culture. So that nurses are willing to report incidents openly to prevent similar or worse incidents from happening in the future. Some studies revealed that is one of the actions that can destroy hospital patient safety culture [7]. Blaming others for actions in the service is not a solution in an incident reporting system because the hospital is an integrated system with many aspects that need to be studied and analyzed so that mistakes can be made accidentally. However, the hospital's environment, facilities, facilities, and infrastructure also contribute to causing patient safety incidents. From the interviews obtained, the researchers also found verbal responses from nurses in which nurses had high hopes that this blame culture could be followed up immediately.

For this reason, it is necessary to have a positive response from the hospital to be firm in following up on PSI reporting by not blaming each other when incidents are found or reported because there are feelings of fear felt by nurses. With the follow - up to this blame culture, the researcher hopes that nurses' fears will disappear. Nurses' motivation in reporting can increase, and patient safety incidents, especially those with severe impacts (sentinel), will not occur or decrease.

### **Less Responsive and Caring**

Based on nurses' experience, hospitals respond or give feedback after nurses report patient safety incidents. It was conveyed by the head of the room that considering the importance of patient safety, a fast response from the hospital is highly expected so that nurses in the room are motivated in reporting incidents. The results of this study are supported by research conducted by Riehle et al., where the

lack of acknowledgment and feedback from reported incidents can reduce nurses' motivation in reporting incidents [12]. Also, in his study, Macrae found that the hospital's responsiveness in responding or providing feedback on each patient safety incident reporting will build a patient safety reporting culture in the hospital [19].

Another study conducted by Hewitt et al. shows that the purpose of the PSI reporting system is that nurses no longer hide incidents or feel afraid and have no barriers to reporting incidents openly and honestly to superiors for improvement and learning for all staff [32]. Judging from the final results of achieving the goals of this PSI report, the researchers tried to relate it to King's nursing theory with the goal attainment model to take responsibility for the hospital's PSI incidence. Based on the experience of nurses in reporting PSI found, hospitals need to conduct retraining and direct monitoring by superiors (roadshow) and be carried out regularly.

While talking with several nurses in the room, the researcher also found that the nurses were enthusiastic about participating in this study. The nurses hoped that the hospital could follow up on the obstacles and complaints related to PSI reporting. Nurses also hope to have another opportunity to participate in re-socialization or regular training so that nurses get the latest information regarding patient safety. It is hoped that through regular training, the motivation of nurses in reporting PSI can also increase. This effort can be a strategy for hospitals in preparing plans to achieve the goals of PSI reporting, namely increasing the motivation of nurses in reporting PSI and reporting data submitted is also open and honest to superiors.

## 5. Conclusion

The conclusions obtained regarding the experience of nurses in reporting PSI in the inpatient room are:

- 1) The nurse perceives that the incident is a condition that causes injury to patients from unintentional and unexpected actions and must be reported to superiors to improve patient safety.
- 2) Based on the nurse's experience, if an incident causes injury, has a negative impact on the Patient, or is fatal to the Patient's condition, the nurse immediately decides to treat the patient. After that, the nurse reported the incident to the supervisor.
- 3) Reporting is also not only reported on weekdays but also on holidays. On holidays, nurses can directly report incidents to the head of the room or superiors, while on holidays, nurses report PSI to supervisory nurses assigned to work on holidays.
- 4) Patient Safety Incidents reported by nurses to superiors make nurses feel calm or relieved because they have contributed to improving patient safety so that incidents are not reoccurred.
- 5) On the other hand, if the incident caused an injury or had a negative impact, the nurse expressed fear that she chose not to report PSI.
- 6) Nurse Gets a response from superiors after reporting a patient safety incident. There are conditions where nurses get reprimands or warnings if they report incidents that cause injury to patients.

- 7) Nurses also get rewards in the form of praise and evaluation scores of staff work evaluations from superiors. Praise can be verbal for contributing to patient safety.
- 8) The difficulty experienced by nurses was difficulty in writing or typing PSI reports.
- 9) Another difficulty experienced by nurses when reporting PSI was communicating either via telephone or directly with the supervising nurse assigned on holidays.
- 10) There is a blame culture that makes nurses feel worried about reporting patient safety incidents
- 11) The lack of responsiveness of the hospital that they feel is a big hope for nurses and the head of the ward to be followed up considering that incidents can happen anytime and anywhere

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