

Factors Affecting Incident Reporting – A Qualitative Study

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Abstract- Incident reporting is an integral part of patient safety. Therefore, studying enablers and barriers to incident reporting is important to improve quality of patient care. Nursing Officers, who are front line health care providers, play an important role in incident reporting in hospital setup. The objective of this study was to describe enablers and barriers for incident reporting by Nursing Officers in Medical, Surgical, Paediatric, Gynaecology and Obstetrics wards in the Teaching Hospital, Kandy. This was a qualitative study, and the study instrument was key informant interview. Key informants were selected within the Teaching Hospital, Kandy using maximum variation sampling technique. Qualitative analysis of the key informant interviews was done with thematic analysis. Lengthy process of incident reporting, presence of culture of blame, insufficient knowledge on incident reporting, presence of heavy work load and lack of feedback for the reported incidents acted as barriers for incident reporting while training on incident reporting acted as an enabler. Simplification of the process, formalizing the feedback mechanism, changing the blame culture and continuation of training programmes can be recommended to improve incident reporting in these selected wards in the Teaching Hospital, Kandy.

Index Terms- Incident reporting, Patient safety, Barriers, Enablers, Teaching Hospital, Kandy

I. INTRODUCTION

The Institute of Medicine stated “To err is human”, highlighting the possibility of making errors by healthcare providers (Kohn et al., 1999). Harvard Medical Practice Study reveals that the death toll due to medical errors each year in the United States is equivalent of a jumbo jet crashing each and every day (Watcher, 2012). Similarly, World Health Organization states that every tenth patient in Europe faces a preventable adverse event (World Health Organization, 2014). However, with the socio economic development of the society, the patients’ expectations for healthcare is increasing. In order to maintain the quality of a service, the gap between customers’ expectations and their perceptions on the service that they receive has to be reduced (Parasuraman, Zeithaml and Berry, 1985). As medical errors have significant impact on

patients’ perceived service, errors have to be reduced in order to improve service quality in healthcare settings.

For the purpose of reducing errors, it is important for healthcare providers to learn from errors occurring in healthcare settings. The ancient Greek philosopher Aristotle had mentioned ‘Quality is not an act, it is a habit’, and this quote emphasizes the importance of the learned behavior in this context (Kaizen Institute - India, 2013). However, adverse events are not only due to personnel factors such as carelessness and incompetency of health care providers; underlying problems prevailing in those settings also contribute greatly to such incidents (Morath and Turnbull, 2005). An expert group in the national health system of the United Kingdom has also recommended learning from failures (Department of Health - London, 2000).

In order to learn from errors and failures, data on patient safety incidents should be available. Patient safety related data can be used in identifying health hazards, determining where to allocate resources, and in deciding interventions for the purpose of improving patient safety (Pronovost et al., 2008).

The way of gathering patient safety related data is incident reporting. Many researchers consider incident reporting system as an effective tool for learning from incidents (Pfeiffer, Mansor and Wehner, 2009; Vincent, 2007). Moreover, incident reporting highlights the areas where improvements are needed (Elder et al., 2007). The Institute of Medicine also, in their four tiered strategic approach, has recommended incident reporting for learning from errors (Kohn et al., 1999). The World Alliance for Patient Safety, in their forward programme published in 2005, has taken the theme “Reporting and Learning” as their sixth action area (World Health Organization, 2004).

Literature has shown that there are weaknesses in incident reporting all around the world. (Cullen, et al., 1995; Elder et al. 2007; Pfeiffer et al. 2009)

II. METHODOLOGY

This was a hospital based analytical cross sectional study and was carried out in selected ward in the Teaching Hospital, Kandy. Key informant interviews were done to collect data and therefore this was a qualitative study.

The main objective of this was to describe enablers and barriers to incident reporting by Nursing Officers in Medical, Surgical, Paediatric, Gynaecology and Obstetrics wards in the Teaching Hospital, Kandy.

Maximum variation sampling, which is a type of purposive sampling, was taken for the selection of key informants for key informant interviews. The Director, Deputy Directors, Medical Officer in charge of the QMU, Nursing Officer in charge of the QMU, and Ward Sisters in Medical, Surgical, Paediatric, Gynaecology and Obstetrics wards were taken to the study population. The reason for selecting maximum variation sampling was to assess the phenomenon related to research questions broadly as seen by different people (Cohen and Crabtree, 2006).

The unit of analysis of this study was a Nursing Officer attached to a basic specialty ward i.e. Medical, Surgical, Paediatric, Gynaecology and Obstetrics wards, of the Teaching Hospital, Kandy.

The study was conducted from September 2016 to August 2017. The data was collected from 15th of April, 2017 to 15th of May, 2017.

Ethical clearance was obtained from the Ethics Review Committee of the Post Graduate Institute of Medicine, which is an affiliated institute of the University of Colombo. Approval for data collection was taken from the Director of the Teaching Hospital, Kandy.

Data was analyzed with thematic analysis technique as described by Braun and Clarke, (2006).

III. RESULTS

Findings of the key informant interviews were thematized as shown in the Table 1.

Table 1: Thematic Analysis – Factors Affecting

Incident Reporting

Theme
Process
Culture of blame
Knowledge
Workload
Feedback

Figure 4.2 shows the pattern diagram developed after thematic analysis.



Figure 1: Thematic Analysis – Patterns

IV. DISCUSSION

Process in relation to incident reporting was one the most prominent findings of the key informant interviews, and it was mentioned as one of the most important barriers for incident reporting.

Many key informants mentioned that books were available at section matrons’ offices for documentation of the incidents happening in wards. Once an incident happened in a certain ward, a nursing officer was supposed to write the complaint book and go to the relevant section matron’s office at a convenient time and he or she had to document the incident in that book according to a given format. That was an established practice in this setting. In addition to that process, the formal incident reporting form introduced by the Ministry of Health was brought to the ward from the Quality Management Unit and filled. Thus, it can be noted that there were two processes. i.e. the well-established traditional incident reporting process and the use of newly introduced incident reporting form by the Ministry of Health according to the circular 01-38/2016 (Ministry of Health, 2016). Some Ward Sisters, in their interviews, stated that there were two processes for reporting an incident. They felt that documentation in a book and filling the newly introduced incident reporting form as a duplication of work. As one key informant stated “There are too many steps in the incident reporting process.” Ward Sisters act as leaders for the nursing staff, their views on the currently practicing process might have transmitted to the Nursing Officers. That might have given the nursing staff the feeling of additional burden in reporting an incident. According to the study done by Elder et al. (2007), lack of time was a barrier for reporting. Therefore, presence of two processes would have further hindered their incident reporting behaviour in this setting.

At the same time, one of the key informants revealed “Training programmes affected as enablers to incident reporting”. Therefore, extension of training programmes to build leadership skills in middle level and operational level managers would be beneficial in an attempt of improving incident reporting.

According to the analyzed data of the key informant interviews, feedback was one of the factors acting as a barrier for incident reporting in this study (Figure 1). It was reported

that the Nursing Officers were not well aware of the actions taken for the incidents reported by them, and as a consequence they might tend to believe that it was useless to report. These findings tally with the results of the qualitative study done by Kingston et al (2004) and with study done in six South Australian hospitals by Evans et al (2006).

Streamlining the process of incident reporting, Creating a supportive environment for incident reporting, Formalizing the incident reporting forms, Continuation of training on incident reporting, Formalizing the feedback mechanism, Appraising for reporting incidents, Application of digital Technology to report incidents can be recommended to improve incident reporting.

V. CONCLUSION

Lengthy process of incident reporting, presence of culture of blame, insufficient knowledge on incident reporting, presence of heavy work load and lack of feedback for the reported incidents acted as barriers for incident reporting while training on incident reporting acted as an enabler for the Nursing Officers employed in Medical, Surgical, Paediatric, Gynaecology and Obstetrics wards in the Teaching Hospital, Kandy.

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LIMITATIONS

This study was conducted in Medical, Surgical, Paediatric, Gynaecology and Obstetrics wards in the Teaching Hospital, Kandy. Many factors can vary between region to region and hospital to hospital. Thus the results may not be generalized to all of the hospitals in Sri Lanka.

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