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PERCEPTION OF REGISTERED NURSES REGARDING CLINICAL ERROR REPORTING

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ABSTRACT

Patient safety is a concern worldwide and is a significant challenge faced by healthcare systems today. Clinical incident reporting has an important role in the area of risk management in the healthcare setting with regard to inconsistencies that may exist within the routine organizational operations or patient care. So, in this concern, an exploratory study was conducted on 70 registered nurses to assess the perception of registered nurses regarding clinical error reporting in New Delhi. Majority of RNs agree that understaffing, heavy work load and fatigue, lack of formalized pathway for communication or error feedback structure is the main cause of error occurrence. Many RNs have neutral perception that non - uniformity in standardization of care and lack of professional support causes errors. Most of the RNs disagree to lack of complete patient information and lack of professional responsibility and accountability is the cause of error occurrence. Maximum of RNs agree that time constraints, inappropriate reaction of the authorities regarding the severity of the error, reporting near misses can facilitate a blame free approach, and fear of loss of physician's confidence are the reasons for not reporting the errors. Most of the RNs disagree to lack of knowledge and skill in how to report errors. Majority of RNs have neutral opinion that defected safety culture, embarrassment being recognized as incompetent, loss of reputation/status and disclosure is also an element that contributes to the creation of a culture of safety is the reason why errors are not reported.

INTRODUCTION

Many types of errors that involve medications, health care acquired infections, rule violations, management practices, and non-standardized nursing practices, and medical devices have been targeted for reporting and dissemination mechanisms. One study found that the majority of error reports involved delays or omissions of medications, diagnostic tests, or necessary/planned procedures; medication errors, and

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malfunctioning equipment. 10% of the reported errors required life-sustaining interventions (61% of which resulted from delays/omissions of prescribed non-medication treatments and necessary planned procedures), and 3% might have caused the patient's death [1-4].

In a study of surgical ICUs, the type of events reported were related to medications, tests, treatments, or procedures [5]. Another study found that the major types of errors reported were of unsafe conditions or near misses, adverse events that harmed patients, medication/infusion errors, and patient falls [6]. In another study, researchers found that the majority of reports involved medication errors, surgical errors, falls,



and problems with procedures [7]. An important part of patient safety is the issue of medication administration within the acute care setting that has long been the focus of scrutiny and research because it contributes directly to patient morbidity and mortality [1].

Each stake holder is potentially impacted when errors occur. These errors can be classified as either acts of commission of error or omission of care. Such errors can occur in intentional or unintentional manner.

One survey of nurses in the Midwest found that nurses could recognize errors and events associated with intentional wrong doing related to questionable behavior. Nurses were more apt to report serious errors but not intentional errors [8]. In one survey of physicians and nurses, physicians identified twice as many barriers to reporting than did nurses; both identified time and extra work involved in documenting an error. However, nurses were more concerned about anonymity, "telling" on someone else, fear of lawsuits, and the necessity of reporting errors that did not result in patient harm [9]. One survey in a State with mandatory reporting found that both physicians (40%) and nurses (30%) were concerned about the lack of anonymity of reports and that the reports would be used punitively against the individual who has submitted the report [10]. Another survey of nurses in Korea found that 32% were worried that their errors were kept in files; 66% felt that their suggestions to improve patient safety were ignored; 83% felt that it was by chance that more errors did not happen; 52% believed their units had serious patient safety problems; and 56% reported problems talking with physicians [11].

In a study author explored reasons for low incident reporting rates among 198 healthcare staff and identified fear that junior staff would be blamed (36%), no necessity to report (31%), increase workload (29%) and fears of litigation (23%) as the main reasons. Some staff felt that incident reporting made little contribution to the quality of care, while others believed that reporting was worthwhile and could benefit staff and patients [12].

Clinical incident reporting identifies actual and potential risks to patient safety and then eliminates those risks through a system of procedural changes, policy enactment or changes in staff education. A survey of 210 nurses using open and closed questions was conducted across three separate acute hospitals in the Irish midlands region. While the majority of participants (90%) had submitted at least one clinical incident report, few received prompt feedback (12%) or prior appropriate training (30%) on this topic. Fear of repercussion or disciplinary action from management was not considered an issue in terms of barriers to reporting [13]. Although medical error reporting has been studied, underreporting remains pervasive. The study aimed to identify the organizational factors with the greatest perceived effect on error reporting and to determine whether associations differ for management and clinical staff. It was also found that although management support for patient safety was significantly related to error reporting among clinical staff, this association was not significant among management. This difference is relevant because managers may not be aware that their failure to demonstrate support for safety leads to underreporting by frontline clinical staff. Findings from this study can help hospitals to evaluate their efforts to strengthen error reporting [14].

MATERIALS AND METHODS

The study was conducted in 2016. This was an exploratory study which used a clinical error reporting opinionnaire to assess the perception of registered nurses regarding clinical error reporting in a quaternary care hospital located in New Delhi.

Tools Used: A 5-point Likert scale- Clinical Error Reporting Opinionnaire was used. The tool comprised of two sections - Reasons of Errors Occurrence and Reasons of Errors Not Reported. Each item has five responsesstrongly agree, agree, neutral, disagree and strongly disagree. Total number of items were 24. The maximum and minimum marks awarded for each item were 5 &1.

Study Subjects: 70 registered nurses working in different clinical areas like General ward, O.T., Pediatrics unit, ICU, HDU etc. of Indraprastha Apollo Hospital, New Delhi were part of the study.

Data Collection: Registered nurses were selected by purposive sampling method. They were interviewed personally by the researchers. Ethical clearance from organizational review board was taken before starting the study. Before the questionnaire was given to the participants, the aims and objectives of the study were explained to them.

RESULTS

Fig. 1-4 show the distribution of background information of the registered nurses. Out of 70 participants, 36 (51.4%) were in the age group of 24 and less than 24 years; 39 (55.7%) had done diploma in General Nursing and Midwifery; 26 (40%) admitted that common error made by nurses is documentation error, 26 (37.2%) had professional experience of 1-2 years. It was found that all registered nurse were females and dealt with issues/errors by reporting to senior colleagues/ physician.

Table 1(a) shows the item wise frequency and percentage distribution of opinionnaire score – reasons of error occurrence as per the Registered Nurses. Majority of the RNs agreed that understaffing& heavy work load,



fatigue/disruption of right practice or frequent shift changes. Knowledge gaps, lack of complete patient information& lack of formalized pathway for communication feedback structure & or error Communication gap among health team (f = 31, 28, 26, 24, 23 respectively) are the causes of error occurrence. Maximum RNs disagreed that lack of professional responsibility and accountability & non-uniformity in standardization of care and lack of professional support (f = 22 & 20 respectively) are the causes of error occurrence.

Table 1(b) shows item wise frequency & percentage distribution of opinionnaire score – reasons of errors not reported as per the Registered Nurses. Majority

of the RNs agreed that time constraints, inappropriate reaction of the authorities regarding the severity of the error, reporting near misses can facilitate a blame-free approach, inadequate physician supervision, fear of loss of physician's confidence, embarrassment being recognized as incompetent & loss of reputation/status (f = 39, 32, 29, 27, 24, 23& 22 respectively) are the reasons of errors not reported. Many of RNs disagreed that lack of knowledge and skill in how to report errors and defected safety culture are the reasons why errors are not reported (f = 32& 22 respectively).

Table 2(a) & 2(b) shows mean, median & standard deviation of opinionnaire score of registered nurses.



Table 1 (a). Item wise Frequency & Percentage Distribution of Opinionnaire Score – Reasons of Error Occurrence

S. No.	Item	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
		f	%	f	%	F	%	f	%	f	%
1	Understaffing	21	30	31	44.28	9	12.85	9	12.85	0	0
2	Communication gap among health team	5	7.14	23	32.85	20	28.57	21	30	1	1.42
3	Non-uniformity in	9	12.85	9	12.85	29	41.42	20	28.57	3	4.28

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	standardization of care										
4	Lack of complete patient information	2	2.85	24	34.28	20	28.57	23	32.85	1	1.42
5	Fatigue/disruption of right practice or frequent shift changes	7	10	28	40	18	25.71	16	22.85	1	1.42
6	Lack of formalized pathway for communication or error feedback structure	7	10	24	34.28	22	31.42	17	24.28	0	0
7	Heavy work load	12	17.14	31	44.28	20	28.57	6	8.57	1	1.42
8	Lack of professional support	8	11.42	16	22.85	26	37.14	20	28.57	0	0
9	Knowledge gaps	8	11.42	26	37.14	14	20	20	28.57	2	2.85
10	Lack of professional responsibility and accountability	7	10	21	30	14	20	22	31.42	6	8.57

Table 1 (b). Item wise Frequency & Percentage Distribution of Opinionnaire Score – Reasons of Errors Not Reported

S.	Item	Stro Ag	Strongly Agree		gree	Neutral		Disagree		Strongly Disagree	
110.		f	%	f	%	F	%	f	%	f	%
1	Reporting error will result in unintended consequences (scolding, payback, or punishment)	16	22.85	17	24.28	23	32.85	10	14.28	4	5.71
2	Reporting near misses can facilitate a blame-free approach.	2	2.85	29	41.42	20	28.57	15	21.42	4	5.71
3	Disclosure is also an element that contributes to the creation of a culture of safety	3	4.28	21	30	28	40	13	18.57	5	7.14
4	Time constraints	4	5.71	39	55.71	12	17.14	12	17.14	3	4.28
5	Inadequate physician supervision	9	12.85	27	38.57	15	21.42	19	27.14	0	0
6	Fear of loss of physician's confidence	4	5.71	24	34.28	24	34.28	13	18.57	5	7.14
7	Defected safety culture	3	4.28	16	22.85	27	38.57	22	31.42	2	2.85
8	Threat of legal / disciplinary action (Suspension, Termination, etc.)	10	14.28	18	25.71	21	30	18	25.7	3	4.28
9	Embarrassment being recognized as incompetent	2	2.85	23	32.85	25	35.71	15	21.42	5	7.14
10	Inappropriate reaction of the authorities regarding the severity of the error	6	8.57	32	45.71	18	25.71	11	15.7	3	4.28
11	Loss of reputation/status	5	7.14	22	31.42	24	34.28	17	24.28	2	2.85
12	Lack of knowledge and skill in how to report errors	4	5.71	16	22.85	7	10	32	45.71	11	15.7

Table 2(a). Mean, Median, Standard Deviation of Opinionnaire Score (Causes Of Error Occurrence)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Mean	8.6	23.3	19.2	1.5	17.4
Median	9	23.5	19	0	18.5
Standard deviation	1.823	2.426	2.109	0.659	2.029



	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Mean	5.7	23.6	20.4	3.9	16.4
Median	5.5	23.5	22	3.5	16
Standard deviation	1.632	2.799	2.509	1.036	2.393

Table 2(b). Mean, Median, Standard Deviation of Opinionnaire Score (Reasons Of Errors Not Reported)

DISCUSSION& CONCLUSION

When a mistake is made, admitting and promptly reporting the error to an appropriate authority is the 'right thing to do'. Hiding errors can have serious adverse consequences at both practical and moral level. Healthcare workers, who strive to provide high quality patient care and continually promote improvements in the area of patient safety, can be further assisted by identifying factors and causes of clinical incidents that will promote effective management of such issues [15].

The study was conducted with an aim to assess the perception of registered nurses on clinical error reporting and to develop and disseminate guidelines to registered nurses on importance of clinical error reporting. In the present study, majority of RNs agree that understaffing, heavy work load and fatigue, lack of formalized pathway for communication or error feedback structure is the main cause of error occurrence. These findings were in agreement with Fitzgerald, Cawley & Rowan (2010) who found insufficient time and heavy workload were frequently cited as perceived barriers to effective clinical incident reporting [13].

Jordanian (2000) found that fear of disciplinary action and the reaction of nurse managers were the most frequent reasons related to nurses 'failure to report MAE [16]. In the current study, most of the RNs disagree to lack of knowledge and skill in how to report errors. Majority of RNs have neutral opinion that defected safety culture, embarrassment being recognized as incompetent, loss of reputation/status and disclosure is also an element that contributes to the creation of a culture of safety is the reason why errors are not reported.

A similar study has shown that frequencies of error types recorded vary between countries and regions. Some of these differences may be real, while others may simply be due to different reporting routines and classification systems. Efforts to increase patient safety within hospital settings are numerous and have resulted in

organizational, cultural, and systemic manv environmental changes that have reduced harm [17]. Although much attention has been focused on finding ways to identify medical errors and thereby reduce harm in hospital settings, few efforts have been directed at these issues in ambulatory settings. Duke University's Department of Community and Family Medicine has developed and implemented a practical, voluntary reporting system with classification and tracking of types of errors. Initially created in the Family Medicine Center, this system is now used in all the department's wide variety of clinical operations. By reporting errors, analyzing error patterns, and addressing them, the clinical practices have become better able to identify faulty systems and error-prone areas and to change processes to prevent future errors. Studies have found that most errors in primary care practice are preventable [18].

As Mohr and Batalden (2002) suggested, improving patient safety should start on the front lines. To achieve this, it may be a good start to establish a clinical microsystems in which a small, organized group of clinicians and staff with a shared vision works together to provide safe care for a defined set of patients. Error reporting systems have the potential of assisting in continuous practice redesign so that patient safety is improved. The system described here has the advantages of being simple and usable in a busy practice setting. Use of simple error tracking systems. Education needs to be broadened to include explicit patient safety topics, such as human factors, and methods, such as simulation, designed to create a generation of health-care workers who deliver consistently safe care [19].

Harm caused by committing the wrong action or omitting to perform the necessary action can be reduced by the presence of SOPs. Good leadership and the development of systems to support SOPs are needed to aid their implementation.

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