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Feature Article

Should I report? A qualitative study of barriers to incident reporting among nurses working in nursing homes

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ABSTRACT

Adverse events, errors and acts of inadequate care have been shown to occur quite frequently in hospitals, and there is growing evidence that this poor care may also occur in nursing homes. Based on hospital studies, we know that incidents are only reported to a limited extent and that there may be a high number of unrecorded cases. Moreover, little is known about the barriers to incident reporting in nursing homes compared to hospitals. Consequently, the aim of this study was to explore the barriers to incident reporting in nursing homes. Thematic analysis of 13 semi-structured interviews with nurses revealed that unclear outcomes, lack of support and culture, fear of vilification and conflicts, unclear routines, technological knowledge and confidence, time and degree of severity were the main drivers of not reporting incidents. These findings may be important in planning quality and safety improvement interventions in nursing homes.

Introduction

Patient safety is a term that has been well-established in recent years. It has been defined as "the prevention of harm to patients"[1] and as "the prevention of errors and adverse effects to patients associated with health care."[2] There is little doubt that when patients are treated and cared for within the health care system, they are exposed to an environment consisting of complex interactions. This complexity may lead to an increased risk of unanticipated incidents and adverse events.[3] In their groundbreaking report in the late 1990s, "*To Err Is Human*,"[4] the Institute of Medicine (IOM) concluded that thousands of people were injured because of health care treatment each year. In 1999, it was estimated that the total cost of preventable adverse events in the United States (U.S.) was between $17 billion and $29 billion annually.[5] Consequently, awareness of quality of care and treatment was increased, not only inside but also outside the health care system.[3,4] Emphasis was placed on a care delivery system that "prevents errors, learns from the errors that do occur, and is built on a culture of safety that involves health care professionals, organizations, and patients."[3]

The U.S. Department of Health and Human Services, Office of Inspector General (OIG), defined the term "adverse event" as "*harm to a patient that comes as a result of medical care.*"[6] In a review of eight studies including 74,485 patient records, de Vries et al[7] found that nearly one in 10 patients experienced adverse events during hospital admission. The majority of these events were related either to surgery (39.6%) or medications (15.1%). Although the OIG definition of adverse events includes the failure to provide needed care, these events do not always involve "errors, negligence and poor quality of care."[6] However, studies have also shown that nurses frequently report missed care (defined as the omission of any aspect of required patient care)[8,9] and that the amount of care that isn't performed ranges from 26 to 76%. Missed care has been associated with nurse-patient ratios[10] and nurses' perceptions of patient safety.[11]

In the late 1990s, the IOM found that the lack of awareness of the high number of daily errors "exists because the vast majority of errors are not reported."[12] In recent years, several randomized controlled trials of interventions aimed at improving patient safety across various health care settings have been published.[13–17] Additionally, standardized patient safety taxonomies have been developed for hospitals, several U.S. states have laws for reporting adverse events and the U.S. Congress passed the Patient Safety and

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Quality Improvement Act that includes incident reporting as a significant contributor to improving quality. The latter is known to be essential to improving patient safety.[18–23] However, despite research efforts and the implementation of incident reporting systems, underreporting seems to persist as a significant problem.[24]

The problem of underreporting incidents may stem from a complex mix of factors. Lawton and Parker,[25] in a study of 315 doctors, nurses and midwives from three English National Health Service (NHS) Trusts, found that doctors were the most reluctant to report incidents and that the risk of not reporting them increased if the incident did not result in an adverse event or did not constitute a direct violation of protocols. In a study during the mid-1990s that investigated nurses' perceptions of medication error reporting in hospitals, Wakefield et al[26] found, that fear, disagreement over whether an error occurred, administrative responses, and effort required to report were the main drivers of incidents not being reported. Indeed, these results have been supported by several studies showing that nurses avoid error reporting because of prior experiences and personal consequences, such as anxiety, depression and social exclusion.[27–32] Lafton et al[33] also argue that a lack of knowledge concerning what should be reported constitutes an important driver of underreporting, whereas Ammenwerth et al[34] found that a lack of electronic confidence prevented nurses from reporting. Younger age and a higher educational level have also been associated with increased likelihood of reporting incidents.[35]

Although substantial attention has been paid to patient safety in hospital settings in recent years, far less is known about these issues in nursing home settings.[6] Most existing studies have primarily focused on medication-related adverse events.[36] The recently published OIG report[6] found that 22% of Medicare beneficiaries experienced adverse events during their stay in a skilled nursing facility. This finding included not only events related to medications but also events related to resident care (e.g., the development of pressure ulcers, falls, skin tears) or related to infections. Fifty-nine percent of these cases were likely preventable. In a study in Norway, Malmedal et al[37] investigated the prevalence of reporting inadequate care among nursing staff in 16 nursing homes. A total of 91% reported that they had observed at least one act of inadequate care, and 87% reported that they had committed at least one act of inadequate care.[37] Negligent and emotional acts were frequently reported.[37]

Although nurses have a profound role in ensuring patient safety and quality of care, several studies have shown that they may be underreporting incidents.[12,30,32] There is currently a paucity of studies that have explored potential barriers of incident reporting in nursing home settings. Consequently, the aim of this study was to explore how nurses who work in long-term wards in nursing homes experience and perceive barriers to incident reporting.

Methods

Because the aim of this study was to obtain information that is based on the values, opinions and social contexts of the population in question, a qualitative approach was the most appropriate method.

In reviewing the quality and safety in health care literature, several different terms are used – some narrower than others (e.g., adverse event or near miss).[38] We chose to use a broad definition to explore the respondents' views of incident reporting, although this approach resulted in a wide range of circumstances (e.g., overt errors, errors of omission and poor quality of care). We consequently used the term "incident" as the basis of our study. An incident has previously been described in the literature as an "event or circumstance which could have or did harm to anyone or which resulted in a complaint, loss or damage."[38] However, in our view, patients admitted to long-term care settings in nursing homes may not always be able (e.g., because of cognitive impairment) to lodge a complaint themselves. Consequently, incidents that are viewed by nurses as having the potential to result in a complaint, damage and harm may be of equal importance.

Setting

This study was conducted in seven nursing homes in three different municipalities in the county of Østfold in the south eastern part of Norway. The county covers 3889 km^2 and consists of 18 municipalities with approximately 300,000 inhabitants.

All Norwegian municipalities ensure that there is a 24-hour based service staffed by medical professionals. Nursing homes offer both short-term and long-term residency accommodation. Short-term accommodation can be arranged if, for example, a recipient needs training (rehabilitation) or extensive professional medical assistance for a limited period. An "own contribution" charge is made for outpatient, overnight short-term and long-term admittances. The cost is stipulated annually in the national budget. The long-term wards are classified into regular units (RUs) and special care units (SCUs) for persons with dementia. Patients who are admitted for long-term stays pay a particular proportion of their income (pension, earnings on interest and so forth). The institution cannot demand payment from capital assets (fixed property, bank deposits, shares, etc.).

Participants

The 17 nursing homes (the total number of nursing homes in the three municipalities) were identified through official registries and invited to participate in the study. The sites were selected because of their convenient accessibility and proximity to the Østfold University College and the two researchers (IWP/LPJJ). The respondents were recruited in three phases: Phase 1) All nursing homes identified were contacted and given oral and written information about the study; Phase 2) Nurse administrators at the participating sites, informed members of their staff about the proposed study and identified nurses who were willing to participate in an interview; Phase 3) The individual participants identified in phase 2 were contacted by phone. All participants were then given updated oral and written information, and individual interview appointments were scheduled.

A total of 24 nurses were approached, and 13 gave their consent to participate. The respondents represented seven nursing homes in all three municipalities. Individual semi-structured interviews were conducted from April 2013 to October 2013. The characteristics of respondents and non-respondents are listed in Table 1.

Data collection

Socio-demographic characteristics (age and time since graduation from nursing school) were collected through self-reports. Semi-structured interviews were conducted face-to-face at the nurses' workplace during working hours (IWP). All interviews were performed in a closed room, avoiding unnecessary disturbance. To explore the nurses' perspectives on barriers to incident reporting, an interview guide was developed to direct the individual sessions. The guide included the following topics: 1) previous experiences with incident reporting and their relation to barrier development (questions such as "Can you describe previous experiences with incident reporting?", "How were these handled?", "Do you think prior experiences may limit incident reporting?"); 2) Systems and routines (questions such as "Can you describe the routines you have at work when it comes to reporting incidents?", "Can you describe