ARTÍCULO ORIGINAL

Gac Méd Caracas 2022;130(4):753-758
DOI: 10.47307/GMC.2022.130.4.10

Nurses attitude and communication on reporting incidents on patients safety culture in Ende Regional General Hospital

Actitud y comunicación de los enfermeros acerca el reporte de incidencias sobre la cultura de seguridad del paciente en el Hospital General Regional Ende

Try Ayu Patmawati [1a], Yoseph Woge[2a], Anatolia K Doondori[3a], Sisilia Leny Cahyani[4a], Haeril Amir[5b]

SUMMARY

Objective: *This study aimed to assess the factors that affect the level of incident reporting in the Ende Regional General Hospital.* **Methods:** *The research design was descriptive-analytic with a cross-sectional approach to analyze incident reporting culture and factors influencing patient safety incident reporting culture in nurses at the Ende Regional General Hospital (RSUD). The population involved 162 nurses at the Ende General Hospital with a purposive sampling technique. The instrument used was the Incident Reporting Culture Questionnaire and the attitude, communication, and teamwork questionnaire.* **Result:** *There was a significant nurses' attitude (p=0.004) and nurses' communication (p= 0.001) toward incident reporting.* **Conclusion:** *All health workers must work together so that patient safety incident reporting becomes a culture. The culture of reporting patient safety incidents at RSUD Ende must be improved. Nurses' communication and attitudes should be monitored more closely because they are closely related to the culture of reporting incidents in hospitals.*

Keywords: *Incident reporting, patient safety, communication, attitude.*

DOI: https://doi.org/10.47307/GMC.2022.130.4.10

ORCID: https://orcid.org/0000-0002-5059-333X[1]
ORCID: https://orcid.org/0000-0003-1420-5595[2]
ORCID: https://orcid.org/0000-0002-5059-333X[3]
ORCID: https://orcid.org/0000-0002-4129-0134[4]

[a]Ende Nursing Study Program, Poltekkes Kemenkes Kupang, Indonesia.
[b]Department of Nursing, Faculty of Public Health, Universitas Muslim Indonesia, Makassar, Indonesia.

*Corresponding author: Try Ayu Patmawati
Ende Nursing Study Program, Poltekkes Kemenkes Kupang, Indonesia. Tel: +62 82336442281
E-mail: tryayupatma@poltekeskupang.ac.id

Recibido: 12 de noviembre 2022
Aceptado: 23 de noviembre 2022

RESUMEN

Objetivo: *Este estudio tuvo como objetivo evaluar los factores que afectan el nivel de notificación de incidentes en el Hospital General Regional de Ende.* **Métodos***: El diseño de investigación fue descriptivo-analítico con enfoque transversal para analizar la cultura de notificación de incidentes y los factores que influyen en la cultura de notificación de incidentes de seguridad del paciente por las enfermeras del Hospital General Regional de Ende (RSUD). La población fueron 162 enfermeras del Hospital General de Ende con una técnica de muestreo intencional. El instrumento utilizado fue el Cuestionario de Cultura de Reporte de Incidentes y el cuestionario de actitud, comunicación y trabajo en equipo.* **Resultado:** *Exiate una reación significativa entre la actitud de los enfermeros (p=0,004) y la comunicación de los*

enfermeros (p= 0,001) hacia el reporte de incidentes. **Conclusión:** *Todos los trabajadores del área de la salud deben trabajar juntos para que la notificación de incidentes de seguridad del paciente se convierta en una cultura. Se debe mejorar la cultura de reporte de incidentes de seguridad del paciente en RSUD Ende. La comunicación y las actitudes de las enfermeras deben monitorearse más de cerca porque están estrechamente relacionadas con la cultura de informar incidentes en los hospitales.*

Palabras clave: *Reporte de incidentes, seguridad del paciente, comunicación, actitud.*

INTRODUCTION

Patient safety incident reporting is at the heart of service quality, which is an important part of the learning process and internal reform, renewal, and revision of policies, including standard operating procedures and existing guidelines. Incident reporting in healthcare is considered a way to monitor, prevent and reduce the occurrence of patient safety events, but still relies on voluntary reporting by staff.

Based on the previous research of Patmawati and Djano (1), using the Incident Reporting Culture Questionnaire (IRCQ) instrument, it was found that the incident reporting culture showed a negative response of 60.3 %. In the study, it was also found that the collegial atmosphere factor due to discomfort and punishment was the factor that received the largest negative response in reporting incidents, and nurses were reluctant to report because it would disrupt intimacy and teamwork and feel afraid of blaming.

Several studies have also stated that blame is the biggest factor that hinders reporting of safety incidents (2-4) so management control is very much needed. In addition, other inhibiting factors are time constraints, unsatisfactory processes, lack of knowledge, level of education, cultural norms, perceptions of nurses, nurse attitudes, inadequate feedback, and management and leadership support (5-10). Communication failures in Incident reporting are also one of the most influential barriers. Communication failures are often identified after a root cause analysis is carried out following serious adverse events (11,12). For a patient safety culture at the area/work unit level, communication regarding safety procedures and work systems should be strengthened by the leadership to encourage incident reporting and thus the development of patient safety (8).

In hospitals, incident reporting is an approach that must be improved to create a patient safety culture, but the big problem is that there are obstacles related to incident reporting. Therefore, the purpose of this study is to further assess what factors affect the level of incident reporting, especially in the Ende Regional General Hospital.

METHODS

The research design used in this study was descriptive-analytic with a cross-sectional approach to analyze incident reporting culture and factors influencing patient safety about incident reporting culture in nurses at the Ende Regional General Hospital (RSUD). The population in this study was 162 nurses at the Ende General Hospital, using purposive sampling techniques. The instrument used was the Incident Reporting Culture Questionnaire and the attitude, communication, and teamwork questionnaire.

Ethical Clearance

The study was officially approved and permitted by the hospital director and the head nurse. The study protocol was approved by the Health Research Ethics Committee of the Health Polytechnic of Kupang (No. LB.02.03/1/0059/2022). All participants signed informed consent after being fully explained the purpose and benefits of the study. They were also informed that their participation in this study was voluntary and that they could refuse or withdraw from the study at any time without giving any reason. Patient confidentiality was guaranteed by encoding all data.

RESULTS

Table 1 shows that the average age of the respondents is 37.17, consisting of 19 males (8.6

%) and 143 females (88,3 %), in addition to 162 respondents, 30 nurses (18.5 %) are educated Nurses, Bachelors as many as 7 nurses (4,3 %) and Diploma as many as 125 nurses (77,2 %). Table 1 also shows that most of the respondents have worked for more than 5 years.

Table 1

Distribution of The Characteristics of Respondent in ENDE Regional General Hospital

Characteristics	Mean ± SD	n (%)
Age (year)	37.17± 6.72	
Gender		
Male		19 (11.7)
Female		143 (88.3)
Education		
Diploma		125 (77.2)
Bachelor		7 (4.3)
Professional Nurses		30 (18.5)
Working Length (year)		
< 5		28 (17.3)
>= 5		134 (82.7)

In Table 2 is observed that respondents who show a negative response to incident reporting culture are 63.6 % while the positive response is 36.4 %.

Table 2

Distribution of Respondents Based on The Incident Reporting Culture of Nursing in ENDE Regional General Hospital

Incident Reporting Culture	n	Percentage (%)
Negative response	103	63.6
Positive response	35	36.4

Table 3 shows that respondents who have good communication 121 (63.6 %) and less 41 (25.3 %)

Table 3

Distribution of Respondents Based on Communication of Nursing in ENDE Regional General Hospital

Communication	N	Percentage (%)
Good	121	74,7
Less	41	25,3

Table 4 shows that respondents who have a good attitude are 61 (37.7 %) and less are 5 (3.1 %)

Table 4

Distribution of Respondents Based on Communication of Nursing in ENDE Regional General Hospital

Attitude	n	Percentage (%)
Good	61	37.7
Moderate	96	59.3
Less	5	3.1

Table 5 shows that nurses' communication has a significant relationship with Incident reporting culture (p-value = 0.001)

Table 5

Correlation of nurses' communication toward incident reporting

Commu-nication	Incident Reporting Culture				P-value
	Negative		Positive		
	N	%	n	%	
Good	68	66.0	53	89.8	0.001
Less	35	34.0	6	10.2	

Table 6 shows that nurses' attitude has a significant relationship with Incident reporting culture (p-value = 0.004)

Table 6

Correlation of nurses' attitude toward incident reporting

Attitude	Incident Reporting Culture				P-value
	Negative		Positive		
	n	%	n	%	
					0.004
Good	2	28.2	32	54.2	
Moderate	3	68.9	25	42.4	
Less	3	2.9	2	3.4	

DISCUSSION

Reporting patient safety incidents is important to improve the hospital service system. The main reason for reporting incidents is to improve patient safety the belief is that safety can be improved by learning from incidents and near misses, rather than pretending that they have not happened. There is a need to gather information that can be used to improve hospital systems to minimize errors in healthcare, and many strategies and tools have also been developed to reduce errors. It is believed by quality and safety organizations, and the consumers of healthcare systems, that incident reporting is better for understanding errors and their contributing factors. Critical incident reporting and learning (13).

Based on our results on incident reporting culture, we observe a negative response of 63.6 % and a positive response of 36.4 %. The low positive response to reporting this incident is similar to those reported by others (1,14-16) who indicate that several factors are involved, including that some nurses are afraid of disturbing relationships between colleagues as well as the lack of feedback when someone reports the incident. The response to incident reporting must be followed up immediately by analyzing the causes of errors, getting solutions, and monitoring evaluations, without adequate feedback it will not encourage reports or provide satisfaction for nurse reporting (16,17).

In addition, it was also showed that nurses' commu-nication has a significant relationship with Incident reporting culture, in accordance with research (18,19) where is stated that communication is very important in health services, and communication and patient involvement in incident reporting is highly recommended for improving patient safety. Therefore, Kathy et al. (20) stated that inadequate and poor communication is a serious safety challenge. Thus, overcoming communication barriers requires the detection and reporting of barriers through routine safety checks and the development of good collaboration (21,22).

To improve the patient safety culture at the area/work unit level, communication regarding safety procedures and work systems should be strengthened by the leadership to encourage incident reporting and thus the development of patient safety (8).

Furthermore, we also revealed that nurses' attitude has a significant relationship with Incident reporting culture. This is reinforced by research (23,24) where is demonstrated that nurses' attitudes have a significant effect on incident reporting culture. Also, it was observed that "a collegial atmosphere due to the discomfort and punishment" has a negative response as much as 79.6 % of studies (2-5,7), where it was stated that one of the main challenges for reporting incidents related to patient safety is the fear of being blamed and punished. In effect, in general, only a small percentage of nurse's report incidents formally, possibly it could be due to the unfamiliarity with the process. Other factors which have been identified are cultural issues such as fear of punitive action, legal ramifications, and discrimination at the workplace.

In addition, the Incident management, confidential and system-driven subscale, also shows a negative response of 58.0 % in this study. This is a concern because maintaining confidentiality in incident reporting is very important. A reporting culture that emphasizes learning from mistakes, effective feedback after reporting, a collegial atmosphere of less punishment, and confidential and system-driven incident management can increase nurses' willingness to report (25,26). In this regard, Howell et al. (27) showed that an open environment and reduced fear of punishment responses increased incident reporting.

CONCLUSION

The hospital and all health workers must work together so that patient safety incident reporting becomes a culture. The culture of reporting patient safety incidents at RSUD Ende must be improved. Nurses' communication and attitudes should be monitored more closely because they are closely related to the culture of reporting incidents in hospitals. The entire hospital, both leadership, and staff must jointly discuss issues related to patient safety and incidents and improve attitudes and communication and improve feedback, thereby encouraging incident reporting.

REFERENCES

1. Patmawati TA, Djano NAR. Cultural Analysis of Reporting Patient Safety Incidents to Nurses at the Regional General Hospital (RSUD) Sawerigading Palopo. J Nursing Muhammadiyah. 2020;5(2).
2. Suryanto S, Febri DT. Relationship between Patient Safety Culture and Patient Safety Incident Reporting by Nurses in Hospital Inpatient Rooms. University of Northern Sumatra; 2018.
3. Najjar S, Nafouri N, Vanhaecht K, Euwema M. The relationship between patient safety culture and adverse events: a study in Palestinian hospitals. Saf Heal. 2015;1(16):1-9.
4. El-Jardali F, Dimassi H, Jamal D, Jaafar M, Hemadeh N. Predictors and outcomes of patient safety culture in hospitals. BMC Health Serv Res. 2011;11(45).
5. Wagner C, Smits M, Sorra J, Huang C. Assessing patient safety culture in hospitals across countries. Int J Qual Heal Care. 2013;25(3):213-221.
6. Whitaker J, Ibrahim J. Incident reporting feedback experience in a UK secondary care setting, Are staff increasingly reluctant to complete incidence forms ? Publisihing R Coll Surg Engl. 2016;82-84.
7. Carayon P, Wetterneck TB, Rivera-Rodriguez AJ, Hundt AS, Hoonakker P, Holden R, et al. Human factors systems approach to healthcare quality and patient safety. Appl Ergon. 2014;45(1).
8. Yoo MS, Kim KJ. Exploring the Influence of Nurse Work Environment and Patient Safety Culture on Attitudes Toward Incident Reporting. J Nurs Adm. 2017;00(0):1-7.
9. Prang IW, Jelsness-Jørgensen L-P. Should I report? A qualitative study of barriers to incident reporting among nurses working in nursing homes. Geriatr Nurs (Minneap). 2014;35(6):441-447.
10. Kirwan M, Matthews A, Scott PA. International Journal of Nursing Studies The impact of the work environment of nurses on patient safety outcomes: A multi-level modeling approach. Int J Nurs Stud. 2013;50(2):253-263.
11. Umberfield E, Ghaferi AA, Krein SL, Manojlovich M. Using Incident Reports to Assess Communication Failures and Patient Outcomes. Jt Comm J Qual Patient Saf. 2016:1-8.
12. Amir H. Strategies In Preventing The Transmission Of COVID-19 A Quarantine, Isolation, Lockdown, Tracing, Testing, and Treatment (3t): Literature Review. Asia-Pasific J Helath Manag. 2022;17(2):1-6.
13. Mahajan RP. Critical incident reporting and learning. British J Anaesthesia. 2010;105(1):69-75.
14. Adrini TM, Harijanto T, Woro UE. Factors Affecting the Low Reporting of Incidents at the Pharmacy Installation of Ngudi Waluyo Wlingi Hospital. J Kedokt Brawijayak. 2015;28(2):214-220.
15. Widodo FY, Harijanto T. Analysis of Low Reports of Patient Safety Incidents in Hospitals. J Kedokt Brawijaya. 2015;28(2):206-213.
16. Mandriani E, Yetti H, Hardisman H. Analysis of Patient Safety Culture Dimensions by Health Workers at RSUD Dr Rasidin Padang in 2018. J Health Andalas. 2019;8(1):131-137.
17. Lederman R, Dreyfus S, Matchan J, Hons BIS, Knott JC, Milton SK. Electronic error-reporting systems: A case study into the impact on nurse reporting of medical errors. Nurs Outlook. 2013;61(6):417-426.e5.
18. Burgener AM. Enhancing Communication to Improve Patient Safety and Increase Patient Satisfaction. Health Care Manag (Frederick). 2020;39(3):128-132.
19. Connell KJO, Shaw KN, Ruddy RM, Lichenstein R, Olsen CS, Funai T, et al. Incident Reporting to Improve Patient Safety The Effects of Process Variance on Pediatric Patient Safety in the Emergency Department. Pediatr Emerg Care. 2018;34(4):237-242.
20. Shaw KN, Lillis KA, Ruddy RM, Mahajan PV, Lichenstein R, Olsen CS, et al. Reported medication events in a pediatric emergency research network : sharing to improve patient safety. Emerg Med J. 2013:815-819.
21. Rosse F Van, Bruijne M De, Suurmond J. International J Nursing Studies Language barriers and patient safety risks in hospital care. Mixed methods study. Int J Nurs Stud. 2016;54:45-53.
22. Vaismoradi M, Jordan S, Kangasniemi M. Patient participation in patient safety and nursing input – a systematic review. J Clin Nurs. 2014:1-13.
23. Kusumawati AS, Handiyani H, Rachmi SF. Patient safety culture and nurses' attitude on incident reporting in Indonesia. Enfemeria Clin. 2019;29.

24. Anggraeni D, Ahsan A, Azzuhri M. The Influence of Patient Safety Culture on Attitudes of Reporting Incidents to Nurses in the Inpatient Installation of Tk Hospital. II Dr. Soepraoen. J Manaj App. 2016;(66):309-321.
25. Scot S, Henneman E. Underreporting of medical errors. MEDSURG Nurs. 2017;26(3).
26. Pham JC, Girard T, Pronovost PJ. What to do with healthcare Incident Reporting Systems. J Public Health Res. 2013;2.
27. Howell A, Burns EM, Bouras G, Donaldson LJ, Athanasiou T, Darzi A. Can Patient Safety Incident Reports Be Used to Compare Hospital Safety ? Results from a Quantitative Analysis of the English National Reporting and Learning System Data. Plos One. 2015;61:1-15.