



BARRIERS TO REPORT PATIENT SAFETY INCIDENTS IN HOSPITAL: SCOPING REVIEW

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ABSTRACT

Patient safety incident reporting is part of the patient safety programme. At the hospital level, this reporting is to find out the causes of patient safety incidents and find the root causes to anticipate that the incident will not happen again. According to the National Reporting and Learning System (NRLS) report, from August 2021 to July 2022, there were 2,410,311 reports of patient safety incidents in the UK. According to Malaysian Ministry of Health (MoH) data, there were 151,225 reports of patient safety incidents in 2021. The purpose of this scoping review is to evaluate the current literature on barriers to reporting patient safety incidents and summarise evidence relating to differences in barriers to reporting patient safety incidents in Indonesian and overseas hospitals. This research uses the scoping review method. Scoping review is a method used to identify literature comprehensively through various sources with various research methods and related to the research topic. The results showed that the barriers in reporting patient safety incidents are Management Support, Lack of Education and Training, Patient Safety Knowledge, Safety Motivation, Workload, Coworker Support. Barriers to reporting patient safety incidents, both in hospitals in Indonesia and abroad, have similar problems.

Keywords: barriers; hospitals; patient safety incidents; reporting

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INTRODUCTION

Patient safety is a system designed to make patient care safer.(Abdelmaksoud et al., 2024) Patient safety has been and remains a major concern in healthcare systems around the world. Population-based studies from various countries, especially developed countries with developed patient incident reporting systems, consistently show high rates of preventable medical injuries and deaths.(Almansour, 2024). About 1 in every 10 patients is harmed in healthcare and more than 3 million deaths occur annually due to unsafe care.(Dhamanti et al., 2022) In low- to middle-income countries, as many as 4 in 100 people die due to unsafe care. Over 50% of harm (1 in every 20 patients) is preventable; half of this harm is attributable to medicines.(Dhamanti et al., 2019) Some estimates suggest that as many as 4 in 10 patients are harmed in primary and outpatient healthcare, while 80% (23.6-85%) of this harm is avoidable.(Donaldson et al., 2014) Common adverse factors that can harm patients are medication errors, unsafe surgical procedures, healthcare-associated infections, diagnostic errors, patient falls, pressure sores, patient misidentification, unsafe blood transfusions and venous thromboembolism. Patient loss has the potential to reduce global economic growth by 0.7% per year. On a global scale, the indirect costs amount to trillions of US dollars annually (Dhamanti et al., 2022); (Rahmattuhan et al., 2023).

In May 2002, the World Health Organisation (WHO) passed a resolution urging countries to pay great attention to patient safety. It also called on the Director-General of the World Health Organization (WHO) to take a series of steps to improve patient safety. The resolution sets out

WHO's responsibilities in providing technical support to member states, including developing reporting systems, reducing risks, formulating evidence-based policies, fostering a culture of safety, and promoting a research agenda on patient safety.(Almansour, 2024)Patient safety incident reporting is part of a patient safety programme. At the hospital level, reporting aims to determine the causes of patient safety incidents and find the root causes to anticipate that the incident will not recur. Non-compliance in reporting is a failure related to an incident that occurs. This will result in the learning process to improve patient care being delayed. In addition to reducing patient safety incidents, this reporting also improves the quality of health services and patient safety.(Abdelmaksoud et al., 2024). Salmasi et al (2015) in their study of six countries in Southeast Asia: Singapore, Malaysia, Thailand, Vietnam, Philippines and Indonesia stated that reporting of patient safety incidents in some countries is still relatively low. (Salmasi et al., 2015).This is due to the lack of data related to medical errors from almost 50% of countries in Southeast Asia and weaknesses in the reporting system in the region.(Gqaleni & Mkhize, 2024). According to the National Reporting and Learning System (NRLS) report, from August 2021 to July 2022, there were 2.410.311 reports of patient safety incidents in the UK. (Hacking, 2012). According to Malaysian Ministry of Health (MoH) data, there were 151.225 patient safety incident reports in 2021.

Various countries around the world report patient safety incidents in healthcare facilities. According to the National Reporting and Learning System (NRLS) report, from August 2021 to July 2022, there were 2.410.311 patient safety incident reports in the UK. (Abdelmaksoud et al., 2024). According to Malaysian Ministry of Health (MoH) data, there were 151.225 patient safety incident reports in 2021.WHO has published a technical document describing the purpose, strengths and limitations of patient safety incident reporting systems. The report emphasises that data obtained from incident reports are invaluable for understanding the scale and nature of harm arising from health services.(Micah DJ, et al, 2024)Incident reporting has the potential to identify areas of service failure as well as highlight opportunities to save patients' lives. (Yali & Nzala, 2022)However, incident reporting systems are still not optimised, and patient safety incident reporting rates remain low. (Dhamanti et al., 2019). Although some countries and hospitals are showing improvements in incident reporting, this progress has been uneven, especially in regional hospitals. The aim of this scoping review is to evaluate the current literature on barriers to reporting patient safety incidents and summarise evidence relating to differences in barriers to reporting patient safety incidents in Indonesian and overseas hospitals

METHOD

This research uses the scoping review method. Scoping review is a method used to identify literature comprehensively through various sources with various research methods and related to the research topic. The framework used is Arskey and O'Malley (2015) which consists of several stages, namely: (1) identifying research questions, (2) determining keywords, (3) determining inclusion and exclusion criteria, (4) collecting articles and selecting studies, (5) mapping data with tables, compiling, summarising and reporting results. (Micah et al, 2024).

Step 1: Identifying the Research Question

We followed the framework outlined by Arksey and O'Malley. In their methodological paper on scoping studies and by utilising methods from two recent publications. Scoping reviews differ from systematic reviews in their breadth and purpose. Systematic reviews tend to ask questions that are more narrowly defined and have been formally quality assessed. Scoping reviews ask broader questions and do not assess the quality of the studies reviewed. Scoping reviews can be conducted to examine the range and scope of research on a topic, summarise

and disseminate findings, identify gaps in the literature, or to determine the value of conducting a systematic review. (Hacking, 2012) The purpose of this scoping review is to summarise and disseminate findings. Specifically the main research question in this review was: What are the barriers to reporting patient safety incidents in hospitals? The secondary research question is: What are the differences in barriers to reporting patient safety incidents in Indonesian and overseas hospitals?

Step 2: Defining keywords

The keywords used are ‘Barriers’ AND ‘Reporting’ AND ‘Patient Safety Incident’ OR ‘Medical Error’ OR ‘Healthcare Incident’ AND ‘hospitals’

Step 3: Determine inclusion and exclusion criteria

Inclusion and exclusion criteria were defined in table 1.

Table 1.

Inclusion and Exclusion Criteria	
Inclusion Criteria	Exclusion Criteria
Articles published in 2020-2024	Not published in a journal
Original research	Results are not factors associated with reporting patient safety incidents
Qualitative and Quantitative Design	This article is a review of existing research
Free full-text	Not full text
Article is the result of research into barriers to reporting patient safety incidents	

Step 4: Article collection and study selection

Article search was conducted through online databases namely Science Direct, Scopus, PubMed. Article selection was done based on PRISMA - ScR. The results of this stage are shown in figure 1.

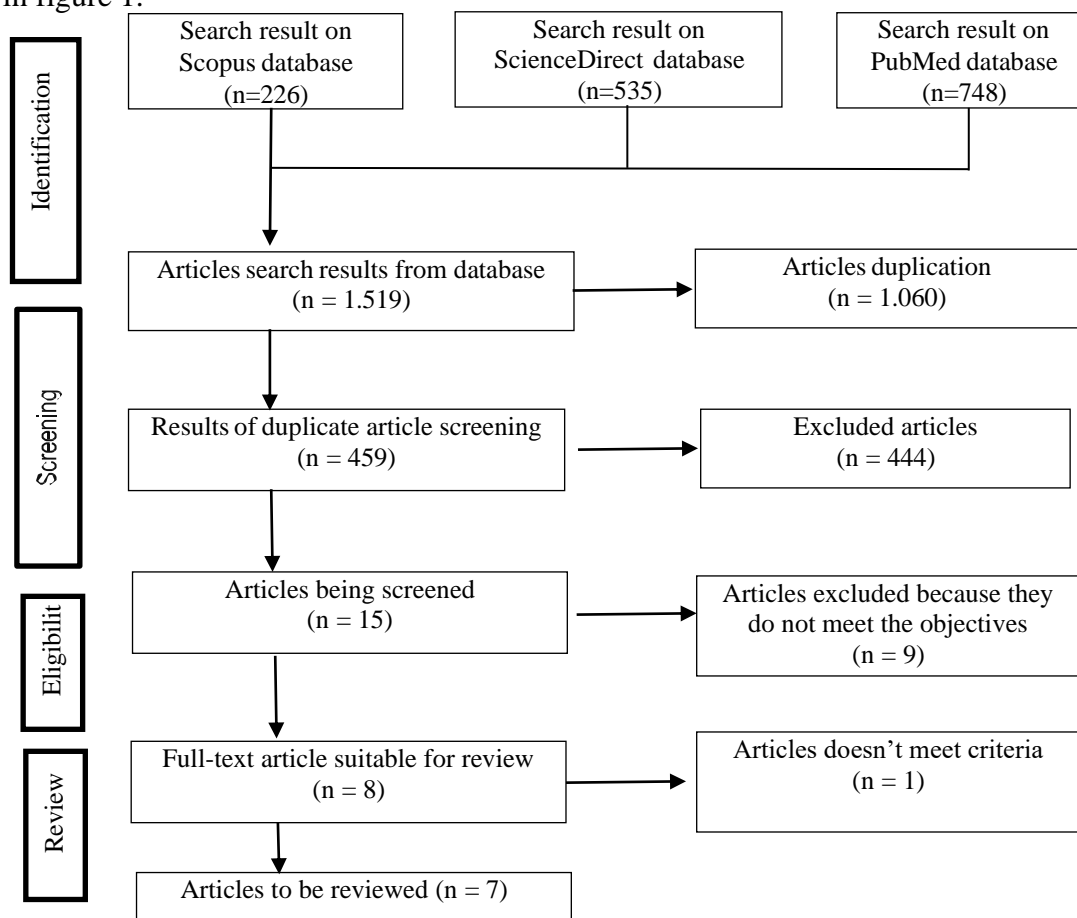


Fig 1. PRISMA Flowchart of included articles

RESULT

7 articles were identified based on PRISMA - ScR as listed in table 2. These 7 articles addressed barriers to reporting patient safety incidents in hospitals, based on primary research conducted by researchers. 7 articles in English published in 2021 and 2024. All articles are research conducted in Indonesia and abroad using qualitative, cross-sectional, retrospective methods. Barriers to reporting in Indonesian hospitals patient safety incidents: knowledge, leadership, workload, no feedback, no policy, reporting system. Barriers to reporting patient safety incidents in Australia hospitals: Understanding and Knowledge, Reporting System, Reporting Culture, Workload and Time, Colleague Support. Barriers to reporting patient safety incidents in Saudi Arabia hospitals: fear, knowledge, leadership support, workload, reporting system, and motivation. . Barriers to reporting patient safety incidents in South Korea hospitals: Culture, Security Climate, Knowledge, Authentic Leadership, Motivation. Barriers to reporting patient safety incidents in Ethiopia hospitals: professional status, job training, time constraints, fear, hospital management support, teamwork within the unit, and openness of communication. Barriers to patient safety incidents reporting in South Africa (Kwazulu_Natal) hospitals: Ineffective reporting system, Management Support, Inadequate Education and Training, Poor Human Resources. Barriers to patient safety incidents reporting in India (West-Bengal) hospitals: Fear of Litigation, Errors in Drug Management, Diagnostic Delays, Communication Between Stakeholders, Organisational Managerial Dysfunction

Table 2.
Article Analysis

No.	Author and Year	Title	Method	Sample	Result
1.	Gqaleni & Mkhize, 2024)	Barriers to implementing patient safety incident reporting and learning guidelines in specialised care units, KwaZulu-Natal: A qualitative study	A descriptiv, explorative qualitative	41	ineffective reporting system affecting the communication of Patient safety incident guidelines, inadequate institutional and management support for the healthcare professionals, insufficient education and training of healthcare professionals, and poor human resources affecting the implementation of Patient Safety Incident guidelines.(Gqaleni & Mkhize, 2024)
2.	Shatavisa Mukherjee M. Pharm, Siddhartha Roy MD, n.d.), 2024	Safety incident reporting and barriers (SIRaB) study: Strategies and approaches for investigating patient safety events in a hospital set-up	(a) Retrospective assessment of all safety incidents in the past 1 year, and (b) Understanding the barriers of safety reporting by interviewing the major stakeholders in patient safety reporting framework.Results were statistically analyzed.	106	Among the various factors identified as barriers in safety incident reporting, fear of litigation was the most observed component. the events occurring due to inter-stakeholder communication errors. 4.22% of the PSEs were attributed to organizational managerial dysfunctionalities.(Shatavisa Mukherjee M. Pharm, Siddhartha Roy MD, n.d.)
3.	Shemsu et al., 2024)	Patient safety incident reporting behavior and its associated factors among healthcare professionals in	Cross-sectional study	354	The factors identified to be associated with the incident reporting behavior were professional status, on-job training, the long time needed for reporting, fear of administration sanction, presence of feedback to errors, presence of hospital

No.	Author and Year	Title	Method	Sample	Result
		Hadiya zone, Ethiopia: A facility based cross-sectional study			management support, teamwork within the unit, and communication openness (Shemsu et al., 2024)
4.	Sookhee Yoon, taewha Lee, 2022	Factors Influencing Military Nurses' Reporting of Patient Safety Events in South Korea: A Structural Equation Modeling Approach	a cross-sectional and descriptive correlational design	303	just culture, safety climate, and patient safety knowledge either directly or indirectly affected patient safety event reporting among military nurses (Yoon & Lee, 2022)
5.	Husam Almansour, 2023	Barriers Preventing the Reporting of Incidents and Near Misses Among Healthcare Professionals	Cross-sectional	30	Barriers reported by the participants were classified across six themes: fear, lack of knowledge, lack of leadership support, workload, reporting system, and lack of motivation. (Almansour, 2024)
6.	Shady Abdelmaksoud, 2024	Medication error reporting attitudes and practices in a regional Australian hospital: a qualitative study	a qualitative study	12	Doctors described that they did not report because other clinicians detect and report medication errors. The pressures from heavy workloads, staff shortages, and competing tasks meant the time for MER was limited and given less priority. Several participants commented on the reporting culture of their organisation and some clinicians reported concern over creating uncomfortable situations among their co-workers. (Abdelmaksoud et al., 2024)
7.	Dhamanti et al, 2022	Factors contributing to under-reporting of patient safety incidents in Indonesia: leaders' perspectives	a qualitative study	25	The key factors contributing to the under-reporting of patient safety incidents were categorized as hospital related and nonhospital related (government or independent agency). The hospital-related factors were: lack of understanding, knowledge, and responsibility for reporting; lack of leadership and institutional culture of reporting incidents; perception of reporting as an additional burden. The nonhospital-related factors were: lack of feedback and training; lack of confidentiality mechanisms in the system; absence of policy safeguards to prevent any punitive measures against the reporting hospital; lack of leadership. (Dhamanti et al., 2022)

DISCUSSION

Patient safety has been, and still is, a cause for concern in healthcare systems all over the world.(Organization & Services, 2005). Incident reporting system have been in place in Indonesia for over a decade.(Bakar, 2005). There were practical and cultural barriers to reporting incidents among health workers in Indonesian public hospitals. There were conflicting findings in the barriers of reporting incidents,these barriers must be identified, discussed, and resolved by health workers and theirmanagers or supervisors to improve incident reporting.(Dhamanti et al., 2020). Both doctors and nurses believe they should report most incidents, but nurses do so more frequently than doctors.(Evans et al., 2006). Staff must

be encouraged to report less serious incidents and near misses as well as more serious errors if lessons are to be learned and patient safety enhanced.(Cozens, 2002)

Barriers to reporting patient safety incidents in Indonesia are: “did not know how to report,” “did not know where to report,” and “lack of feedback”, lack of knowledge and lack of socialization or training as practical barriers in reporting incidents and fear to report. (Arruum et al., 2019), (Tirzaningrum et al., 2023). In this present study, seven themes emerged the reasons for low patient safety incident reporting among Indonesian nurses. : Understanding incident reporting; The culture; Consequences of reporting; Socialization and training; Facilities; Feedback; and Rewards and punishments. (Pramesona et al., 2023). Involving patients in patient safety investigations could increase patient centeredness, patient autonomy, and transparency and make analyses more effective by adding unique and potentially actionable information.(James, 2013) Research in Korea found barriers to Disclosure of Patient Safety Incidents, including a closed organizational culture, fear of worsening relationships with patients, and concerns about workload.(Choi et al., 2019)

This study identified several barriers to report patient safety incidents in hospitals, both in Indonesia and abroad: lack of management support, limited training, high workload, low safety motivation, lack of peer support, and weaknesses in the reporting system. These barriers are consistent with other studies, which also show that fear of sanctions or litigation hinders reporting. A holistic approach, such as increased management support, regular training, and an environment that supports a culture of safety, is important to encourage better reporting and improve healthcare quality. Multiple means of feeding back recommended actions and safety information may be usefully employed to promote safety awareness, improve clinical processes and promote future reporting.(J Benn, M Koutantji, L Wallace, P Spurgeon, M Rejman, A Healey, 2007)

CONCLUSIONS

This study shows that reporting patient safety incidents has an important role in improving the quality of health services and preventing the recurrence of incidents that harm patients. However, there are various obstacles that affect compliance in reporting the incident. Barriers to reporting patient safety incidents, both in hospitals in Indonesia and abroad, have similar problems. Factors identified as barriers include: Management Support, Insufficient Education and Training, Workload: Safety Motivation, Colleague Support, and Reporting System.

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