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A Study to Assess the Knowledge, Attitude and Perceived Barriers on Incident Reporting among Staff Nurses Working in a Tertiary Care Hospital, Ludhiana, Punjab

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Abstract

Background of the Study: The term 'adverse event' describes harm to the patient as a result of medical care. Patient safety event reporting systems are ubiquitous in hospitals and are a mainstay of efforts to detect patient safety and quality problems. Incident reporting is frequently used as a general term for all voluntary patient safety event reporting systems which rely on those involved in events to provide detailed information.

Aim: To assess the knowledge, attitude and perceived barriers to incident reporting among the staff nurses working in a tertiary care hospital, Ludhiana.

Methodology: A descriptive study was conducted in the month of May 2017 in Dayanand Medical College and Hospital, Ludhiana. A total of 60 staff nurses were selected by convenient sampling technique and 4 parts of tools were used for the collection of data. The tools included socio-demographic profile, Questionnaire to assess the knowledge, Likert scale to assess the attitude and a Checklist to assess the perceived barriers. Validity of the research tool was established under the guidance of research supervisor and other experts.

Result: Most of the staff nurses working in DMC & H, Ludhiana had average knowledge and positive attitude towards incident reporting and the co-relation of knowledge and attitude came out to be weakly positive.

Conclusion: The staff nurses had average knowledge, positive attitude towards the incident reporting. There was weak positive correlation between knowledge and attitude of staff nurses. Fear of legal action, too busy/ lack of time and fear of career/ personal reputation were the common perceived barriers by staff nurses regarding incident reporting.

Keywords: *Knowledge, Attitude, Perceived barriers, Staff nurses.*

Introduction

The term 'adverse event' describes harm to a patient as a result of Medical care. Hospital and Health Care Department must track and analyse instances of patient harm as a condition of participation in medical programme. Instance reporting systems are a common means that Hospital needs to use in this condition. Hospitals can demonstrate their compliance with this and all other conditions through a survey by State Survey Agency or Accreditation under an approved Medical Accreditation Program.[1]

Patient safety event reporting systems are ubiquitous in hospital and are a mainstay of efforts to detect patient safety events and quality problems. Incident reporting is frequently used as a general term for all voluntary patient safety event reporting systems, which rely on those involved in events to provide detailed information. Initial reports often come from the frontline personnel directly involved in an event

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or the action leading up to it (example – the nurses, pharmacists, or physician caring for a patient when a medication error occurred) rather than management or patient safety professionals. Voluntary event reporting is therefore a passive form of surveillance for near misses or unsafe conditions, in contrast to more active methods of surveillance such as direct observation of providers or chart review using trigger tools.[2]

The traditional event reporting system have been paper based, technological enhancement have allowed the development of web based systems and systems that can receive information from electronic medical records. Specialized systems have also been developed for specific settings, such as the Intensive Care Unit safety.[2]

Voluntary event reporting system need not to be confined to a single hospital or organization. The United Kingdom's National patient safety agency maintains the National learning and reporting system, a nationwide voluntary event reporting system and the MEDMARX voluntary medication error reporting system in the U.S. has led to much valuable research.[3]

At the National level, regulation implementing the patient safety and quality improvement act became effective on January 19, 2009. The Legislation provides confidentiality, privilege, protection for patient safety information when health care providers work with new expert's entity known as Patient Safety Organizations (PSOs).[4]

The Health Care Agency has also developed common format standardize definitions and reporting format for patient safety events in order to facilitate aggregation of patient safety information. Since their initial release in 2009, the common format has been updated and expanded to cover the broad range of safety events.[4]All hospitals are required to maintain a confidential event reporting system, existing voluntary reporting system have a shared interest in developing ways to compare benchmark and safety data. Health Care Agency will encourage use of the initial set of common formats in Hospitals in their internal event reporting systems and encourage other voluntary reporting systems to consider adopting the common format as well.

Material and Method

Research Design: The research design is a blueprint to conduct a research study, which involves the description of research approach, study settings, sampling size, sampling technique, tools and methods of data collection and analysis to answer specific research questions or for testing research hypothesis.

A descriptive design was used to assess the knowledge, attitude and perceived barriers among staff nurses.

Research Settings: The study was conducted in DMC & H, Ludhiana which is an autonomous institute of Medical education and research. The institute was established in 1964 in its Old Dayanand Hospital in Civil Lines, Ludhiana.

Now the institute is being run in its new building. "The new Dayanand Medical College and Hospital" in Tagore Nagar, Ludhiana. The hospital have capacity of 1326 beds which renders excellent services to all specialities such as in-patient and out-patient units of Surgery, Medicine, Gastroenterology, Oncology, Paediatrics, Psychiatric, Gynaecology, Orthopaedics, Neurosurgery, Burns, Plastic surgery, Urology, Cardiology, Skin, Eye, E.N.T department and Intensive care units, Emergency trauma units and Medical ICU and Surgery ICU.

Target Population: The target or the study population is the population which meets the criteria for inclusion stipulated by the researcher. The target population for the research study was staff nurses working in DMC & H, Ludhiana.

Sample Size: The sample size were 60 staff nurses working in DMC & H, Ludhiana.

Sampling Technique: Sampling is the process of selecting a portion of population to represent the entire population (Polit & Hungler).[9]

Convenience sampling technique was used to collect data from the staff nurses.

Inclusion and exclusion criteria

Inclusion criteria

The staff nurses who were:

- Available at the time of data collection.
- Willing to participate in the study.

Exclusion criteria

- Floating staff nurses.

Selection and development of research tool(s): The most important aspect of investigation is the collection of appropriate information which provides necessary data to answer the questions raised in the study.

So, the tool will be developed on the basis of

- Review of literature
- Consultation with the experts in the field of research and nursing
- An informal observation in the concerned area

Tool is divided into 4 parts:

Part A: Socio-demographic profile which included age, gender, educational qualification, work experience and training institute.

Part B: Self structured questionnaire to assess the knowledge of the staff nurses.

Part C: Likert scale to assess the attitude of the staff nurses.

Part D: Checklist to assess the perceived barriers among the staff nurses.

Major findings of the study:

- The findings of the study concluded that majority of the staff nurses i.e. 47 (78.33%) were in the age group of 21 – 30 years and most of them were females i.e.55 (91.67%).
- In case of educational status, most of the staff nurses were B.Sc. Nursing qualified i.e.40 (66.67%).
- Most of the staff nurses i.e. 38 (63.34%) were in the work experience group of 01 – 05 years and maximum were from private institute i.e. 52 (86.66%).
- Among the three variables which were under the study i.e. knowledge, attitude and perceived barriers, it was found that maximum of the staff nurses i.e. 35 (58.33) had average knowledge and 48 (80%) had a positive attitude towards incident reporting and fear of legal action i.e. 47 (78.33%) and too busy/lack of time i.e. 43(71.66%) were common barriers perceived by staff nurses regarding incident reporting.

In case of correlation of knowledge with attitude of staff nurses, it is found that there is a weak positive correlation between knowledge and attitude of staff nurses however it is statistically non-significant at 0.05 level of significance.

Conclusion

The present study revealed that a majority of staff nurses had average knowledge and positive attitude towards the incident reporting. Fear of legal action, too busy/lack of time and fear of career and personal reputation regarding incident reporting were three common barriers perceived by staff nurses. The study results revealed that there was a weak positive correlation between knowledge and attitude of staff nurses.

There was no association between knowledge and attitude with age, gender, educational qualification, work experience and training institute.

Ethical Considerations: This is a descriptive study. The data was collected unanimously and confidentiality of information was maintained. It was ensured that the study should not affect the subject in any way.

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Conflict of Interest: Nil

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