Inhibiting and Supporting Factors in Reporting Patient Safety Incidents among Healthcare Workers: A Literature Review

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Abstract. Reporting hospital incidents is still a matter of pros and cons in its implementation, both from the perspective of patients and hospital staff. However, this is detrimental if it is not immediately corrected by building and strengthening a safety culture. The present study aimed to determine the inhibiting and supporting factors in reporting patient safety incidents among healthcare workers. This study used a literature review method by collecting online literature data sources and obtained 5 (five) pieces of literature related to inhibiting and supporting factors in reporting patient safety incidents among healthcare workers. Inhibiting factors consist of individual aspects (feelings of fear of being blamed and threats of intimidation), psychological aspects (worries about worsening the hospital's image), organizational aspects (lack of safety culture), and government aspects (no laws to protect whistle-blowers). Meanwhile, supporting factors include supportive organizational support, developing and strengthening a patient safety culture, hospitals regulating reporting patient safety incidents, continuous evaluation in implementing patient safety training, and support for government laws and regulations protecting staff. Efforts to support the reporting of patient safety incidents by fostering and strengthening a culture of patient safety through a culture of learning, a culture of reporting, a culture of fairness, and a culture of information openness in hospitals can support the realization of reporting patient safety incidents safely and comfortably.

Keywords: Patient Safety Incidents, Inhibiting Factors, Supporting Factors, Literature Review.

INTRODUCTION

Patient safety is crucial in implementing health services as a benchmark for providing the best health services and avoiding or reducing patient accidents [1]. It can act as a reference or hospital procedure in providing health services to patients by trying to avoid or at least reduce the risk of accidents in the hope that patients can feel safe and secure. Apart from that, patient safety is also touched upon in the hospital

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accreditation assessment provisions according to Ministry of Health standards with a focus on patient safety. Patient safety itself has 6 (six) target parts, including accurate patient identification, increasing effective communication, increasing the safety of drugs that must be alert (high-alert), ensuring the right location, proper procedure, suitable patient operation, reducing the risk of service-related infections. Health and reducing the risk of patient falls [2]. The goals of patient safety are realizing a culture of patient safety in hospitals, increasing hospital accountability towards patients and the community, reducing the number of adverse events in hospitals, and implementing prevention programs to prevent the recurrence of adverse events [3]. However, the fact is that the fear of being blamed, punished, and threatened with intimidation is still a 'threat' for health workers, as well as the fear of worsening the hospital's image in reporting patient safety incidents. In fact, with open and fair reporting of patient safety incidents, health workers, hospitals, and patients can improve patient safety efforts and obtain positive benefits. The present study aimed to determine the inhibiting and supporting factors in reporting patient safety incidents.

SUBJECT AND METHOD

This research uses a literature review method by specifically reviewing or summarizing literature from online data sources in Google Scholar with a publication period of 2020 – 2023 to provide a more comprehensive understanding of the inhibiting and supporting factors in reporting patient safety incidents. The keywords in searching for this data source are inhibiting factors in reporting patient safety incidents and supporting factors in reporting patient safety incidents. The inclusion criteria in screening data sources are that the period of research literature to be reviewed is limited to the last four years (2020-2023), English and Indonesian language journals, full-text journals, and journal research objects are inhibiting and supporting factors in reporting patient safety incidents. Meanwhile, the exclusion criteria for this research are journals other than English and Indonesian and paid journals. The articles included are research articles conducted in Indonesia and Japan. It can be seen from the year of publication that there are two articles published in 2023, one published in 2022, one published in 2021, and one published in 2020. Of these articles, three use literature reviews, one use quantitative observational, and one use descriptive quantitative

RESULTS

The literature reviewed in this research was published from 2019 to 2023 in 5 (five) journals. Then, a study was drawn up regarding inhibiting and supporting factors in reporting patient safety incidents, and the conclusions in each journal obtained several results, including the following:

Table 1. Summary of research results based on research type

No.	Author and Year	Title	Methods	Results
1	Nofita Tudang Rombeallo, Takdir Tahir and Ariyanti Saleh (2022)	Faktor Penyebab Rendahnya Pelaporan Insiden Keselamatan Pasien di Rumah Sakit: Literature Review	*Literature Review*	Barriers for health workers in reporting patient safety incidents in hospitals come from the individuals themselves: a. Feelings of fear of being punished, blamed, judged incompetent, reputation damage, and intimidation if reporting an incident b.Lack of knowledge, skills, and abilities in reporting incidents To support incident reporting, commitment from policymakers is needed to improve the patient safety incident reporting system (Rombeallo, Tahir and Saleh, 2022)
2	Astari Ekaningtyas and Nasiatul Aisyah Salim (2023)	Factors Associated with Reporting Patient Safety Incidents by Nurses at Panembahan Senopati Hospital Bantul Yogyakarta	Observational Quantitative	Inhibiting factors: lack of non-punitive response to errors, open communication, feedback due to feelings of fear and guilt if reporting incidents. However, there are supporting factors to foster a non-punitive response, namely, developing and strengthening a culture of patient safety through a culture of learning, justice, and reporting. It also allows patients and their families to report their experiences while in the hospital. [5].
3	Tamaamah Habibah and Inge Dhamanti (2020)	Faktor yang Menghambat Pelaporan Insiden Keselamatan Pasien di Rumah	*Literature Review*	Barriers to incident reporting, namely: a. Individual, namely feelings of fear of intimidation or punishment

		Sakit: Literature Review		b. Organization, namely low feedback on incident reporting and never investigating the root cause of the problem c. Government, namely the absence of laws that protect health workers who report medical errors To support incident reporting, further evaluation of implementing patient safety incident reporting in hospitals is needed. [6].
4	Salsabila Nurislami, Bayu Anggileo Pramesona, Risal Wintoko and Rasmi Zakiah Oktarlina (2023)	Factors Influencing Reporting of Patient Safety Incidents: Literature Review	*Literature Review*	Factors that influence the reporting of patient safety incidents generally come from three factors, namely: a. Individual, including knowledge, skills, and abilities in carrying out reports and awareness of patient safety b.Psychology, including perceptions, attitudes, and beliefs that patient safety is beneficial, putting aside feelings of fear of being blamed or punished because of protecting colleagues and the reputation of the workplace a. As one of the supporting factors in reporting incidents, the organization includes a supportive environment and no-blame work culture, availability of a patient safety team, guidelines and report format, anonymity of reports, and good feedback in the form of further investigation and corrective action. [7].

5	Masaru Kurihara, Yoshimasa Nagao, and Yasuharu Tokuda (2021)	*Incident reporting among physicians-in-training in Japan: A national survey*	Quantitative descriptive	Of the 6,164 doctors undergoing training, it was found that although 78% had taken patient safety training, 44% had not submitted an incident report in the previous year, and 40.6% did not know how to submit an incident report. [8].

DISCUSSION

Based on the results of this research, several inhibiting and supporting factors were obtained in reporting patient safety incidents. These factors are for various reasons but are generally related to patient safety culture. Patient safety culture is the primary and most important basis for reporting safety incidents. This culture has a significant impact on individuals and organizations. For example, one of the inhibiting and dominating factors in reporting patient safety incidents is that which originates from individuals. Feelings of fear, worry about being blamed, not knowing how to report, and threats of intimidation if they report a patient safety incident (Habibah and Inge, 2020; Rombeallo, Tahir and Saleh, 2022; Nurislami *et al.*, 2023). As a result, individuals choose not to report it. Even though reporting this incident has a positive impact and benefit on patient safety and fosters a positive image for the organization. Meanwhile, not all individuals share this view because they are trapped in fear and worry.

Apart from the feelings of fear that individuals have, some organizations lack non-punitive responses [5], Moreover, they are not investigating the root causes of patient safety problems [6]. This particular condition can occur due to the perception (psychological aspect) that reporting patient safety incidents gives the organization a bad image [6], [7]. In fact, on the contrary, an investigation into the root of the problem can result in improvements for the organization to protect its image and patient safety. Moreover, hospitals are essential in supporting patient safety efforts as a health organization. Then, from a government perspective, it was found that there was no law to protect health workers who reported medical errors [6]. This effort also prevents an atmosphere of non-punitive attitudes from being realized. There is a blaming culture and feelings of discomfort with fellow health workers to maintain conducive working relationships. So, it would be better to have policies or laws that protect health workers who report medical errors or patient safety incidents, hoping to encourage and strengthen a patient safety culture.

Regarding individual knowledge, it was found that the cause of delays in reporting patient safety incidents was a lack of knowledge, abilities, and skills (Rombeallo, Tahir and Saleh, 2022; Nurislami *et al.*, 2023). This condition is also related to patient safety culture, which means there are obstacles to its implementation. This aspect of knowledge can be improved by strengthening the patient safety culture through a learning culture. Health workers can acquire this learning culture through training

programs in hospitals. However, it is not just about carrying out training; monitoring must be done by evaluating patient safety training and alternative methods through a reporting culture. The aim is to strengthen the patient safety culture. As one example, the first national survey on incident reporting in Japan found that half of junior residents had not submitted patient safety incident reports due to residents' lack of experience in making patient safety incident reports, even though 96% of residents had taken patient safety training, so alternative methods through strengthening were needed patient safety reporting culture [8].

Some of these inhibiting factors can be overcome with supporting factors for reporting patient safety incidents, including supportive organizational support. Hospitals can play their role in establishing regulations and fostering and strengthening a patient safety culture so that health workers have the confidence or courage to be open because they do not have fear or are threatened with intimidation in reporting patient safety incidents. Hospitals also participate in creating patient safety training programs, such as learning culture, reporting culture, fair culture, and patient safety culture. In this way, an atmosphere of openness will be created and benefit patients and hospitals.

Second, develop and strengthen a patient safety culture. This effort can be achieved by the strength of hospital regulations regarding patient safety culture, providing patient safety training programs, and monitoring and evaluating the implementation of patient safety culture when providing health services to patients. Third, hospitals regulate regulations regarding reporting patient safety incidents (including format, reporting system, and patient safety team) to avoid a culture of blaming each other, which leads to feelings of fear and the threat of intimidation—fourth, continuous and ongoing evaluation in implementing patient safety training. Without monitoring (evaluation), hospitals cannot make continuous improvements to improve patient safety culture so that the hospital's image will have a positive value. Fifth, government support in protecting health workers when reporting medical errors or patient safety through legislation. The existence of legal protection for medical personnel in reporting medical errors or patient safety incidents not only gives officers a sense of confidence but also provides a deterrent effect on parties who are negligent in providing services that are not oriented toward patient safety.

CONCLUSION

Based on the results and discussion above, it can be concluded that inhibiting and supporting factors in reporting patient safety incidents have their role. Inhibiting factors (individual, psychological, organizational, and governmental aspects) can create negative value for the hospital, in contrast to supporting factors (supportive organizational support; developing and strengthening a patient safety culture; the hospital regulates regulations related to reporting patient safety incidents; ongoing evaluation- continuous and continuous implementation of patient safety training; and support for government laws and regulations in protecting health workers) provide positive value for hospitals. This supporting factor should be adopted or used in health service activities not only in hospitals but all health facilities can also apply it.

Implementing patient safety incident reporting means that patient safety culture can be fulfilled so patients feel safe, comfortable, and safe.

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