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RESEARCH ARTICLE

Patient Safety Incident Reporting Challenges in Indonesian Private Hospitals

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Abstract

Reporting patient safety incidents is essential in improving learning and patient safety. It is necessary to identify reporting challenges to improve the reporting process's success. This study assessed the challenges of patient incident reporting and learning systems in Indonesian private hospitals. This qualitative participatory action research is used. In October 2022, data was collected using a videoconferencing application. This study included 34 quality improvement and patient safety team members from 22 private hospitals. In this study, inductive analysis was used. The challenges of patient safety incident reporting are examined in six categories in this study: reporting environment, reporting rules and content, analysis and investigation, governance, action and learning, and patient and family engagement. The challenges mostly come from reporting environment components such as reporting difficulty and ignorance, a lack of time for analysis, the fear of making a mistake in the reporting process, and insufficient management support. Multiple challenges were encountered in different patient safety incident components. A positive environment for reporting patient safety incidents needs a multifaceted approach, including increased hospital leadership commitment and policies and procedures.

Keywords: Incident reporting, Indonesia, patient safety, private hospitals

Introduction

High-quality health care is predicated on patient safety.[1] The emergence of this issue results from the increasing complexity of healthcare systems and the resulting increase in patient harm in healthcare facilities.[2] Unsafe care likely ranks among the top 10 causes of death and disability worldwide.[3] Moreover, conditions are worse in low- and middle-income countries, where an estimated 134 million adverse events due to unsafe care occur in hospitals, leading to 2.6 million deaths. It also has an economic impact; the WHO estimates that 20–40% of all healthcare expenditures worldwide are wasted due to substandard care.[4,5] Data collected from 2015 to 2019 in Indonesia shows that patient safety incidents continue to increase, whereas in 2019, incidents reached 7,465 cases.[6] By increasing opportunities to learn from errors, reporting incidents protects patients from preventable harm.[7] Reporting systems can provide warnings, identify significant problems, and explain their root causes. They play an essential role in raising awareness and fostering a culture of safety.[8] Utilizing incident reporting systems for authentic learning to achieve sustainable risk reductions and improvements in patient safety is needed.[9]

The Indonesian patient safety incident reporting system appeared ineffective due to its inability to collect adequate national incident reporting data and its lack of transparency; these shortcomings impeded national-level learning.[10] Another study revealed that hospital-related factors included a lack of understanding, knowledge, and responsibility for incident reporting, a lack of leadership and institutional culture, and the perception of incident reporting as an additional burden.[11] Another study revealed a lack of knowledge, socialization, or training as practical barriers to incident reporting and fear of reporting as cultural barriers.[12] The Indonesian

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government must urgently improve the system by implementing specific regulations and establishing a robust infrastructure at all levels to support incident reporting.[13]

In 2020, the WHO launched patient safety incident reporting and learning systems, whereas the guideline includes a self-assessment that can be used for patient safety incident reporting.[9] The tool is created for exploration and discussion to identify, strengthen, and develop system gaps. The tool identifies patient safety incident reporting and learning systems in the hospital by exploring six big themes, i.e., (1) environment for reporting, (2) reporting rules and content, (3) analysis and investigation, (4) governance, (5) action and learning, and (6) patient and family engagement.[9] As the guidance had already been released when this study was conducted, it was unnecessary to utilize it. This study evaluated Indonesian private hospitals' patient incident reporting and learning systems.

Methods

This research used a qualitative participatory action research approach to explore patient safety incident reporting and learning system challenges. It was a self-reflective inquiry that researchers and participants undertake so they can understand and improve upon the practices in which they participate and the situations in which they find themselves.[14] Before the study, the researchers invited approximately 90 private hospitals, class C and D, members of one hospital group. Hospitals participating in this study were from provinces such as Lampung, Jakarta, West Java, Central Java, East Java, and Yogyakarta. After that, 34 participants from 22 hospitals in classes C and D were willing to participate in this study. Data was collected during October 2022.

Participants (informants) in this study were chosen using an expert sampling technique, one of the purposive sampling methods. Informants were selected based on their knowledge and experience to provide valuable insights related to the research objectives.[15] One or two informants from a hospital's quality improvement and patient safety teams could participate in this study. Those units were selected because the patient safety unit of a hospital is responsible for developing patient safety programs and recording, reporting, and analyzing incidents to build learning solutions. There was a total of 34 participants in this study.

The measurement instrument is based on reporting patient safety incidents and learning systems, including technical reports and guidance from the World Health Organization.[9] It is intended as a tool for exploration and discussion to identify, strengthen, and develop system gaps. It is not limited to health services that already have a system; those without one can also use it. In this study, six semi-structured questions are used to measure six aspects of implementation and challenges, including (1) environment for reporting, (2) reporting rules and content, (3) analysis and investigation, (4) governance, (5) action and learning, and (6) patient and family engagement.

Using a video conferencing platform, the focus group discussion was conducted since the participants came from several cities in Indonesia; hence, it was only possible to gather some participants to meet face-to-face. Participants were separated into two distinct groups. The discussion was moderated by two male researchers, MAS and MIN, and two female researchers, EL and ER. The researchers are university instructors. EL is a lecturer in family medicine and public health, ER and MIN are lecturers in the public health department, and MAS is a lecturer in the management department. The researchers are trained in qualitative research and have relevant experience in the field. The discussion lasted approximately two hours, and interview questions were designed to explore various topics, including challenges and potential strategies for enhancing patient incident reporting and learning systems. Before data collection, informants were provided with information regarding the research's background, the absence of any conflicts of interest, the study's objectives and methods, and those who agreed to participate signed a consent form. Throughout the research process, anonymity and secrecy were maintained. With number 204/EC-KEPK FKIK UMY/X/2022, the Ethics Committee of Research of the Faculty of Medicine and Health Sciences at Muhammadiyah University Yogyakarta granted ethical approval for this study. This study is reported using the consolidated criteria for reporting qualitative checklists (COREQ).[16]

The data were analyzed using thematic content analysis techniques, a method for identifying, analyzing, and reporting data patterns using Microsoft Excel software (Microsoft, Redmond, WA, 2010). Seven steps adapted from Dahlgren

and Fallsberg for the data analysis procedure, including familiarization, condensation, comparison, grouping, articulation, labeling, and contrasting, were conducted.[17] This study used a direct qualitative content analysis where the research topic was previously determined based on the research instruments that covered the six previously mentioned topics.[18] Using the inductive method, themes were then derived from the data, while EL, MA, and MIN performed cross-checks on the themes and codes throughout the analysis.

Results

There were 34 research participants, including 28 females and six males (Table). Most respondents were between 31 and 40, with the youngest 23 years old and the oldest 53 years old. Most respondents were registered nurses (n=21) with a bachelor's degree (n=18). Respondents are officers in each hospital's quality improvement and patient safety units. In addition, the results of this study are comprised of six components: (1) reporting environment; (2) regulations and reporting content; 3) analysis and investigation; (4) management; (5) action and learning; and (6) patient and family participation.

In the reporting environment, ease of report creation, time availability, motivation, and management support are discussed. The results demonstrated that hospital employees still need to comprehend how to create incident reports regarding patient safety. This makes them less motivated to produce reports.

"Due to several reasons such as negative judgment, being busy so they have to make a report later, they don't understand how to make an incident report, laziness, don't have the courage, and because they are afraid of being blamed and judged." (infection and prevention control nurse, 35 years old, female, nurse)

Regarding the motivation and awareness of reporting patient safety incidents, informants reported that health workers were hesitant to report patient safety incidents because they feared negative evaluations, such as poor performance on incidents that had occurred.

"Our colleagues still have a feeling of fear, the sense that they will later become bad for judges of performance when they later report the incident." (Head of Quality Assurance and Patient Safety, 51 years old, female, nurse)

Table Participants' Characteristics

Variables	n=34
Gender	
Male	6
Female	28
Age (years)	
≤30	8
31–40	15
>40	11
Profession	
Nurse	21
Medic (physician, dentist)	8
Others	6
Education	
Diploma	7
Bachelor	18
Master/specialist	9

In addition, the patient safety incidents that must be reported to the Ministry of Health cause the hospital to fear that it will receive an unfavorable evaluation if a patient safety incident is reported.

"It's true that our incident report also has to be reported to the Ministry of Health, but for now, we only want it to come from the hospital environment to improve quality. That's actually what I want to say. I'm not afraid, but I'm still scared that my performance will be negative." (Head of Quality Assurance and Patient Safety, 51 years old, female, nurse)

In addition, there is a problem with reporting near misses in hospitals, where reporting incidents is high but reporting undesirable events is low. This is because hospital personnel fear the negative repercussions of reporting adverse events.

"There are many reports of several incidents, such as near-miss incidents or something that doesn't cause problems like that. But if it's been an adverse event, this is Sentinel. How about this later? This problem needs to be audited or something like that, so why doesn't it feel right? This incident shouldn't happen anymore." (Head

of Quality Committee, 53 years old, female, medical doctor)

On the other hand, near-misses were not reported because the hospital staff believed that the incident had been resolved, so they did not report this type of incident.

"As for the reporting itself, in other hospitals, there may be a lot of near-miss incidents; in fact, in our case, the near-miss incidents are limited because they have been handled. So, it doesn't need to be reported, but related to adverse events, they are often reported." (Secretary of Quality Committee, 40 years old, female, nurse)

Another topic associated with the reporting environment is management support. Informants reported minimal management support for patient safety incident reporting against the sentinel criterion. This is because management is concerned that reporting sentinel events, such as the revocation of hospital permits, will result in repercussions.

"On the other hand, we feel that the directors themselves don't seem to support certain matters to be reported because there is still a feeling of fear, especially with sentinel events, so there is confusion about whether sentinel events must be reported, whether they can affect, for example, hospital license and everything." (Head of Quality Committee, 53 years old, female, medical doctor)

In addition, informants believed that management continued to think that the presence of patient safety incidents indicated subpar performance by hospital personnel. On the other hand, management is considered to be focused on humans as the cause of patient safety incidents and does not view the incident as a systemic issue. This demonstrates that management support for patient safety incident reporting remains restricted.

"So, there are still two opinions when an incident occurs. One considers that it is okay to report due to improvement. But one side of the other management staff believes that the performance in the unit is negative." (Head of Quality Assurance and Patient Safety, 51 years old, female, nurse)

In addition, informants believed that management support for implementing follow-up on patient safety incident recommendations for additional investigations remained minimal.

"For example, there was an incident, and then an analysis of the root of the problem was carried out; it turned out that the end of the problem was that there was no regulation yet, which made a regulation take quite a long time to create the regulation, so that was the obstacle." (Head of Quality Committee, 47 years old, female, nurse)

Several issues relating to the clarity of reporting criteria, training, and mechanisms for patients or their families to submit patient safety incident reports were examined regarding reporting regulations and content. Regarding the clarity of the criteria, the informant stated that the officer did not comprehend the requirements for a patient safety incident. He did not report the occurrence because he believed it was unnecessary. The informant also stated that officers had erroneously reported work safety incidents rather than patient safety.

"In general, it's easy, yes, the only drawback is to report it; this is an incident, but some of the staff don't understand that this is an incident that must be reported immediately and then immediately fill out the form on the RS SIM to report it immediately. This is what sometimes results in low incident reports." (Head of Quality Committee, 53 years old, female, medical doctor)

"But starting from near miss, no harm and adverse events, those who don't understand that. Later, we usually directly discuss things with the head of the room, who comes to report. We read the report, uh, this is included in the near miss report, because this hasn't taken any medication yet, no, it's not no harm incident, if that's the case, it's more like an injury, for example. I have several times received reports related to OSH; for example, the NSA reported it to us, then we clarified that this did not report to us." (Head of Quality Committee, 47 years old, female, nurse)

Officers had difficulty classifying the incident as a near-injury, a potential injury, or an unwelcome occurrence. This is because officers need to comprehend the criteria for each incident. In addition, informants from mental hospitals

reported that officers sometimes lacked clarity regarding whether a given incident constituted a patient safety incident or was caused by the patient's condition.

"Then, related to the Sentinel, we might be confused if we were in a psychiatric hospital. Is this because of the patient's condition? According to friends, this is sometimes not because of unexpected events but because of the patient's condition. This is what sometimes makes our colleague think that this is not a sentinel like that." (Head of Quality Assurance and Patient Safety, 51 years old, female, nurse)

The study results also indicate a need for more training and education regarding reporting patient safety incidents.

"After participating in the training, the staff earlier understood that they had already started trying to make an analysis. However, our colleague is doing the analysis, and the others could be more confident, so they are still groping around." (Secretary of Quality Committee, 37 years old, female, hospital administrator)

The final topic examined is how patients or their families submit patient safety incident reports. It has been determined that forms for reporting patient safety incidents by patients and patient families are available. The mechanism still needs to be implemented, so reporting has yet to go smoothly.

"Indeed, there is (a patient reporting mechanism), but it still needs to be implemented. We've tried to make the form, but we still need the mechanism. For the form, there is a simple form, how to report or maybe report it to the staff later, the new staff will report it, it's not very clear." (Head of Quality Committee, 47 years old, female, nurse)

The implementation of incident analysis and investigation is explained in the analysis and investigation section, and the confidentiality of reporting and the use of the patient safety incident reporting information system are discussed in the management section. The outcomes demonstrated that hospital personnel needed to comprehend the analysis of patient safety incident reporting.

"For this follow-up analysis, the unit's confidence is still low in our hospital, so they often ask us to join the quality committee. There is a sub-committee for patient safety in the next room. Usually, the person in charge indeed contacts us directly, so later in the grading, we have to guide it for discussion like that, so later they try to make it first, and then we guide." (Head of Quality Committee, 41 years old, female, medical doctor)

Additionally, it was discovered that the hospital safety unit continued to hold concurrent positions with other hospital positions. This hinders their performance of their duties, particularly regarding further analysis and investigation.

"But in terms of analysis and grading, they are still not very confident, and they still often ask the quality committee if the quality committee is still not fully functioning correctly because they still hold multiple positions; in other words, this quality committee is only for accreditation." (Secretary of Quality Committee, 37 years old, female, nurse)

On the other hand, some hospitals have conducted a thorough analysis, categorizing the causes of patient safety incidents based on their origins and involving experts, hospital administrators, and the HRD department. Concerning the confidentiality and anonymity of reporting, all informants stated that privacy and anonymity were ensured in both the printed form and the information system. Regarding ease of reporting, the study results indicate that some hospitals still use manual forms (rather than information systems) where hospital staff believe it is challenging to report patient safety incidents. Manual reporting necessitates the completion of multiple forms, which can interfere with other tasks.

"Where we report, it is still manual, so if we take it from the first discussion, their reporting is still low because too much should be written based on sheets adopted from the Ministry of Health." (Secretary of Quality Committee, 37 years old, female, nurse)

In terms of action and learning, support for staff involved in incidents is discussed. The

formulation of actions to reduce patient safety incidents was discussed in terms of involving patients and families. The Human Resources department assists personnel involved in reporting patient safety incidents. Patient participation in the reporting and analyzing of patient safety incidents has yet to be carried out optimally. In Indonesian health services, there has yet to be a culture in which patients discuss safety incidents and formulate actions to reduce patient safety incidents. In addition, the hospital is concerned that they will be held accountable if they disclose patient safety incidents to their patients.

"It has yet to be entrenched in Indonesia, so we must be careful about incidents there. Looking for the right words, so that we are good, everything is like that, more towards us not wanting incidents, no. But internally, we take lessons, we immediately take care of them, don't make omissions, but we don't convey (to the patient) the discussion yet." (Head of Quality Committee 47 years old, female, nurse)

Discussion

The study results indicate that the patient safety system faces numerous obstacles. The reporting environment presents the most barriers. According to the study results, manual reporting is one of the obstacles to reporting patient safety incidents. Manual reporting requires the creator to write down and send the file, which is not considered concise. As shown in this study, computerized reporting systems are regarded as more efficient in facilitating the reporting of patient safety incidents.[19] According to a study conducted in Brazil, computer-based reporting of patient safety incidents in hospitals can increase the number of volunteers reporting quality incidents.[20]

The study's results indicated that some staff must still comprehend patient safety incident report preparation or analysis. According to studies, medical professionals must still understand the reporting system for patient safety incidents.[21] When reporting incidents involving patient safety, inadequate training is one of the causes of confusion among healthcare workers. Similar research conducted in Indonesia indicates that training related to incident reporting is still inadequate in all hospitals, and some healthcare professionals believe that the government pays insufficient attention to reporting patient safety incidents.[11] Additionally, research conducted in South Korea indicates that there still needs to be more knowledge and skills about incident reporting, such as using tools such as root cause analysis and failure mode and effects analysis, what should be reported, and how to report.[22]

A lack of staff motivation to report patient safety incidents is one of the obstacles to accomplishing this. This is due to negative judgment in reporting patient safety incidents. The obstacles include a culture of shaming and blaming, a lack of time to report, a lack of knowledge of the reporting system, and a lack of management support.[21] The emphasis must shift from the individual to the system, with an emphasis on learning rather than punishment and disciplinary sanctions; the recent opioid epidemic is an illustration of ineffective guidelines. Unfortunately, the leading cause of underreporting is fear of sanctions.[23]

One of the barriers to reporting patient safety incidents is the need for more feedback from management regarding patient safety incidents. Due to the lack of feedback, it was also possible for reporters to become cynical about the incident reporting system, which could have a demoralizing effect and serve as a reason not to use the incident reporting system.[24] The role of leadership, the credibility and content of information, effective dissemination channels, the capacity for rapid action, and the requirement for feedback at all organizational levels are needed for healthcare organizations to learn from care delivery failures; incident reporting systems must provide effective feedback.[25]

Since only one subset of non-profit private hospitals participated in this study, it is impossible to generalize the findings to cover all hospital types in Indonesia. This study is the first to examine the reporting of patient safety incidents and the learning system by WHO recommendations. Therefore, additional research is required to assess the incident reporting and learning system in Indonesia's other types of hospitals.

Conclusions

Multiple challenges were encountered in different patient safety incident components. The reporting environment, which could have been more conducive to reporting patient safety incidents, presented the most significant challenges. The

ease of reporting and management support must be improved to improve incident reporting. Education and training should be provided for hospital staff and management to enhance their understanding of the importance of the incident reporting system and create a positive reporting environment. Moreover, this study emphasizes leadership and organization support and feedback in order to support a positive environment for incident reporting.

Conflict of Interest

All of the authors declare no conflict of interest.

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