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Barriers of Reporting Errors among Nurses in a Tertiary Hospital

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Abstract

Backgroun

d: Reporting errors in healthcare organizations is aimed to detect patient safety and quality of care issues. Reporting errors is frequently used as a general term for patient safety event reporting systems, which depend on those involved in events to provide detailed information. This study aimed to identify barriers of reporting errors at one tertiaryhospital in Saudi Arabia from the perspective of nurses themselves.

Methodology: A descriptive cross-sectional study was conducted. The data were collected by a questionnaire that was distributed among 154 nurses varying between male and female staff nurses working at the tertiary hospital. A descriptive statistical analysis was used to analyze the data.

Results: Nurses revealed that there are several barriers to report incidents; however, lack of time and complexity of works were the main barriers for nurses to report incidents within the hospital units particularly for nurses who have 11-20 years of experience.

Conclusion: Conducting this study has several advantages. Firstly, to identify the common barriers of reporting errors in clinical practice among nurses. Secondly, identifying the barriers and strategies of reporting incidents will enhance the patient safety across the organization and encourage the staff to report the errors.

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Introduction

Reporting errors in clinical practice is critical to enhance patient safety and improve the quality of care [1]. The aim of reporting errorsis to gather allthe required information onpatient safety reported by healthcare professionals as well as to enable health care organizations to use this information to understand system errors and create changes to reduce the likelihood of the reoccurrence of the error[2].Therefore, reporting all types of errors by healthcare professionals is crucial [3].

Medical errors can be reported through mandatory or voluntary reporting systems. Mandatory reporting system is aimed to report injuries or illnesses related to the misuse of particular medical devices [4]. On the other hand, voluntary reporting system is aimed to provide detailed information about the occurrence of errors and their causes. Moreover, the frontline practitioners have the opportunity toreport the occurrence of errorsas a complete story without fear,these stories aresignificant to understand the occurrence of errors[4]. Thus, the voluntary reporting system is most commonly used in healthcare organizations than mandatory reporting system as practitioners must not be forced to report the occurrence of errors; however, practitioners need free blame culture and freedom from punishment, which is found with a voluntary reporting system [4].

Several evidences have suggested that healthcare professionals under report errors as a result of a number of barriers that have been identified and need to be taken into account within healthcare organizations. For example, despite the attempts to encourage a more proactive attitude to maintaining safety in healthcare organizations, the fear of disciplinary action and thinking that error reporting is unnecessary because no harm has been incurred have both been considered barriers to nurses in reporting patient safety incidents [2]. In a study conducted in the US, the nominal group technique was used to develop a survey tool to identify barriers to incident reporting in clinical practice among physicians and nurses. The group involved one in-patient assistant nurse manager, staff nurses (n = 3), one out-patient nurse manager, physicians (n = 3) and one non-clinical administrator in order to list the factors that could be barriers to reporting errors in clinical practice and then to vote for the most important factors contributing to the underreporting of errors. After distributing a total of 122 validated questionnaires the researchers subsequently found that 30% of nurses were anxious about reporting errors due to lack of anonymity and the potential for punitive outcomes [2]. No assurance of the anonymity of reporters considers high frequency barriers by 10% as an organizational factor.

A further study was carried outto explore the factors that facilitate the operation of patient safety incident reporting systems. According to the study results, nurses reported that the poor design of incident reporting systems including a lack of anonymity was the most frequent perceived barrier to report errors[5]. The data of this study were collected from 42 nurses at 42 general hospitals in Korea via face-to-face interviews[5].

It should be noted that there are significant differences between nurses and physicians regarding their opinion about barriers of reporting errors. In USa study aimed to identify potential barriers of using the reporting system[6]. The researcher distributed surveys among nurses and physicians (n = 858, response rate 41%) who reported that fears of reporting any incidents would be used against them. This issue appeared to 40% with physicians and 30% of nurses. Hence, this study clearly pointed out to the importance of having protection in reporting errors among healthcare providers. Furthermore, another study published in the UK reported that health

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care professionals especially doctors are reluctant to report adverse event to a superior; however, physicians are most likely to report an incident to a colleague [7]. Both studies showed that doctors thought the reporting of errors is the responsibility of the nurse who is providing the care for the patient at the time of the event.

Similarly, a survey of Korean nurses demonstrated that 32% were concerned that a record of any errors would be kept on their personal files [8].Researchers in this study aimed to describe nurses' perceptions of the frequency of error reporting by emailing patient safety culture questionnaires to 960 nurses in Korean teaching hospitals. However, in an earlier review of medication errors documented on standard report forms completed between April 1994 and August 1999 in a UK teaching hospital, nurses considered errors only required reporting when the outcome would be analyzed to prevent further recurrence [9].

In Saudi Arabia, 63% of registered nurses raised their concerns about their willingness to report Medication Administration Errors [10]. Major barriers to nurses reporting medication administration errors in this study included fear of reporting and receiving negative feedback from nursing administration, lack of awareness regarding the reporting policy and finally the complicated bureaucratic process of reporting incidents. Likewise, a further study revealed three main reasons for barriers to reporting an error in public hospitals: 1. Lack of awareness among healthcare providers regarding the incident reporting policy, 2. Workload leading to time pressures and an associated inability to report errors and finally 3. The non-availability of report forms on the ward[11]. The factors were each highlighted by different healthcare professionals (including nurses) (n = 106, 57.5% response rate) in response to a questionnaire regarding their experience of medication errors in Saudi Arabia [11].Thus, error reporting is an organizational issue that should be an integral part of an organization's culture. However, nurses involved in errors seemed to be treated in a punitive way (*named, blamed and shamed*). Hence, the fear of negative consequences and feedback, lack of awareness of reporting incidents and blaming individual nurses were the main barriers to nurses reporting errors in clinical practice across various healthcare organizations.

In South Australia, a qualitative studydemonstratedthat the common barriers to report incidents were inadequate time and feedback,deficiencies in knowledge, unsatisfactory processes, beliefs about risk, cultural norms, lack of value in the process and cultural differences between doctors and nurses[12]. In this study, the data was collected by using five focus groupswith 19 nurses and 14 medical staff from different clinical wards (two medical wards, one surgical ward, one intensive care unit and emergency department)[12].

In Jordan, a descriptive study aimed to examine the awareness of Jordanian nurses and physicians in reporting the incidentsand barriers to report incidents [13]. The authors reported that the awareness of reporting incident among nurses was more than physicians. However, a total of 42.6% of nurses reported the occurrence ofincidents within the last month while only 24.6% of physicians reported the incidents in the last month. The major barriers to reporting incidents were: (1)nurses' and physicians' beliefs that reportingnear misses is not important, (2) fear of disciplinary actions and (3) lack of feedback regarding the errors with a significant difference between physicians and nurses. A total of 66.7% was of concern for nurses' and physicians' belief that reporting errors would not lead to change within the system. Moreover, the errors perceived by physicians. Additionally, about (71.3% of physicians n = 82 vs. 37.7% of nurses n = 93) did not know whose responsibility to report incident. Thus, it should be noted that there issignificant differences between nurses and physicians regarding their awareness of reporting error[13]. belief that junior staff were blamed in the occurrence of errors was the most significant barrier of reporting errors perceived by physicians. Additionally, about (71.3% of physicians n = 82 vs. 37.7% of nurses n = 93) did not know whose responsibility to report incident. Thus, it should be noted that there issignificant differences between nurses and physicians regarding their awareness of reporting error [13].

Reporting the errors have been found as an effective strategy to reduce the reoccurrence of errors. For example, more than 90% of healthcare workers believe that they should report errors,and safety organizationsrecommend incident reporting to better understand errors and their contributing factors [3] .In a period between November 2001 and June 2003 a cross sectional survey of doctors and nurses was taken to assess the percentage of awareness, the use of incident reporting system and to identify barriers inhibiting reporting of incidents in hospitals [36]. Hospitals sampled included three referral hospitals: one major referral hospital, and two rural base hospitals in South Australia. A nameless survey of 587 nurses and 186 doctors was used in six hospitals in South Australia (response rate 72.8%). Lack of feedback (57.7%) was found as the major barriers to reporterrors amongphysicians, complete the incident form is taking too long (54.2%), and finally a belief that the type of incident is minor and not causing harm (51.2%). However, nurses reported that the major barriers to report errors among nurses were lack of feedback (61.8%), a belief that there was no need in reporting near misses (49.0%), and when there is a workload nurses forget to report errors (48.1%).

The result of the above studies demonstrated that there are several barriers of reporting incidents reported by all healthcare professionals, such as fear of disciplinary action and thinking error reporting is unnecessary, lack of anonymity and the potential for punitive outcomes which indicate the most frequently perceived barrier to incident reporting. Additionally, there is inadequate time and negative feedback, deficiencies in knowledge, cultural norms and beliefs about risk. However, no studies have been found to identify the barriers of reporting errors in nursing practice from the perception of nurses themselveswithin the context of Saudi Arabia. Hence, this study is important to measure the knowledge and the awareness of nurses about the reporting system, and found the barriers that prevent them from reporting errors in nursing practice and finally to maintain high safety measures for the patients.

Materials and Methods

This study was conducted by using a non-experimental descriptive cross-sectional research design. This research design was chosen in order to identify barriers of reporting errors in nursing practice within a tertiary hospital to find out what are the barriers that inhibit reporting errors[14]. This study employed a purposive sampling to select the target population. The decision regarding the selection of participants was based on the need to access those nurses whom are most knowledgeable about reporting incidents. Thus, the decision has been made to include both head nurses and staff nurses working in general care words and have experience for more than three years [14]. The sample size of this study was calculated in the rocs of data collection. However, the minimum sample size recommended for

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survey is 154 of 95% confidence level, varying between male and female nursing staff.

Setting

The research was conducted inone tertiary hospital in Jeddah, Saudi Arabiawithin the following clinical wards: medical and surgical general pediatric wards, male and female medical,male and female surgical general wards and emergency ward and department.

Data collection

The data were collected by using an adapted questionnaire from "*Barriers and strategies of reporting medical errors in public hospitals in Riyadh city: A survey-study*" conducted by Alduaiset al. (2014)[15] to collect data from staff nurses and head nurses. The survey is about the barriers of reporting the medical errors which consists of three parts. The first one is demographic part which include gender, age, nationality, level of education and experience while the second part is more about statements of barriers to report medical errors, the last part shows strategies that could be used to improve the reporting of medical errors. The reliability of the questionnaire was measured by using Cronbachalpha (0.9).

Ethical approvals of this study were obtained from the targeted hospital. The participant information sheet stated clearly and provided all information about the study as well as the voluntary participation for the participants. Additionally, the questionnaire distributed on the participants depending on inclusion criteria. The process of protecting participants' names involved removing their names and ascribing them codes during the analysis and reporting phases, so that data cannot be traced back to particular individuals. In addition, it was clearly stated that participants have the right to refuse participate, without giving a reason. Prior to commencing data collection, participants had the opportunity to ask any questions, and then if they agree to participate, they completed and signed the study consent form.

Data analysis

A descriptive analysis used to analyze the data of this study using IBM SPSS Statistics for Windows, Version 20 (IBM Corp., Armonk, NY USA) to identify percentage, frequency and standard deviation. The relation between barriers and years of experience was tested by using ANOVA. Moreover, Cross tab was also used to identify the relation between years of experience groups and barriers.

Results

Demographics

A total of 84 nurses participated in the study; 4.8% (n = 4) of them were male and 95.2% (n = 80) were female. The age of most of them 46.4% (n = 39) were between 20-30 years old, 29.8% (n = 25) were between 31-40 years old, 16.7% (n = 14) were between 41-50 years old, and 7.1% (n = 6) were 51 and above. Majority of study sample 53.6% (n = 45) has a diploma degree, and 46.4% (n = 39) had a bachelor degree. All of study participants werenon-Saudi 100% (n = 84). Considering the years of experience, a total of 31 staff nursesranged from (21-30) years of clinical experience 36.9%, while a total of 28 staff nurses ranged from (11-20) years of clinical experience 33.3%, 23 staff nurses ranged from (3-10) years of clinical experience27.4% and 2 staff nurses have 31 years of clinical experience 2.4% (Table 1).

Variables	Number of Participants (Percentage)	Standard Deviation
Gender		
Male	4 (4.8%)	0.214
Female	80 (95.2%)	
Nationality		
Saudi	0 (000.0%)	0.000
Non-Saudi	84 (100.0%)	
Level of education		
Diploma	45 (53.6%)	0.502
Bachelor	39 (46.4%)	
Master	0 (00.0%)	
Board	0 (00.0%)	
Other	0 (00.0%)	
Age		
20-30	39 (46.4%)	0.951
31-40	25 (29.8%)	
41-50	14 (16.7%)	
51 and above	6 (7.1%)	
Years of experience		
3-10	23 (27.4%)	0.852
11-20	28 (33.3%)	
21-30	31 (36.9%)	
31 and above	2 (2.4%)	

Table 1: Demographics characteristics of the study sample.

Barriers of reporting incidents

Table 2 demonstrates the barriers of reporting nursing errors with the percentage range from 20.2% to 1.2%. According to the below table, the study participants strongly agreed that lack of time 20.2% (n = 17) was the major barrier of underreporting errors in different clinical wards. Moreover, complexity of work 16.7% (n = 14) is also highlighted by study participants as barriers of reporting errors in different clinical wards within the hospital. Conversely, a total of 84 participants disagreed that lack of knowledge 23.8% and lack of procedures 29.8% were considered as barriers of reporting errors in different clinical wards within the hospital. In addition, the majority of study participants reported that the following statements within the questionnaire were not found as barriers of reporting errors in this hospital which are: '*reporting errors in not my responsibility*' 42.9% (n = 36), '*reporting errors is not a priority*' 46.4% (n = 39), '*reporting errors will not make any improvement*' 48.8% (n = 41), '*reporting system is inadequate*' 59.5% (n = 50) and ' *difficulty in filling the form*' 46.4% (n = 39). Importantly, a total of 84 participants reported that fear of being blamed 35.7% (n = 30), fear of being punished 35.7% (n = 30) and 48.8% reporting errors is not anonymous (n = 41) were not perceived as barriers of reporting errors within the hospital clinical wards.

Strategies of reporting errors

Table 3 presents several strategies that were strongly agreed by study participants to improve the reporting system within the hospital. A total of 48.8 % (n = 41) strongly agreed that using a computerized system to report medical errors is a strategy to improve the reporting

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Barriers	Number of Participants (Percentage (%))
1. Lack of time	
Strongly Agreed	17 (20.2%)
Agreed	34 (40.5%)
Neutral:	8 (9.5%)
Disagreed	14 (16.7%)
Strongly Disagreed	11 (13.1%)
2. Complexity of work	
Strongly Agreed	14 (16.7%)
Agreed	31 (36.9%)
Neutral	13 (15.5%)
Disagreed	16 (19.0%)
Strongly Disagreed	10 (11.9%)
3. Reporting errors is not my responsibilities	
Strongly Agreed	2 (2.4%))
Agreed	6 (7.1%)
Neutral	5 (6.0%)
Disagreed	36 (42.9%)
Strongly Disagreed	35 (41.7%)
4. Lack of knowledge on what we should reported	
Strongly Agreed	3 (3.6%)
Agreed	5 (6.0%)
Neutral	6 (7.1%)
Disagreed	50 (59.5%)
Strongly Disagreed	20 (23.8%)
5. Lack of procedures on reporting medical errors	
Strongly Agreed	2 (2.4%)
Agreed	12 (14.3%)
Neutral	8 (9.5%)
Disagreed	37 (44.0%)
Strongly Disagreed	25 (29.8%)
6. Reporting errors is not a priority	
Strongly Agreed	0 (0.0%)
Agreed	7 (8.3%)
Neutral	13 (15.5%)
Disagreed	39 (46.4%)
Strongly Disagreed	25 (29.8%)
7. Reporting errors is not anonymous	
Strongly Agreed	2 (2.4%)
Agreed	10 (11.9%)
Neutral	12 (14.3%)
Disagreed	41 (48.8%)
Strongly Disagreed	19 (22.6%)
8. Some medical errors are trivial to report.	
Strongly Agreed	1 (1.2%)
Agreed	13 (15.5%)
Neutral	21 (25.0%)
Disagreed	35 (41.7%)
Strongly Disagreed	14 (16.7%)
9. Reporting errors will not make any improvement.	
Strongly Agreed	5 (6.0%)
Agreed	7 (8.3%)
Neutral	10 (11.9%)
Disagreed	41 (48.8%)
Strongly Disagreed	21 (25.0%)
10. Fear of being blamed	
Strongly Agreed	8 (9.5%)
Agreed	19 (22.6%)
Neutral	15 (17.9%)
Disagreed	30 (35.7%)
Strongly Disagreed	12 (14.3%)

Continued...

Strongly Agreed	Number of Participants (Percentage (%))
11. Fear of being punished	
Strongly Agreed	9 (10.7%)
Agreed	17 (20.2%)
Neutral	16 (19.0%)
Disagreed	30 (35.7%)
Strongly Disagreed	12 (14.3%)
12. Medical errors reporting system are inadequate.	
Strongly Agreed	3 (3.6%)
Agreed	6 (7.1%)
Neutral	9 (10.7%)
Disagreed	50 (59.5%)
Strongly Disagreed	16 (19.0%)
13. Medical errors insurance lead to decrease the medical errors reporting	
Strongly Agreed	1 (1.2%)
Agreed	29 (34.5%)
Neutral	15 (17.9%)
Disagreed	29 (34.5%)
Strongly Disagreed	10 (11.9%)
14. Difficulty in filling the form	
Strongly Agreed	7 (8.3%)
Agreed	8 (9.5%)
Neutral	13 (15.5%)
Disagreed	39 (46.4%)
Strongly Disagreed	17 (20.2%)

Table 2: Distribution of study subjects' opinion about barriers of reporting incident report.

the hospital clinical wards. Furthermore, study participants strongly agreed that reporting errors should not be used against reporter 51.2% (n = 43), encourage the staff to report errors 54.8% (n = 46), staff should be trained on reporting medical errors 50.0% (n = 42) and there should be a clear guidelines and procedures for reporting errors 54.8% (n = 46).

Table 4 shows the relationship between nurses' years of experience and number of barriers to report errors. The below table revealed that there were no significant differences between nurses' years of experience and number of barriers to report errors, except with two variables which show significant relationship, lack of time ($P= 0.045 <0.05$) and complexity of work ($P=0.024 <0.05$).

The result in the above Table 5 showed the years of experience between 11-20 years were complaining of lack of time and complexity of work. Furthermore, nurses have 20 years and above experience lesser reported these barriers. While junior nurses did not consider them as major barriers.

Discussion

This study aimed to identify the barriers of reporting errors in nursing practice in one teaching hospital. In this study, the results revealed that lack of time and complexity of works are the main barriers for nurses to report incident within the hospital units.

Lack of time was the major barrier faced nurses to report incidents within hospital units, which has a negative impact on the patient care. Lack of time in the study context is caused by heavy workload due to staff shortage as encountered by nurses in particular within the general care wards. Therefore, lack of time was found as a burden to report such simple type of errors. This result is in agreement with a

Strategies	Percentage (%)	Frequency
1. Use computerize system.		
Strongly Agreed	48.8 %	41
Agreed	46.4%	39
Neutral	4%	4
Disagreed	0%	0
Strongly Disagreed	0%	0
2. Reporting errors should not be used against reporters.		
Strongly Agreed	51.2 %	43
Agreed	39.3%	33
Neutral:	2.4%	2
Disagreed	7.1%	6
Strongly Disagreed	0%	0
3. Staff should always be encouraged to report medical errors.		
Strongly Agreed	54.8%	46
Agreed	40.5%	34
Neutral:	3.6%	3
Disagreed	1.2%	1
Strongly Disagreed	0%	0
4. Staff should always be provided by feedback on what has been reported.		
Strongly Agreed	54.8%	51
Agreed	39.3%	28
Neutral:	3.6%	2
Disagreed	1.2%	1
Strongly Disagreed	1.2%	2
5. There should be a clear guidelines and procedures for reporting errors.		
Strongly Agreed	54.8%	46
Agreed	39.3%	33
Neutral:	3.6%	3
Disagreed	1.2%	1
Strongly Disagreed	1.2%	1
6. Reporting errors should be mandatory.		
Strongly Agreed	47.6%	40
Agreed	45.2%	38
Neutral	6.0%	5
Disagreed	0%	0
Strongly Disagreed	1.2%	1
7. Staff should be trained on reporting medical errors.		
Strongly Agreed	50.0%	42
Agreed	44.0%	37
Neutral:	6.0%	5
Disagreed	0%	0
Strongly Disagreed	0%	0
8. Forms and other documentation should be clear.		
Strongly Agreed	52.4%	44
Agreed	45.2%	38
Neutral:	2.4%	2
Disagreed	0%	0
Strongly Disagreed	0%	0

Table 3: Strategies to reporting the medical errors.

further studywhich demonstrated that patient care left undone or missed duo to lack of time especially when nurses assigned on a shift with high number of patients [16].

Complexity of work is another important barrier. In nursing, the complexity of work has received increased attention since the Institute of Medicine (IOM) issued its report on medical errors in 2000. Nurses who experience work overload in the unit have difficulties to report incidents that negatively effect on their work because of pressure in the main priority of work. Complexity of work was mentioned as

ANOVA

Barriers	Sum of Squares	Df	Mean Square	F	Sig
1. Lack of Time					
Between groups	10.879	2	5.439	3.218	.045
Within groups	136.931	81	1.691		
Total	147.810	83			
2.Complexity of work					
Between groups	12.008	2	6.004	3.900	.024
Within groups	124.695	81	1.539		
Total	136.702	83			
3. Reporting errors is not my responsibility					
Between groups	1.332	2	.666	.683	.508
Within groups	78.953	81	.975		
Total	80.286	83			
4. Lack of knowledge on what we should reported					
Between groups	3.786	2	1.893	2.225	.115
Within groups	68.916	81	.851		
Total	72.702	83			
5. Lack of procedures on reporting medical errors					
Between groups	1.832	2	.916	.780	.462
Within groups	95.156	81	1.175		
Total	96.988	83			
6. Reporting errors is not a priority					
Between groups	3.039	2	1.520	1.956	.148
Within groups	62.913	81	.777		
Total	65.952	83			
7. Reporting errors is not anonymous					
Between groups	.169	2	.084	.081	.922
Within groups	84.534	81	1.044		
Total	84.702	83			
8. Some medical errors are trivial to report					
Between groups	.059	2	.029	.030	.971
Within groups	80.513	81	.994		
Total	80.571	83			
9. Reporting errors will not make any improvement					
Between groups	4.451	2	2.226	1.884	.159
Within groups	95.692	81	1.181		
Total	100.143	83			
10. Fear of being blamed					
Between groups	1.714	2	.857	.565	.571
Within groups	122.988	81	1.518		
Total	124.702	83			
11. Fear of being punished					
Between groups	4.136	2	2.068	1.367	.261
Within groups	122.566	81	1.513		
Total	126.702	83			
12. Medical errors reporting systems are inadequate					
Between groups	1.062	2	.531	.592	.555
Within groups	72.605	81	.896		
Total	73.667	83			
13. Medical errors insurance lead to decrease the medical errors reporting					
Between groups	1.940	2	.970	.817	.445
Within groups	96.203	81	1.188		
Total	98.143	83			
14. Difficulty in filling the form					
Between groups	1.062	2	.531	.388	.680
Within groups	110.974	81	1.370		
Total	112.036	83			

Table 4: Correlations between experience years and the barriers to reporting.

Lack of Time						
Experience	Strongly Agreed	Agreed	Neutral	Disagreed	Strongly Disagreed	Total
3-10	4	6	2	7	4	23
11-20	8	15	1	1	3	28
21 and Above	5	13	5	6	4	33
Total	17	34	8	14	11	84
Complexity of Work						
Experience	Strongly Agreed	Agreed	Neutral	Disagreed	Strongly Disagreed	Total
3-10	1	7	4	7	4	23
11-20	8	11	4	3	2	28
21 and Above	5	13	5	6	4	33
Total	14	32	12	16	10	84

Table 5: Correlation between years of experience group and the major barriers to report.

one of the most common reporting barrier in a study who reported that workload leading to time pressures and an associated inability to report errors[11].

Surprisingly, this study revealed that fear of being blame was not reported by nurses as a barrier of reporting incidents within the hospital units. However, this result of the current study does not support the previous research. Fear of being blamed considered a main barrier in several studies[17]. Additionally, blamingnurses were the main barriers for nurses to report errors inclinical practice across various healthcare organizations in Saudi Arabia[11].Similarly, the results show that fear of being punished was not considered by nurses as a barrier to report errors in the hospital units. However, fear of being punished in the literature was found as a major barrier of reporting incidents not only monopoly to nurses, but also junior staff were blamed most of the time for incidents [13]. Moreover, it was demonstrated that the healthcare providers are fears to report any incidentswould be used against them[6]. This issue appeared to 40% with physiciansand 30% of nurses. A possible explanation for this is that the targeted healthcare organization is encouraging a non-blaming culture among their staff.

The strategies of reporting medical errors practice were described in different studies. For example, the most common strategies that help in reporting medical errors are: Use computerized system, reporting errors shouldn't be used against reporters and staff should always be provided by feedback on what has been reported[13]. Similarly, in the present study the result showed similar strategies helping in reporting nursing errors. Moreover, this study reported that the staff should always be encouraged to report medical errors and there should be a clear guidelines and procedures for reporting errors.

This study shows no significance differences between nurses' years of experience and number of barriers to report incidents, except in lack of time and complexity of work particularly with nurses their experience between 11-20 years. Nurses might perceive that get more experience could be related to their underreporting incidents report. This could attributed to the previous clarification in this study that nurses lack of time and complexity of work made the perception in reporting incidents and deal with these barriers sound difficult particularly in nurses with low level of experience. That could be supported by a study who reported that nurses less than 20 years of experience were facing barriers to report incidents[13].

Conclusion

An understanding of the health care professionals' awareness of reporting nursing errors can promote more effective to protect patients. This study is important to measure the knowledge and the awareness of nurses about the reporting system, and found the barriers that prevent them from reporting errors. Nurses demonstrated that lack of time and complexity of work were the major barriers to report errors. However, fear of being blamed and fear of being punched were not considered as a barriers of reporting incidents among nurses as the targeted hospital is encouraging the non-blaming culture. Healthcare leaders can make a major impact of organizational safety by increase the number of staff and nurses working at this hospital sequenced to decrease nurse patient ratio. Additionally, nurse managers should prevent their staff nurses to do a non-nursing work in order to enhance patient safety firstly and reduce nurses' workload secondary. Moreover, this study was conducted only in one teaching hospital and with small sample size. Therefore, the results of this study cannot be generalized to other healthcare organizations. Thus, a further research is needed to identify the barriers of reporting errors in nursing practice across different healthcare organization, considering large sample size.

Competing Interests

The author declares that she has no competing interests.

Authors Contribution

All authors contributed equally to this work. Banakhar, M. supervised the project and commented on the research project at all stages.

Tambosi, A. Asiri, S. Banjar, Y and Essa Y were involved in the process of data collection and data analysis. All authors discussed the results and implications and all authors contributed in writing up the all chapters/sections of the research project. Banakhar, M wrote the main paper and started the process of publication. All authors contributed extensively to the work presented in this paper.

References

1. Meurier CE, Vincent CA, Parmar DG (1997) Learning from errors in nursing practice. J Adv Nurs 26: 111-119.

2. Uribe CL, Schweikhart SB, Pathak DS, Marsh GB, Fraley RR (2002) Perceived barriers to medical-error reporting: An exploratory investigation. Int J HealthcManag 47: 263-79.
3. Evans SM, Berry JG, Smith BJ, Esterman A, Selim P, et al. (2005) Attitudes and barriers to incident reporting: a collaborative hospital study. Qual Saf Health Care 15: 39-43.
4. Cohen MR (2000) Why error reporting systems should be voluntary. BMJ 320: 728-729.
5. Hwang J, Lee SL, Ae Park H (2012) Barriers to the Operation of Patient Safety Incident Reporting Systems in Korean General Hospitals. Healthc Inform Res 18: 279-286.
6. Haper M, Helmreich R (2005) Identifying Barriers to the Success of a Reporting System.
7. Lawton R, Parker D (2002) Barriers to incident reporting in a healthcare system. Qual Saf Health Care 11: 15-18.
8. Kim J, An K, Kim MK, Yoon SH (2007) Nurses' perception of error reporting and patient safety culture in Korea. West J Nurs Res 29: 827-844.
9. Ross LM, Wallace J, Paton JY (2000) Medication errors in a pediatric teaching hospital in the UK: five years operational experience. Arch Dis Child 83: 492-496.
10. Almutary HH, Lewis PA (2012) Nurses' willingness to report medication administration errors in Saudi Arabia. Qual Manag Health Care 21: 119-126.
11. Tobaiqy M, Stewart D(2013) Exploring health professionals' experiences of medication errors in Saudi Arabia. Int J Clin Pharm 35: 542-545.
12. Kingston MJ, Evans SM, Smith BJ, Berry JG (2004) Attitudes of doctors and nurses towards incident reporting: a qualitative analysis. Med J Aust 181: 36-39.
13. AbuAlRub R, AlAkour N, Alatari N (2015) Perceptions of reporting practices and barriers to reporting incidents among registered nurses and physicians in accredited and non-accredited Jordanian hospitals. J Clin Nurs 24: 2973-2982.
14. Basavanthappa BT (2010) Essentials of Nursing Research. (2nd ed.), New Delhi: JAYPEE.
15. Alduais A, Mogali S, Al Shabrain B, Al Enazi A, Al-awad F (2014) Barriers and strategies of reporting medical errors in public hospitals in Riyadh city: A survey-study. IOSR-JNHS 3: 72-85.
16. Ball JE, Murrells T, Rafferty AM, Morrow E, Griffiths P (2014) Care left undone' during nursing shifts: associations with workload and perceived quality of care. BMJ Qual Saf, 23: 116-125.
17. Mohammad AZ, Aljasser IA, Sasidhar B (2016) Barriers to Reporting Medication Administration Errors among Nurses in an Accredited Hospital in Saudi Arabia. BJEMT 11: 1-13.