This study explored how fourth-year nursing students (n = 10) from one urban baccalaureate nursing program perceived incidents potentially harmful to patients, as well as incident reporting. Individual interviews were conducted. Five scenarios were presented in the interviews, with each scenario portraying a situation that varied in terms of the severity of potential for patient harm and the clinical team members involved. Participants’ responses were analyzed using a descriptive thematic approach. Of the 50 events (10 participants × 5 scenarios), participants identified 37 events as incidents. Three themes emerged regarding how participants identified an incident: scope of practice, professional roles, and harm to the patient. Regarding 48 of the 50 events, participants said they would report these incidents either informally or formally. Findings from this study suggest a need for nursing education regarding what constitutes an incident, as well as how and when to report incidents. [J Nurs Educ. 2014;53(4):238-243.]

Since the publication of To Err Is Human (Institute of Medicine, 2000), the amount of published research on patient safety has more than doubled (Stelfox, Palmisani, Scurlock, Orav, & Bates, 2006). This increase illustrates enhanced interest in creating a safety-conscious health care system. Many of these studies have specifically investigated incidents, reporting, and the relationship of incidents and incident reporting to patient safety. These studies have focused primarily on barriers to incident reporting and the development of reporting systems in which incidents will be regularly reported (Bird, 2005; Espin et al., 2007; Hartnell, MacKinnon, Sketris, & Fleming, 2012; Lawton & Parker, 2002; Meurier, 2000; Throckmorton & Etchegaray, 2007). Anderson, Kodate, Walters, and Dodds (2013) suggest that incident reporting can develop and maintain an awareness of risks. However, before health care professionals can report incidents, they must first identify them.

Understanding how incidents are identified is key to developing an incident-reporting system that health care professionals will regularly use, and it allows both health care institutions and their employees to learn from incidents and use that learning to improve patient safety. Before the barriers to reporting incidents investigated by other studies can be addressed, it is important to first understand how health care professionals and students perceive and identify incidents, as well as what they believe are the appropriate reporting actions. Such an understanding will allow development of a consistent, functional approach to educating health care professionals and support a well-developed incident-reporting system within health care.

For example, Lawton and Parker (2002) found that when incidents affecting patients contradict written protocols, nurses are more likely to report them. Because numerous events that could be deemed incidents may not be specifically covered by written protocols, this absence may lead to many unreported incidents. Professional role also affects incident reporting. Kingston, Evans, Smith, and Berry (2004) reported that nurses are far more likely to report incidents than physicians or other health care professionals. Nurses (including nursing students) are arguably most likely to witness incidents or be involved in incidents or incident reporting because they regularly spend the most time directly with patients and interact with a variety of other health care professionals. The purpose of this study was to explore nursing students’ perceptions of incidents and incident reporting.
Method

To glean an in-depth understanding of nursing students’ perceptions, 10 fourth-year nursing students enrolled at one urban nursing baccalaureate program were recruited on a voluntary basis using posted flyers. The ethnically diverse sample included two men and eight women. The study was approved by the university’s ethics board.

During the interviews, five scenarios (Table 1) were presented to each participant to prompt discussion during the interview. The scenarios were based on ones developed by Espin, Wickson-Griffiths, Wilson, and Lingard (2010). The first four scenarios described events that could be perceived as incidents, and the fifth scenario described an event that could be perceived as a near miss. After reading each scenario, participants were asked the following series of questions:

- Would you consider this to be an incident? Why or why not?
- Would you report this? Why or why not?
- To whom would you report and why?
- How and what would you report?

Because this descriptive study sought to explore nursing students’ perceptions of incidents, a definition of incident was not provided to the participants. The scenarios and questions were pilot tested with four nursing students and three nursing professors who were not involved in the study to assess relevance, comprehensiveness, and readability.

Together, the scenarios portrayed a range of situations that varied in terms of the severity of potential for patient harm, the
clinical team members involved, and the outcome for the patient. In all of the scenarios, a nurse collaborated with another health care professional as described in Table 1. Data collection was concluded when no new themes emerged (Kuzel, 1999). Participants’ responses were analyzed using a descriptive thematic approach. Following verbatim transcription of each interview, responses to the open-ended questions were analyzed for emergent themes. Two researchers individually read and came together to analyze all transcripts in a constant comparative fashion. This analytical process involved noting of recurrent themes, categorizing related trends, and alternating individual analysis and team discussion to generate a coding structure that accounted for all dominant themes in the data.

Results

Perception of Incidents

Ten participants responded to five scenarios during each interview, yielding a total of 50 potential events. Of these 50 events, participants identified 37 as incidents. Six participants identified nine events as nonincidents, and four participants were uncertain about whether four of the events were incidents. Only in Scenario 4 did all of the participants perceive that an incident had occurred. Table 1 shows the perceived presence and absence of incidents, as well as the number of times participants were unsure about whether an event was an incident.

Three themes emerged in participants’ justification for calling an event an incident: scope of practice, professional roles, and the presence or absence of patient harm. The definition of each theme, a justification example, and the number of times the theme was present are summarized in Table 2.

Scope of Practice. This theme was used to justify calling an event an incident when participants described the health care providers’ actions as outside of their professional role. As one participant said regarding Scenario 4, “...a respiratory therapist should not be touching, at all, IV [intravenous] pumps. It’s not their job.” Scope of practice also was used to justify not calling an event an incident when participants perceived the event as being outside their professional knowledge base. For example, when discussing Scenario 1, one student said, “I’m not in a position [to argue] because he’s a medical resident and I’m a nurse, so there’s a difference in education.”

Professional Roles and Responsibilities. This theme was used to justify calling an event an incident. For example, in Scenario 2, one student suggested:

*The patient is supposed to get repositioned every 2 to 3 hours, and if it states that in the chart, then that’s something that you should do, and if...the night nurse didn’t do it, then she completely didn’t do what her responsibilities were, and she was accountable for it.*

The same reason was used to justify not calling an event an incident. Another participant suggested that no incident occurred in Scenario 2, due to the nurse’s other professional obligations: “[I wouldn’t consider it an incident]...maybe the nurses just got busy or something happened.”

Presence or Absence of Patient Harm. This theme was used to justify calling an event an incident. For example, as one participant stated, “[It is an incident] because there was an actual, a negative or unplanned outcome for the patient that you were really trying to avoid.” In contrast, participants also suggested that when actual patient harm was present, the event was not an incident. As one participant stated, “[This is not an incident] because there wasn’t any harm done to the patient as of yet, there wasn’t anything done which resulted in an injury to the patient.”

<table>
<thead>
<tr>
<th>Theme</th>
<th>Perceptions of an Incident</th>
<th>Example</th>
<th>No. of Times Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of practice</td>
<td>Action of an individual is outside of his or her role, abilities, or knowledge</td>
<td>“I’m not in a position [to argue] because he’s a medical resident and I’m a nurse, so there’s a difference in education.”</td>
<td>3</td>
</tr>
<tr>
<td>Professional roles</td>
<td>Related to professional accountability, responsibilities, and relationships</td>
<td>“The patient is supposed to get repositioned every 2 to 3 hours, and if it states that in the chart, then that’s something that you should do, and if...the night nurse didn’t do it, then she completely didn’t do what her responsibilities were, and she was accountable for it.”</td>
<td>10</td>
</tr>
<tr>
<td>Harm present</td>
<td>Presence of actual or potential harm to patient</td>
<td>“[It is an incident] because there was an actual, a negative or unplanned outcome for the patient that you were really trying to avoid.”</td>
<td>14</td>
</tr>
<tr>
<td>Harm absent</td>
<td>Lack of actual or potential harm to patient</td>
<td>“[This is not an incident] because there wasn’t any harm done to the patient as of yet, there wasn’t anything done which resulted in an injury to the patient.”</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 2

Summary of Themes Justifying Perception of Incidents
Reporting of Incidents

When all 10 participants indicated they perceived an incident to have occurred, 48 of 50 times the participants said they would report it. There were no significant differences across the scenarios regarding the reporting of errors. These reports encompassed three types: informal, formal, or a “ladder” approach, in which participants would escalate their response depending on how the person to whom they reported responded. The number of times participants said they would report each scenario as an incident is shown in Table 1. The definition of each reporting method, a reporting example, and the number of times each reporting method was present in interviews are summarized in Table 3.

Informal Reporting. Of the 48 incidents that participants identified, they indicated they would report the incident informally 36 times. Participants defined informal reporting as documentation of the event in a patient’s chart, speaking to a colleague or supervisor, or reporting either to an internal organizational body (e.g., infection control department) or an external regulatory body (e.g., College of Physicians and Surgeons). For example, one student explained, “I wouldn’t report it...I would talk to the nurse manager on the floor.” Eight of the participants who did not perceive an event as an incident suggested that they would report the event. Seven of these eight participants said that they would report it informally, and one participant said that she would report it using a ladder approach. All four of the participants who were unsure whether the event was an incident said that they would report the event. Three of these four participants indicated that they would report informally, and the fourth participant said that she would use a ladder approach.

Formal Reporting. This process involves the completion of a form designed by the institution for incident reporting. Participants said they would formally report events that they perceived as incidents a total of eight times. These included two times in Scenario 3, three times in Scenario 4, and three times in Scenario 5. Participants explained why they felt that a formal report was necessary. For example, with regard to Scenario 5, one student explained, “The concentration is incorrect...so you would write an incident report.”

When speaking about formal reports, participants suggested they were uncertain about how to formally report an incident. Overall, participants were uncertain about when a formal report was appropriate, what it entailed, and the repercussions of formal reporting. As one participant explained, “I don’t know... how exactly the [formal] procedure works with reporting something, but I’m assuming that there’s a paper and you write something down.”

Ladder Approach. Three participants said that they would use a ladder approach to report what they perceived to be an incident in Scenarios 1, 2, and 5. These participants clearly outlined how they would first report informally to one person or agency, and then move on to another person or agency if the response and actions of the first were unsatisfactory. With regard to Scenario 1, one participant’s statement typified using the ladder approach: “I would speak to the physician overseeing him [the resident] first, then if he was going to deal with it, leave it at that, but if he wasn’t going to do anything, then I would go to the College [of Physicians and Surgeons].”

Justification for Reporting Incidents

When data on participants’ justifications for reporting incidents were analyzed, three themes emerged: patient harm, professional responsibility, and legal accountability (Table 4). First, participants said that they would report incidents in which they perceived actual or potential patient harm. Participants clearly defined the role that harm played in their justification for reporting, such as in scenario 4. As one student said, “I would report it, depending on how the patient reacted, and the patient did react to it in this scenario, because he’s hemodynamically compromised, so I would report it.”

The second justification for reporting was professional responsibility. Regarding Scenario 4, one participant said:
So it’s fairly significant and important for them [respiratory therapists] to make sure that if they are going to do any silencing of the alarms, that they follow it up and let the nurse know... but it’s also the nurse’s responsibility to be monitoring these things, so it’s kind of a shared responsibility there.

Participants described how their position as nursing students played into their decision of how to report. For example, regarding Scenario 3, one participant said:

“I wouldn’t just write a report on someone without talking to them first, and I would not be comfortable approaching a physician about this...I’m a student and he’s a senior physician, I’m not going to, like, yell at him and tell him to wash his hands.

The third justification for reporting was legal accountability. As one nursing student explained, “I would consider if I don’t have something else to significantly back me up, that this actually did happen, down the road, that it would affect my license.”

Participants said they would not report an incident when they perceived no actual harm to the patient. Regarding Scenario 5, one student stated:

[I wouldn’t report because] the nurse, she premixed it and she left it, nothing happened to it, the patient didn’t touch it, and because I am the next nurse and I notice the incorrect dosage, I can just change it myself, and it’s not a big deal.

Participants also suggested that without sound rationale for identifying and reporting an incident, they would do neither. As one participant said, “I don’t feel like I have sound reasoning behind why I would call it an incident, so I wouldn’t report it.”

Discussion

Similar to other studies (Edmondson, 2004; Espin et al., 2007; Throckmorton & Etchegaray, 2007), participants in the current study believed that reporting incidents could harm other health care professionals. Participants suggested that by reporting an incident, they would be “getting that person in trouble.” In addition, they thought that reporting incidents could reflect badly on them. This may be one of the reasons for the discrepancy found between perceiving incidents and informally reporting the incidents.

These findings suggest inconsistency among participants’ perceptions of incidents, especially in the more ambiguous situations. Only in Scenario 4 did all 10 participants perceive the event as an incident. Even with this unanimity, their rationales for identifying an incident varied, and hence, their decisions to report and how to report varied as well. Most participants suggested that they would report the incident to the nurse manager, leaving it to the manager to take further action regarding the event within the scenario. Informal reporting may be a way for nursing students to identify and report incidents where they perceive barriers to formal reporting. This informal dialogue may be a safe place to encourage incident reporting.

Recommendations and Limitations

Nursing students’ lack of knowledge regarding what constitutes an incident and how to report it are barriers to the reporting process. Future research should explore the promotion of a standardized definition of incidents and guidelines for reporting them in both the educational and work contexts. In addition, research should explore the most effective time to deliver this education: during nursing education or after newly graduated nurses are hired by institutions. It might be useful to incorporate scenarios in nursing education, to give students an opportunity to discuss these types of events and others that could arise in practice.

### TABLE 4
Summary of Themes Justifying Reporting of Incidents

<table>
<thead>
<tr>
<th>Theme</th>
<th>Justification for Reporting</th>
<th>Example</th>
<th>No. of Times Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm present</td>
<td>Presence of actual or potential harm to patient</td>
<td>“Potential danger. It doesn’t show, it’s not like the physician is holding a knife and stabbing everyone, but it’s like the same thing. You could easily kill somebody by, you know, provoking infection.”</td>
<td>7</td>
</tr>
<tr>
<td>Professional responsibility</td>
<td>Related to perceived professional accountability, responsibilities, and relationships</td>
<td>“So it’s fairly significant and important for them [respiratory therapists] to make sure that, if they are going to do any silencing of the alarms that they follow it up and let the nurse know... but it’s also the nurse’s responsibility to be monitoring these things, so it’s kind of a shared responsibility there.”</td>
<td>12</td>
</tr>
<tr>
<td>Legal accountability</td>
<td>Potential for legal issues stemming from the incident</td>
<td>“I would consider if I don’t have something else to significantly back me up, that this actually did happen, down the road, that it would affect my license.”</td>
<td>7</td>
</tr>
<tr>
<td>Harm absent</td>
<td>Lack of actual or potential harm to patient</td>
<td>“Because it’s not hurting anyone...it hasn’t been given to the patient or anything, so it’s not an incident...it would be an incident if it was actually given to the patient...the wrong concentration was given.”</td>
<td>1</td>
</tr>
</tbody>
</table>
Limitations of this study included the recruitment of only fourth-year nursing students at a single university. Other educational sites and students in other years of training may have similar or differing perspectives. A larger and more varied sample that includes other health care professionals might be considered for future studies.

Conclusion

The findings from this study suggest a need for education regarding what constitutes an incident, how and when to report incidents, and clarification on the roles of team members in incident reporting. This in turn may inform future practicing nurses to promote the continuity and responsibility of incident reporting as an important aspect of patient safety.

References


