Journal of Current Medical Research and Opinion
Received 25-01-2022 | Revised 18-02-2022 | Accepted 28-02-2022 | Published Online 04-03-2022

DOI: https://doi.org/10.52845/CMRO/2022/5-3-1 **ISSN (O) 2589-8779 | (P) 2589-8760**
CMRO 05 (03), 1148–1151 (2022)

ORIGINAL RESEARCH

Barriers to Reporting Medical Errors in Healthcare Facilities

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Abstract
Medical errors adversely affect healthcare organizations, patients, insurance, and financial systems. Reporting medical mistakes is essential because it increases patients' safety and prevents damage. These mistakes can affect the patient's illness course, cause damage or injury and affect the sick individual and physician relationship. Various issues, including fear, the time required to report, uncertainty about what to report, and the lack of feedback are examples of the primary barriers.

1 | INTRODUCTION

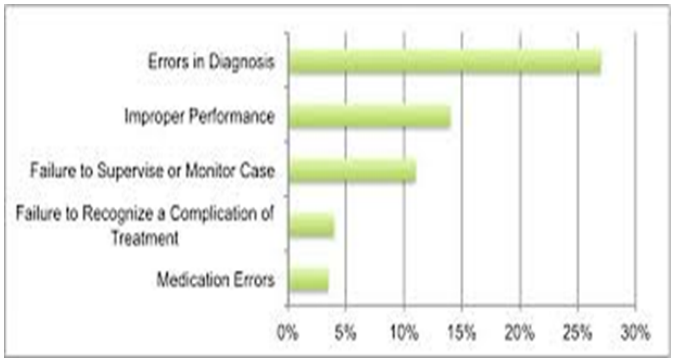

FIGURE 1: IndividualBarriers to Reporting Medical Errors

Fear

Healthcare professionals are afraid to be considered individuals who make significant mistakes, therefore, hesitate to report medical errors. According to Zaghloul et al. (2018), most employees believe that individual fear factors are the most common barrier to exposing medical mistakes. A study conducted by Asgarian et al. (2021) showed that the fear of the consequences of reporting is the most crucial barrier. Rutledge et al. (2018) identified lawsuits' and losing patients' trust fears as the primary error disclosure obstacles in a different study. Rutledge et al. (2018) also determined that medical errors are related to the repercussions of nurses' fears. Moreover, Ghobadian et al. (2021) highlighted that healthcare workers' failure to report medical mistakes include: litigation fears in abuse, not revealing the error, and losing patients' trust. Mansouri et al. (2019) pointed out that clinicians' fear of losing their jobs contributes to the failure of reporting medical errors. Finally, Ghobadian et al. (2019) observed that the medical professionals are unaware of the mistakes because they said they did not make the errors that should be reported.

However, hospitals should assure the clinicians that nobody will blame them after reporting.

Lack of Attention to Medical Mistakes' Importance

Nurses should understand the consequences of medical errors in their profession. Asgarian et al. (2021) explained that employees fail to report medical mistakes, mainly because they pay little or no attention to the errors' essentiality. A study by Soydemir et al. (2017) and Ghobadian et al. (2019) demonstrated that some clinicians do not understand their mistakes. Therefore, the administration should ensure that the employees understand different medical errors and their consequences.

Organization Barriers to Reporting Mistakes

Inadequate Staff Support and Forgetting the Error

Healthcare professionals receive minimal support from their managers, adversely affecting their confidence. Studies reviewed by Asgarian et al. (2021), Rutledge et al. (2018), and Mansouri et al. (2019) emphasized the essentiality of supporting clinicians by giving them a platform to express themselves. A study by Samsiah et al. (2020) identified that some participants forgot the medical mistake they committed. This might result in data bias in the study's outcomes decreasing the number of errors committed by a specific population. Fathi et al. (2017) established that the nursing staff fails to report medical mistakes because of heavy workload and shift work type. These were cited as the two primary reasons for not reporting errors. Samsiah et al. (2020) determined that the number of nurses who fail to report medical mistakes is 45%. Therefore, the hospital leadership plays a primary role in ensuring patient safety by offering a platform for healthcare professionals to air their issues.

Medication mistakes are among the most significant errors in healthcare. An analysis by Mansouri et al. (2019) established that many employees do not report drug errors because of the fear of their adverse effects on financial advantages. Other reasons include the negative or inappropriate managers' attitude towards reported errors. Mansouri et al. (2019) demonstrate that the most critical barrier to reporting drug errors is that individuals are blamed rather than the system. Mauti et al. (2019) established that 53.8% of healthcare professionals believe no punishment should be imposed after committing medical errors. Healthcare administrators should establish why specific medication errors occurred and how they can be prevented in the future.

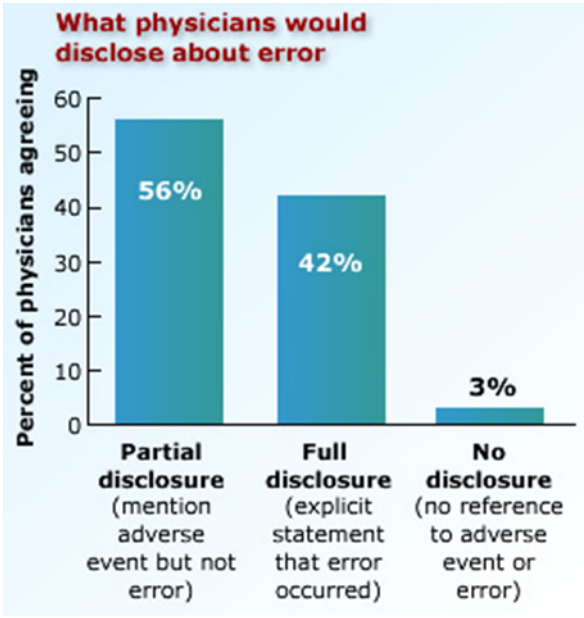

FIGURE 2:

Organizational Facilities

Error Reporting System

Medical errors incidences are high, but there are low reporting rates. Alves et al. (2019) suggest the essentiality of establishing an efficient recording reporting system to manage and analyze the errors in all healthcare organizations. Zaghloul et al. (2018) emphasized the essentiality of implementing an anonymous system to highlight unnecessary mistakes or information. The system should also emphasize care processes care and their implications.

Example of Error Reporting System

Training the Staff Members

Hospital and nursing administrators should carry out regular training courses in healthcare organizations.

Supplementary information The online version of this article (https://doi.org/10.52845/CMRO/2022/5-3-1) contains supplementary material, which is available to authorized users.

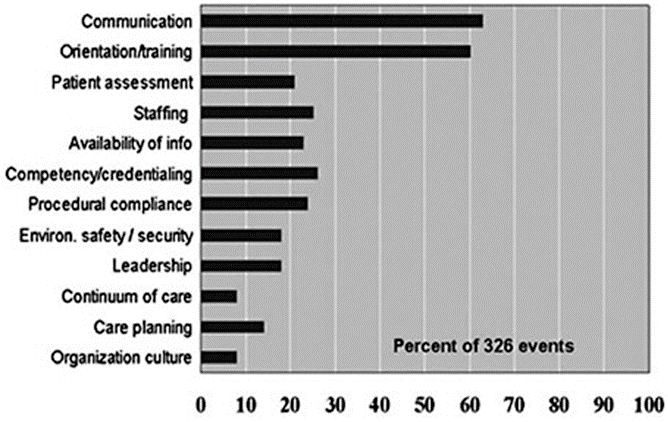

FIGURE 3: EducationalFacilities

According to Fathi et al. (2017), the knowledge and skills from the training guide clinicians about the safe and proper use of various medications and minimize errors. In addition, Zaghloul et al. (2018) argued that healthcare organizations administrators should offer training opportunities and workshops. These programs should incorporate accidents disclosure, advice and assist healthcare workers such as surgeons in handling different errors.

The Appropriate Managers' Behaviors

Creating a friendly and conducive environment is essential to remove medical error reporting barriers. Mansouri et al. (2019) argue that hospital report refusal rates are significantly increasing. According to Fathi et al. (2017), the nurse managers should respond to the nurses' reports positively. Therefore, this will increase the clinicians' confidence and report any medical error they commit in the workplace. Mansouri et al. (2019) explained that the administrators focus on the individuals who committed the mistake; therefore, clinicians find it challenging to report drug mistakes. Likewise, the leaders' inappropriate response to medical mistakes' announcement by employees is among the issues raised by Ghobadian et al. (2021). The managers should consider other factors involved when the error occurred.

Medication Administration Errors

Avoid Blaming the Staff Members

A behavioral change in the face of employee errors is crucial. Samsiah et al. (2020) and Mansouri et al. (2019) argue that the barriers of blaming the staff, punishment, and fear can be removed through effective feedback for corrective actions. Asgarian et al. (2021) say that the administrators' attitude determines the possibility of employees committing and reporting errors. In another study, Mansouri et al. (2019) argue that healthcare organizations' administrators should encourage clinicians to report the mistakes to maximize patient safety. According to Alves et al. (2019), the primary responsibility of hospitals and their workers is to ensure that patients get competent care and their safety is guaranteed. However, Samsiah et al. (2020) argue that blaming individuals who commit medical errors minimizes their possibility of reporting the mistakes. This increases the chances of adverse effects on the patients' health and safety.

2 | CONCLUSION

In summary, medical mistakes are crucial and influential in medical outcomes and care quality. The reason is that these errors result in adverse effects such as injury, damage, or death. Patient safety is a priority; therefore, hospital managers should take steps to remove the barriers to reporting medical errors. This can be achieved by adopting measures such as introducing an easy error registration system, training, changing managers' behaviors, and improving patient safety culture.

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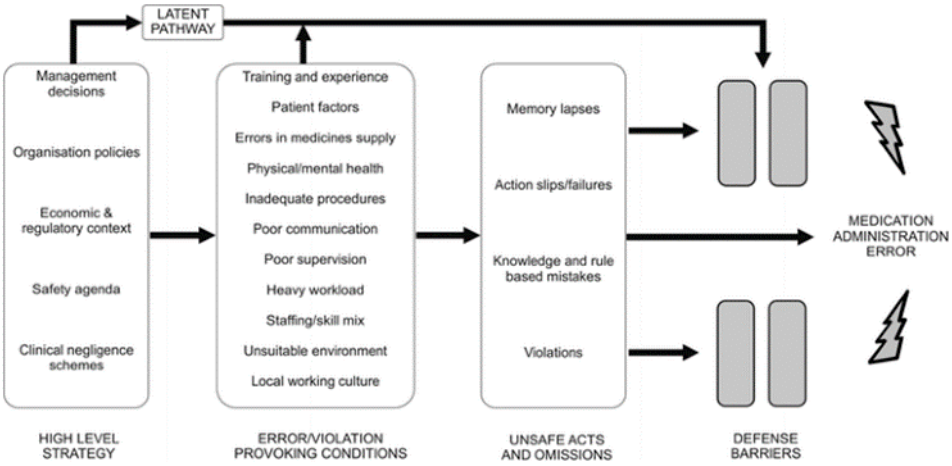

FIGURE 4:

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How to cite this article: Alsuwaileh, F. A., Sabr, A. K., Althagafi, M. A., Alanazi , A. I., Alasiri, S. A., Almarshad, S. A., & Albrethen, I. A. (2022). Barriers to Reporting Medical Errors in Healthcare Facilities. Journal of Current Medical Research and Opinion, 5(03), 1148−1151. https://doi.org/10.52845/CMRO/2022/5-3-1