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Patients' willingness to complete written incident report forms in one UK tertiary cancer hospital

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Abstract

This article examines patients' willingness to complete incident report forms (IRF), providing a description of the event or concern. Differing from other studies, its design enabled patients to report incidents when and if they felt this necessary, rather than responding to researchers' questions. 145 patients receiving treatment for cancer in a UK hospital were invited to participate. Of the 100 patients who agreed to participate, only 13 completed a total of 22 forms. The form's purpose was not easily understood, often perceived as complaining and patients tended to report relatively trivial matters. Contrary to previous studies, this study found little evidence that IRFs are the right tool for enabling patients' proactive involvement in safety improvement. Asking patients to monitor their safety by completing IRFs may serve to undermine patients' trust in their clinicians while duplicating resources.

Key words

Incident reporting, safety, patient involvement, cancer

Introduction

While the advantages of patients' proactive involvement towards improving the safety of healthcare have been discussed widely,[1–3] few empirical studies have tested patients' willingness to be involved.[4] Further, evidence indicates that patients' deferential attitudes towards clinicians,

concerns about being labelled as difficult and clinicians responding negatively or defensively to being questioned are barriers to patients' more active involvement.[4] However, the few existing studies suggest that patients may be willing to report formally incidents such as medication errors, as this does not require the explicit questioning of clinicians.[5,6] In a recent literature review of patient incident reporting, Ward and Armitage[7] noted that although the studies reviewed found that patients were willing to report incidents, the study methods involved researchers actively requesting patients' views, using surveys or semi-structured interviews; the authors concluding that such researcher-led methods may have exaggerated the extent to which patients are willing participants. This paper examines the willingness of patients in a UK hospital to complete incident reporting forms (IRFs), providing a description of the event or concern.

Incident Reporting Systems (IRS)

IRSs are considered to be pivotal towards improving patient safety by providing data about the frequency and severity of incidents to facilitate safety performance improvement. Such systems require employees' willingness to report, in confidence, 'adverse events' or 'patient safety incidents', which are any unintended or unexpected incidents that led to harm for one or more persons and 'near misses', which are any events that did not cause harm but had the potential to do so.[8]

IRSs generally ask for information about the what, when and where of the incident or near miss for the purpose of investigation. Analysis of the data is then undertaken to identify and aggregate any similar incidents, for example patient falls or prescribing errors. Certain categories of incident, often those considered to have caused severe harm are subjected to a detailed investigation to identify and correct underlying systems failures.

However, such IRSs are not without problems. They are expensive and bureaucratic to administer with little evidence of their effectiveness for patient safety improvements.[9] Other barriers to reporting include: under reporting by clinicians[10–12]; disagreement about what counts as a reportable event; and fear of blame[13]. Despite the problems associated with IRSs they have been implemented across healthcare systems worldwide. Yet, generally, patients do not have access to IRSs thus their experiences of harm may go unreported and unacknowledged. This is important because when encouraged to report, patients often highlight incidents not documented in the IRS by clinicians.[14]

Arguably, patients' involvement in IRSs could provide hospital patients with a voice enabling them to contribute proactively to healthcare safety without requiring them directly to confront clinicians. While factors that reduce patients' *ability* to be active participants in healthcare safety include several illness related factors such as confusion, general frailty, serious illness and depression[15–18]. Other obstacles to involvement including inability to communicate fluently in the native language; low health literacy; physical factors such as hearing, speech and visual impairments; and loss of motor skills.[19,20] The purpose of this study is to examine the *willingness* of patients in a UK tertiary cancer hospital to complete IRFs.

Method

Setting

Our study was undertaken in a tertiary cancer hospital in the UK. Cancer patients often require prolonged periods of hospital treatment and there is some evidence to suggest that patients with prolonged illnesses are generally familiar with the healthcare system and some of the problems associated with it.[21–23] Cancer treatment itself carries many risks, such as infection following

chemotherapy; therefore patients may be sensitive to safety issues. This combination of familiarity with the healthcare system, awareness of problems, and sensitivity to safety issues, means that they may be more likely to report safety issues than other patients would be. Prior to recruitment, ethical approval was obtained from NRES Committee London - Surrey Borders (project ID 131289).

Study design

The study was an observational study, exploring the extent to which patients report incidents.

In addition to a patient information sheet describing the project and what participation would involve, a researcher explained the study to potential participants, emphasizing that the incident forms were anonymous. Potential participants were also informed that the nurses and doctors caring for them would be aware of the study but not informed of the individual participants. If a nurse or doctor were to ask to see a completed form, they could politely refuse. However, it was explained that they were at liberty, should they wish, to show any of their forms to the nurses or doctors.

Participants

Between April and August 2014, we sought to recruit a maximum variation purposive sample of 100 patients, 25 respectively from the hospital's 4 mixed-sex wards. Inclusion criteria comprised adult in-patients over the age of 18 who were able to give their consent to participation in the study. Exclusion criteria included: less than 24 hours in hospital; patients in side rooms under restricted access due to illness; deemed inappropriate by the nursing staff because of psychological conditions such as depression; patients being too ill; and non-English speakers. Non-English speaking patients were excluded on the basis of the difficulty (time and costs involved) in accessing hospital-based interpreters' services.

Reporting form and data collection

Patients agreeing to participate were given paper incident forms replicating the computerised format used by many UK NHS hospitals (see Appendix). It was explained that participation required completing a form every time they thought they had been involved in, or witnessed, what they thought was an unsafe event or a near miss; that the forms should be used when they judged it appropriate; and that they decide how they wished to complete them. Participants were given a number of blank forms and self-sealing envelopes in which to store completed forms. Three times per week a researcher visited and collected completed forms until the respective participants were discharged from hospital.

Data analysis

Analysis proceeded firstly by counting the number of participants not completing a single form. Then the reasons participants gave for this, having been documented in field notes, were categorised into key themes. Following this, the total number of incident reports completed was counted and the number of reports per participant noted. Then the contents of the forms were transcribed and tabulated into the factor types and the influencing contributory factors using Vincent et al.'s framework.[24] This framework describes how errors can be analysed systematically to reveal the complex chain of events, including the underlying organisational factors, which may have led to an incident. This was a largely subjective process. Two researchers categorised the incidents independently and where they disagreed the incident was discussed and a third researcher was asked for her opinion until a consensus was reached.

Findings

Non-reporting by participants

In total, 145 patients were invited to participate in the study 45 (31%) declining our invitation to contribute, most not giving a reason. Others volunteering reasons such as: 'wouldn't report

anything, the hospital is excellent' and 'I am just a labourer, doctor knows best', reflecting a paternalistic view of healthcare.[25] Many patients said they were too tired or too unwell. Participants included 51 men and 49 women, aged between 27 and 85 years, with varying lengths of stay (2-120 days).

87 of the 100 patients, who agreed to participate, failed to complete a single form. Table 1 provides key themes and illustrative quotes for why the majority of participants did not complete any forms. The various justifications given showing similarity with the reasons given by those patients who declined to participate.

Table 1 Reasons for not reporting

Themes	Number	Quotes
Nothing to report	28	'Not seen anything that was worth mentioning' 'Did not observe anything I thought would be relevant' 'Can't think of anything to say, have not seen anything happening'.
Health reasons	22	'Asleep most of the time or can't concentrate more than 5 minutes at a time' 'Have not had the chance to write anything as not been feeling too good.' 'I have a couple of things that I would like to make a note of but I have not been feeling well.'
Excellent hospital	13	'I doubt that there will ever be an incident to report as the hospital is wonderful and the staff are doing an excellent job' 'They are all excellent, can't fault the ward or hospital staff in any way'
No reason given	11	
No time	6	'I will write everything down when I get the chance'
Misunderstanding	3	'The forms have a tendency to be perceived by other patients as complaining forms and no-one wants to come across as complaining.'
Trust	2	'Our age group don't like to ask too many questions and we trust the doctors know what they are doing'
Making comparisons	2	'If this had been x hospital I would have had any amount of issues to raise'

Number and type of incidents reported

A total of 22 written reports was received from 13 participants. Three participants completed three forms, two participants completed two and seven completed one form. Further, one of the

participants who provided three forms and one who provided one form requested that a researcher complete the incident forms as they said their writing was poor. Six patients who did not complete an incident form recounted incidents that they could have reported. All of these reports were related to individual staff factors of poor communication. For example, one patient was upset by the lack of privacy around patient-doctor conversations. Another said that a doctor had told her that her endoscopy results were available. However, she had not yet been for her endoscopy. One patient who had fallen reported this to a nurse, while a researcher was present, but the participant chose not complete an incident form about this.

Of the 22 incidents reported: 12 (54.5%) were work environment type issues (for example, a broken tumbler, noise levels in the ward, a draughty window, an uncomfortable chair and a dirty spoon); three (14%) were individual staff factors (employees' apparent lack of knowledge and skills); two (9%) highlighted team factors (poor co-ordination between the ward and the pharmacy department); two (9%) related to organisational and management factors (transport delays and pharmacy closed evenings and weekends); two (9%) to patient factors (disruptive patient and a dropped glass); and one (4.5%) was a 'nothing to report'. For 14 (64%) of the incidents reported, patients had informed the nurses verbally.

Discussion

These results indicate that patients are reluctant to contribute to the writing of incident reports while in hospital, contradicting previous studies which found that patients are generally willing participants in this form of safety improvement initiative.[7,26] These results further contradict studies specific to cancer patients which found that the longer duration of care in a cancer centre increased the likelihood of patients reporting concerns about safety.[27,28] However, this study

differed from other studies as its design enabled patients to report incidents, rather than patients responding to questions asked by researchers, hence the method employed may account, at least in part, for the differences in results. Indeed, some patients in this study were willing to recount incidents to a researcher, but chose not to document these on the written form.

Of those agreeing to participate, very few actually completed, and returned, a single form, supporting an argument that patients' positive intentions to participate do not always predict engagement in actual behaviours.[29] In addition, the (few) patients who did report incidents tended to report non-clinical issues such as a broken glass, consistent with an argument that patients tend to be more willing to get involved in reporting mundane issues, non-threatening to clinicians.[30] Further, some participants misunderstood the purpose behind the IRFs, the forms often being perceived as a method of complaining rather than helping to improve safety.

Many explanations for declining to participate or for not completing a single form after agreeing to participate, suggest patients trust clinicians, based on assumptions about their competence and benevolence. In contrast, IRSs reduce the rich communicative clinician-patient interactions at ward level to the numerical rational managerial system of external bureaucratic control of clinicians' work.[31] Therefore, expecting patients to contribute to IRSs may be counter-productive by undermining such trust. Indeed, most of the patients who did choose to complete an incident form had already made their concerns on the relevant issues known to nurses. In the UK, the Patient Advice and Liaison Service (PALS) is available for patients to report concerns about care in a confidential manner. Thus, patient incident reporting may be a duplication of resources, which is of particular importance given concerns about the effectiveness of IRSs for improving patient safety.[9]

Conclusion

In summary, results of this study suggest that patient incident reporting may not be the right tool to promote patients' active involvement with their safety. Although, the study is not without its limitations: it was limited to one hospital, a small sample and a specific group of patients. Therefore the generalisations we can make are invariably theoretical, providing insights relating to cancer patients in one UK hospital. Further research involving different patients in different contexts is required. A future study could also compare what staff report with what patients report.

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