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Incident reporting of ward nurses: A basis of strengthening patient safety standards

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Abstract

This study investigates the challenges ward nurses face in incident reporting, which is crucial for enhancing patient safety in healthcare settings. Utilizing a convergent mixed-method approach, it combines quantitative and qualitative data to offer comprehensive insights. Quantitatively, the study identifies prevalent incident types, revealing clinical incidents as most reported, followed by workplace, near-miss, and non-clinical incidents. Local working conditions emerge as the most significant contributory factor, guiding interventions to address the most influential elements in incident reporting practices. Qualitatively, Giorgi's phenomenological approach is applied to explore the experiences of nine ward nurses. Ten significant themes emerge an open and non-punitive reporting environment, safety culture cultivation, and proactive crisis management. Barriers encompass risk assessment, transparency, and fostering a culture of advocacy. Integrating both findings provides a nuanced understanding of incident reporting among ward nurses, enabling the development of effective interventions. The study recommends a program addressing significant events while targeting underlying variables influencing reporting behaviors. This research contributes valuable insights and recommendations for healthcare practitioners striving to improve incident reporting systems and enhance patient safety in healthcare settings.

Keywords: barriers, contributory factors, incident reporting, ward nurses

Incident reporting of ward nurses: A basis of strengthening patient safety standards

1. Introduction

Incidence reporting is a vital aspect of enhancing patient safety in healthcare settings. It enables healthcare practitioners to recognize and handle possible hazards, lowering patient harm and enhancing service quality. Waterson (2018) underline the relevance of incident reporting in patient safety and argue that it should be an intrinsic aspect of healthcare quality improvement. The Yorkshire Contributory Factors Framework (YCFF) is an excellent technique for identifying and classifying the factors that contribute to occurrences in healthcare settings. Lawton et al. (2019) outline the development, deployment, and assessment of the YCFF, highlighting its potential to improve patient safety. Failures to report incidents, on the other hand, can have a severe impact on patient safety. O'Hara et al. (2020) determined that reporting gaps can result in missed opportunities for learning and development, delays in addressing hazards, and greater damage to patients after conducting a comprehensive review of the literature. As a result, it is vital to understand the variables that contribute to failures in incident reporting and to devise a strategy to prevent them. The research indicates that incident reporting is critical to enhancing patient safety, and the YCFF can be a valuable tool in detecting and managing possible hazards in healthcare settings. Furthermore, while hospitals provide medical and emergency services, they have a complicated and hazardous relationship with errors and catastrophes. These potential risk factors for patient damage must be addressed clearly since they have an impact on both patients and healthcare personnel. These incidents must also be documented and reported to the healthcare system. Because multiple studies have shown that incident reporting improves patient safety, it has become standard policy for many hospitals' accreditation procedures. Moreover, because it collects and organizes patterns for corrective action, it may be used as a learning tool.

Incident reporting is used by healthcare personnel to report unpleasant incidences and near misses. According to studies, a safety-focused culture is often correlated with high reporting rates. To promote and improve patient safety, hospitals and healthcare professionals must implement an effective and consistent incident reporting system. As part of their job, health care employees are required to report incidents. Furthermore, several institutions are looking for strategies to encourage their medical staff to report incidents voluntarily. Despite various attempts, however, there are many incidents of underreporting owing to the repercussions of the action, which has been a cause of dissatisfaction. Fear of accountability and a blaming culture drove healthcare staff to adopt voluntary incident reporting. When participating in incident reporting, healthcare institutions must appreciate the significance of healthcare personnel' concerns about their well-being and job security. This research will look at the difficulties and potential solutions for improving patient safety through incident reporting.

As a nurse at a tenured tertiary hospital for nearly 14 years, the researcher can attest to the importance of incidence reporting in clinical practice. I began as an emergency room nurse, progressed to a supervisor position, and am now the nursing service's training officer. As a training officer, this study will assist me in strengthening and motivating my colleagues to become more aware of the factors and impact of incidence reporting. In lieu of the study, the researcher want to underline the need of incident reporting, particularly to my co-nurses, in order to guarantee patient safety. The researcher, who is also a practicing nurse, set out to assess the difficulties that ward nurses have when reporting occurrences and how this relates to patient safety in light of the difficulties and concerns that nurses confront. The researcher suggested this study to assess ward nurses' challenges in coping with discrepancies in order to provide insights and advice to healthcare practitioners. To guarantee patient safety in healthcare settings, a commitment to incident reporting is required. Healthcare institutions should prioritize the creation and implementation of effective incident-reporting systems that encourage an environment of transparency, honesty, and continuous learning.

Objectives of the Study **-** Specifically, this study intends to identify the nature of incidents commonly encountered in terms of clinical incidents, near-miss incidents, workplace incidents and non-clinical incidents. Next is to determine the extent of incidence reporting in terms of the following contributing factors such as: active failure; situational factors; local working circumstances; latent/organizational factors and latent external factors. Third is to evaluate the impact of the respondent's incident reporting in accordance with patient safety. Lastly, is to develop a proposed plan of interventions that will enhance patient safety through effective incidence-based reporting.

2. Methods

Research Design **-** The main objective of this study was to evaluate the practice of incident reporting among ward nurses in tertiary hospitals in the city of Lipa in order to develop nursing intervention strategies. Mixed method approach was utilized in this study specifically, convergent mixed methods design wherein both quantitative and qualitative data collected and analyzed, then compared the analysis of quantitative and qualitative data to see if the data confirms or disconfirms each other. In this design quantitative and qualitative data were collected concurrently and separately analyzed. After concluding both analyses, the results were compared so that generalizations could be made.

In the context of objectives 1 and 2, a quantitative correlational research design will be utilized to investigate the relationships between variables without the researcher controlling or manipulating them. The intensity and/or direction of the relationship between two (or more) variables is reflected by the correlation. A correlation's direction can be positive or negative (Bhandari, 2022). In combination to a phenomenological qualitative approach which is to answer the third objective of the study, a qualitative approach will be utilized. Interpretation of the five (5) respondents' transcribed responses collected using a semi-structured interview guide. A qualitative phenomenological methodology highlighted the distinct lived experiences of participants. This qualitative design, according to Polit and Beck (2012), employs exploratory research to gain insight into attitudes, motivations, and underlying causes. In this section of the study, the impact of incident reporting in relation to patient safety in designated hospitals in Lipa City, Batangas was investigated and the evaluation and lived-experiences of the respondents were described.

Participants of the Study **-** The study was conducted among ward nurses in selected hospitals in Lipa City. Ward nurses who have experience of six (6) months and above in the hospital and are directly involved with patients will be the specific respondents of the study. Further, newly hired nurses or nurses without direct contact with patients will not be included. In the quantitative approach, the target population of ward nurses in Lipa City is one-hundred fifty (150), however due to tine constraints and conflicting schedule of participants only (109) participants was able to participate in the study. It was consulted to the adviser and the statistician, it was then supported that the number of respondents is enough to support the query of the study. In qualitative aspect, nine (9) respondents were interviewed, their raw responses was transcribed and thematic analysis was derived based from Giorgi’s Existential Phenomenological Research Method.

Data Gathering Instrument **-** A self-made questionnaire will be the main tool to get the information needed from the selected hospital ward nurses in Lipa City. The researcher will utilize books and other relevant sources to create the questionnaire. After making the questionnaire, the researcher will submit it to the advisor and academic experts to get their inputs and approval. It was also submitted to the statistician for Cronbach’s alpha reliability testing prior to the approval of the survey questionnaire. Cronbach’s alpha is a way of assessing reliability by comparing the amount of shared variance, or covariance, among the items making up an instrument to the amount of the overall variance. After approval, the researcher will give the questionnaire it will be pilot tested to thirty (30) participants to check the suitability of the tool prior to dissemination of survey tool to the intended participants. In addition, the researcher will conduct an interview to gain a better understanding of clinical nurses' experiences and narratives in connection to incidence reporting. In interviewing study participants, the researcher will use a semi-structured questions as a guide. The instrument undergone meticulous

validation through reliability testing, approval by the panelist, adviser and institutional ethical committee prior to data gathering.

Data Gathering Procedure - The researcher gathered information and data from books, journals, reviews of papers, electronic databases, and other studies conducted by different researchers. As well, the researcher submitted the questionnaire to the advisor initially to make certain they were accurate and get authorization to hand them out. The researcher then communicated to the Medical Director and the Human Resource Department to get authorization, then initiated the study and carried it out. After the research tool was finished, the researcher utilized Google Forms to do the actual survey. The distribution of the survey questionnaire was facilitated in a timely manner the same time, properly scheduling appointments with my respondents for their interviews throughout June 2023. After the survey, the answers were put through a statistical treatment that was used to write the study's interpretation and findings. Then further, the researcher complied with ethical guidelines and requested the people being studied for consent to be a participant in the study.

Ethical Considerations - In order to conduct the study, the researcher must first get approval to utilize the research instrument and then get authorization from the hospital administration and research ethics committee. The researcher will also give each respondent a letter of consent that gives them permission to participate in the part and collect information. The nurses who are participating in the research will be informed what its goal is. Participants will clearly understand that they can withdraw the research if they choose not to finish it. All the ward nurses who take part in this study will also have to give their official permission, and their confidentiality and anonymity will be ensured.

Data Analysis - The researcher used different statistical treatments to answer the questions in the study. The data that was collected, tabulated, analyzed, and interpreted using descriptive statistics such as: weighted mean and rank were used to determine (a) the nature of incidents commonly encountered by ward nurses and (b) contributory factors to incidence reporting of ward nurses. All analyses were performed using SPSS version 25. In the context of exploring incident reporting and its contributory factors, the weighted mean as a statistical treatment refers to a method used to calculate an average that takes into account the relative importance or significance of different factors within the dataset. This approach is particularly valuable when certain contributory factors hold varying levels of influence on incident reporting practices. The result, the weighted mean, provides a more understanding of the collective impact of various contributory factors on incident reporting practices, allowing researchers to prioritize interventions more effectively.

3. Results and discussion

Table 1 shows the nature of incidents commonly encountered by ward nurses. Overall grand composite mean of the summary table was 4.5 verbally interpreted as “agree”. Among the key result areas clinical incidents and workplace incidents top the ranking with the following weighted mean of 4.56 and 4.54 both verbally interpreted as “strongly agree”. The study by Westbrook et al. (2019) investigates incident reporting systems in acute care hospitals. Clinical incidents, such as medication errors, patient falls, or adverse events, are the most often reported episodes by ward nurses. Clinical events have a direct influence on patient safety, necessitating detailed incident reporting for investigation and improvement. Toering et al. (2019), on the other hand, conduct a systematic study on incident prevention in geriatric care. It emphasizes that ward nurses commonly confront workplace issues such as physical or verbal hostility. Workplace events have a significant influence on the health and safety of healthcare employees and must be addressed in order to create a safe working environment.

The literatures support the ranking of clinical incidents as the most commonly encountered by ward nurses, followed by workplace incidents. Clinical incidents, including medication errors, falls, and adverse events, pose direct risks to patient safety and require incident reporting for analysis and improvement. Workplace incidents, such as physical or verbal aggression, affect the well-being and safety of healthcare workers, highlighting the need for incident reporting and interventions to create a safe working environment. Followed by near-miss

incidents and non-clinical incidents having the weighted means of 4.48 and 4.45 both verbally interpreted as “agree”. In connection to this, Haraldstad et al. (2019) investigate the characteristics of near-miss medication occurrences in long-term senior care. Ward nurses frequently experience near-miss episodes, which entail instances in which damage was narrowly avoided. While near-miss episodes may not result in patient damage, they do give great learning and improvement opportunities. As a result, they rank second in the summary table. Ward nurses in these settings are exposed to non-clinical occurrences such as job injuries or environmental dangers. While non-clinical occurrences are less common than clinical and near-miss accidents, they nonetheless need attention and incident reporting in order to provide a safe working environment. Therefore, they rank as the least common in the summary table.

Table 1

Nature of Incidents Commonly Encountered by Ward Nurses

Indicators	Weighted Mean	Verbal Interpretation	Rank
Clinical Incidents	4.56	Strongly Agree	1
Near-miss Incidents	4.48	Agree	3
Workplace Incidents	4.54	Strongly Agree	2
Non-clinical Incidents	4.45	Agree	4
Composite Mean	4.51	Agree	

Legend: 4.50-5.00 = Strongly Agree; 3.50-4.49 = Agree; 2.50-3.49 = Neither Agree or Disagree; 1.50-2.49 = Disagree; 1.00-1.49 = Strongly Disagree

The above cited studies support the ranking of near-miss incidents as the second most commonly encountered by ward nurses and non-clinical incidents as the least common. Near-miss incidents provide valuable opportunities for improving patient safety, while non-clinical incidents, although less frequent, still require attention for maintaining a safe working environment.

Table 2

Contributory Factors to Incidence Reporting of Ward Nurses

Indicators	Weighted Mean	Verbal Interpretation	Rank
1. Active Failure	4.47	Agree	3.5
Situational Factors	4.47	Agree	3.5
Local Working Conditions	4.50	Strongly Agree	1
Latent / Organizational Factors	4.48	Agree	2
Composite Mean	4.51	Agree	

Legend: 4.50-5.00 = Strongly Agree; 3.50-4.49 = Agree; 2.50-3.49 = Neither Agree or Disagree; 1.50-2.49 = Disagree; 1.00-1.49 = Strongly Disagree

Table 2 shows the summary table of contributory factors to incidence reporting of ward nurses. The overall grand composite mean is 4.46 verbally interpreted as “agree”. The top key result area is local working conditions having a composite mean of 4.50 verbally interpreted as “strongly agree” followed by latent organizational factors on second place with a composite mean of 4.48 verbally interpreted as “agree”. In terms of local working conditions, it incorporates aspects directly relevant to the ward nurses' immediate work environment in terms of local working conditions. Inadequate workforce numbers, a lack of resources, insufficient communication, and an overwhelming workload are examples of signs. These characteristics have a considerable impact on incident reporting methods and patient safety outcomes on the ward (Lake et al., 2018). While, atent organizational factors, on the other hand, pertain to wider systemic and organizational components that impact ward nurses' incident reporting procedures indirectly. Regulatory restrictions, financing limits, changes in healthcare delivery methods, organizational culture, and leadership support are all examples of this (Nieva et al., 2018).

Tying on the third place are the active failure and situational factors both with the same mean of 4.47. Last in the ranking is the key result area latent/external factor garnering a composite mean of 4.40 all verbally interpreted as “agree”. In connection to this, active failure refers to ward nurses' direct activities that lead to patient safety problems like medication mistakes or falls. These factors include direct acts or choices made by frontline healthcare personnel. Identifying and correcting active failures is critical for improving incident

reporting processes and patient safety outcomes (Carthey et al., 2018). While situational factors include the immediate environment in which ward nurses conduct their duties. Workload, personnel numbers, time constraints, interruptions, and other environmental variables can all impact incident reporting processes. Recognizing and resolving situational issues is critical for fostering a safe workplace and improving incident reporting processes (Westbrook et al., 2019).

While latent/external variables are listed last in the chart, their effect on event reporting should not be overlooked. External components outside the control of healthcare institutions, such as environmental conditions, weather disasters, and technology malfunctions, are examples of these issues. Consideration and resolution of latent/external causes lead to a complete knowledge of occurrences and provide a safer care environment. Recognizing the importance of active failure, situational variables, and latent/external factors allows healthcare organizations to establish ways to reduce risks, improve incident reporting processes, and improve patient safety results in the ward context.

3.1 Thematic Analysis

The researcher, using Giorgi's phenomenological approach it as used to investigate the lived experiences and fundamental structure of five (9) ward nurses in chosen hospitals in Lipa City, Batangas. Giorgi's method emphasized revealing the vivid meaning of the participants' experiences; it detailed each participant's unique experience; and it incorporated the participant's entire experience based on changes in context, relationships, time, and perspectives to derive a general structure.

Table 3

Profile of Respondents

Respondent Number	Level of Hospital	Length of Service
1	Primary	14 years
2	Tertiary	3 years
3	Tertiary	1 year
4	Tertiary	5 years
5	Tertiary	7 years
6	Primary	1.5 years
7	Primary	3 years
8	Tertiary	1 year
9	Tertiary	2 years

Theme 1: Contributory Factors in Incident Reporting

Based from the quantitative findings, local working conditions had the highest mean regard by the respondents. In line to this, the following sub- themes: Open and Non-Punitive Reporting Environment, Cultivation of Safety Culture in the Working Environment, Neutralizing Potential Patient Safety Risk, Nurse as Patient Advocates from Incidence, Managing Foreseeable Crisis Proactively, Safety Culture Assessment and Reporting System, Interventional Feedback System of Incidence Reporting, Self-Involvement in Sustainable Learning, Standardized Incident Reporting Systems and Empowering Staff Nurses to Sustainable Development was leaning towards the working conditions and factors that was found contributory factors that impacts incidence reporting of ward nurses correlating to their real life experience.

In connection to the study, incident reporting plays a pivotal role in enhancing patient safety and quality of care within healthcare settings. It provides a mechanism through which healthcare professionals can communicate and document adverse events, near misses, and errors that occur during patient care. However, the mere act of reporting an incident is often influenced by a myriad of contributory factors that extend beyond the event itself. These factors encompass a complex interplay of individual, organizational, and systemic elements that influence whether and how incidents are reported. Understanding these contributory factors is crucial for developing effective strategies to promote a culture of incident reporting, ultimately leading to improved patient outcomes and organizational learning.

Sub theme 1: Open and Non-Punitive Reporting Environment - Incident encourages healthcare workers, particularly nurses, to report incidents without fear of reprisal or negative consequences in a non-punitive incident reporting environment that promotes reporting culture. This encourages open communication and the reporting of near-misses and errors, both of which are crucial for recognizing and resolving potential patient safety threats.

> *Respondent 2: "Incident reporting systems can contribute by addressing the concerns and opinions of nurses. With that, effective solutions may be provided to gradually decrease the errors in the healthcare institution. Awareness to each nurses will also be provided for the culture of safety."*

> *Respondent 3: "Incident reporting helps in making nurses more self-aware about their liabilities, their responsibilities, and how their actions contribute to a safe nursing practice."*

> *Respondent 5: "Incident reporting systems provides a way to monitor potential problems and provides a reminder for us nurses for possible hazards. Incident reporting systems may serve as our protection for future problems."*

> *Respondent 6: "Incident reporting put up an important role to address a potential error occurred. It contains the situation, background, action and even recommendations for the error happened. With this, we can easily understand the situation."*

> *Respondent 8: "Incident reports is one of the vital reports to gather data and have a focus when it terms to safety. With this, the institution can utilize programs and policies to decrease number of the certain incidents."*

When nurses feel confident reporting incidents without fear of penalties, they are more likely to detect and expose system flaws or hidden factors that contribute to patient safety incidents. This early detection can lead to the identification of system-level issues such as insufficient staffing or equipment, allowing for prompt steps to prevent harm (Marx et al., 2019). It also fosters a just culture that places a premium on justice, learning, and responsibility. It recognizes that errors can arise as a result of system failures rather than individual negligence and advocates a balanced approach to event investigation and accountability (Woods et al., 2019).

In conclusion, fostering an open and non-punitive event reporting is crucial for increasing patient safety. It encourages event reporting, enhances learning and improvement, assists in the early detection of system flaws, and is compatible with the concepts of a fair society. Implementing such an environment enables healthcare facilities to develop a culture of safety and continuous improvement, which leads to better patient outcomes.

Sub theme 2: Cultivation of Safety Culture in the Working Environment - Manser et al. (2019) discovered that developing a safety culture in the workplace improved patient outcomes. According to studies, companies with a strong safety culture had fewer adverse events, prescription errors, and healthcare-associated infections, resulting in better patient outcomes. Developing a safety culture improves the psychological safety of healthcare workers. When nurses feel supported and valued in their attempts to improve safety, they are more engaged, satisfied, and driven in their work (Manser et al., 2019). Overall work satisfaction and retention rates among nursing employees improve as a result.

> *Respondent 1: "Incident reporting a safety contributes in promoting a safety of culture among nurses by providing data of incidents which occurred and may possibly occur with their respective containment and corrective actions in which the reported incidents be prevented in re-occurring hence promoting a safety culture among nurses."*

> *Respondent 4: "Incident reporting systems contribute to safety culture among nurses in a way the potential error or error can be addressed properly. Through incident reporting it can provide*

an action and recommendation on how to correct the potential error or error that was done."

A safety culture that encourages open communication and learning, according to Hughes et al. (2019), improves the reporting of accidents and near-misses. Nurses are more likely to report safety concerns, mishaps, and near-misses when they are encouraged rather than reprimanded or penalized (Hughes et al., 2019). Organizations can utilize these reports to identify system flaws and take corrective action to avoid future incidents. Improved Teamwork and Collaboration: A safety culture promotes teamwork and collaboration among healthcare staff. It encourages open communication, active listening, and mutual support, which leads to better coordination and better patient care (Manser et al., 2019). Improved collaboration reduces the likelihood of errors and develops a culture of shared responsibility for patient safety.

Respondent 7: "Incident reporting system contributes to promoting a culture of safety among nurses by keeping records of practices that should be avoided and should serve as a lesson that should not be repeated. By being aware of the circumstances that should be avoided, we cultivate an error-free environment leading to an efficient and quality nursing care to patients."

Respondent 9: "Incident reporting helps in establishing culture safety among nurses by providing the right behavior, beliefs and values to achieve clinical excellence. It is a safe tool where nurses will feel safe in raising concerns and report safety events."

This form of culture encourages nurses to discover and handle potential occupational risks and hazards on their own. Nurses should take preventative measures and follow safety recommendations to avoid potential patient harm by developing a proactive attitude (Weaver et al., 2019). It also fosters a culture of continuous learning and advancement. It encourages businesses to participate in ongoing monitoring, evaluation, and quality improvement activities. Finally, compliance with regulatory requirements and certification criteria is typically associated with a good safety culture. Organizations that prioritize patient safety and cultivate a safety culture are more likely to fulfill and exceed these requirements, resulting in improved results (Manser et al., 2019). Thus, developing a workplace safety culture is critical for improving patient outcomes, increasing employee engagement and satisfaction, increasing incident reporting, strengthening teamwork, proactively identifying risks, promoting continuous learning, and ensuring regulatory compliance. By establishing a safety culture, healthcare organizations may improve patient safety, employee well-being, and high-quality care.

Sub theme 3: Neutralizing Potential Patient Safety Risk **-** To keep patients safe, it is necessary to reduce any patient safety risks. By proactively evaluating and managing risks, healthcare organizations may minimize the incidence of adverse events, medication errors, falls, and other preventable injuries (Hughes et al., 2019). When potential patient safety threats are reduced, patient outcomes are likely to improve. Organizations that successfully identify and manage risks, according to studies, have lower rates of complications, readmissions, and mortality, resulting in better overall patient outcomes (Wang et al., 2019).

Respondent 2: "Effective communication will enable nurses to proactively identify and prevent potential patient safety risks. In addition to that, updated trainings and seminars if there are any changes in the system of the healthcare institution."

Respondent 4: "Incident reporting enables nurses to proactively identify and prevent potential patient safety risks through open communication. Having an open communication can prevent any possible potential error or error."

Potential patient safety risks have been reduced, resulting in a better patient experience and increased satisfaction. Trust, confidence, and contentment with the healthcare organization rise when patients and their families perceive that their safety is a major priority and that any risks are adequately managed (Hughes et al., 2019). Effective risk management and patient safety procedures enhance an organization's reputation. Positive patient experiences and outcomes, as well as a commitment to patient safety, help to boost the organization's

reputation in the community and among stakeholders (Wang et al., 2019). Healthcare organizations can save money by reducing potential patient safety risks. By avoiding adverse events and related difficulties, organizations can lower the economic burden associated with more treatments, longer hospital stays, and legal fines (Hughes et al., 2019). Meeting regulatory and accreditation criteria necessitates reducing potential patient safety problems. Healthcare facilities must demonstrate their commitment to patient safety and risk reduction in order to maintain compliance and retain their image as providers of safe and good care (Wang et al., 2019).

> *Respondent 9: "Through incident reporting, nurses realize that errors are inevitable so everyone is encouraging to speak up for patient's safety and near misses. A strong safety culture encourages all members of the health care team to identify and reduce risks to patient safety by reporting errors and near misses so that root cause analysis can be performed and identified risks are removed from the system."*

By aggressively minimizing potential patient safety risks, healthcare organizations establish a culture of safety among healthcare professionals. This culture encourages continual awareness, open communication, and proactive issue identification and resolution, resulting in a safer care environment (Hughes et al., 2019). Finally, addressing potential patient safety risks is critical for preventing harm, improving patient outcomes, enhancing patient pleasure, bolstering company reputation, cutting healthcare costs, maintaining regulatory compliance, and building a safety culture. By focusing risk reduction and preventative activities, healthcare organizations may create a safer and more dependable care environment for patients and healthcare workers.

Sub-theme No. 4: Nurse as Patient Advocates from Incidence - Nurses are core advocates for patient safety. Nurses help to detect and prevent potential patient injury by reporting events and near-misses. Their involvement as advocates helps to provide a safe care environment and prevent negative events (Ginsburg et al., 2019). Incidence reporting by nurses has the potential to increase patient involvement in their own treatment. When occurrences are reported and handled, patients and their families develop faith in the healthcare system, and they are more likely to actively participate in their treatment and express their concerns (Hughes et al., 2019). Nurses' positioning as patient advocates fosters a culture of safety in healthcare organizations through event reporting. Incident reporting encourages open communication, transparency, and a commitment to continuous improvement. It establishes an environment in which all members of the healthcare team prioritize patient safety. By reporting occurrences, nurses may influence policy changes and improve healthcare practices. Nurses contribute to patient safety debates and decision-making processes by providing data and evidence on incidents (Ginsburg et al., 2019).

> *Respondent 3: "Incident reporting may help in a way that it reminds nurses to not commit the same mistake twice. While it does not necessarily point out the mistake of a nurse, it is a proper documentation explaining their side."*

> *Respondent 5: ": Incident reporting enable nurses to proactively identify and prevent potential safety risks by documenting fundamental information."*

> *Respondent 7: "Incident reports enable us nurses to reflect on the actions that transpired, as the reflection gets deeper, the more critical we become. Through this, aside from being aware of what to do next time, we become more immersed in the reality that our actions have significant impacts on a patient's life."*

Nurses' reporting of incidents helps to build trust and increase communication with patients, families, and colleagues. Nurses who advocate for patient safety by reporting incidents demonstrate their commitment to providing high-quality care and preserving trust in the healthcare system (Hughes et al., 2019). Furthermore, nurses play an important role in ensuring patient safety, empowering patient engagement, improving quality of care, strengthening interdisciplinary collaboration, promoting a culture of safety, enhancing trust and communication, and influencing policy and practice through incident reporting. By recognizing and supporting

nurses in their advocacy role, healthcare organizations may foster a safer and more patient-centered care environment.

Sub-theme No. 5: Managing Foreseeable Crisis Proactively **-** Proactive crisis management is crucial for avoiding negative outcomes and preventing patient damage. By recognizing possible crises through incidence reporting, healthcare organizations may adopt proactive actions to minimize risks and prevent crises from occurring (Hughes et al., 2019). Proactive crisis management helps healthcare providers to respond promptly and efficiently when emergencies do occur. By identifying potential crises through incident reporting, healthcare teams may develop procedures, reaction plans, and training programs to ensure timely reactions and minimize the impact on patient safety (Kane-Gill et al., 2019).

> *Respondent 1: "Reporting incidents enable nurses to proactively identify and prevent potential safety risk by having an effective system where in they can document non-compliance with their respective corrective and preventive actions in which these actions should be monitored and checked for effectiveness resulting to a safe working environment."*

With early care of projected crises, morbidity and mortality rates can be drastically decreased. By recognizing and treating potential crises before they worsen, healthcare institutions may act early, implement appropriate therapies, and minimize unfavorable outcomes for patients (Winters et al., 2019). Proactive crisis management enables healthcare companies to improve resource usage and efficiency. By forecasting and planning for future emergencies, organizations may efficiently deploy resources, streamline workflows, and prevent disruptions to patient care (Kane-Gill et al., 2019).

> *Respondent 6: "Along with incident reporting we can prevent potential patient safety risk through an open communication. Also by, reviewing the set standards, policies or protocols."*

> *Respondent 8: ": Knowing that the said incident happened due to a certain root cause, preventive measures can be acknowledged."*

Preventing unanticipated events enhances both patient and workplace safety. Organizations may set safety standards, provide adequate training, and develop a culture of readiness by detecting potential situations and reporting them. This helps to a safer care environment for both patients and healthcare providers (Hughes et al., 2019). Crisis management that is proactive improves organizational resilience. When healthcare organizations actively detect and handle looming crises, they become better capable of reacting to unexpected occurrences, making educated decisions, and effectively handling difficult situations (Winters et al., 2019). Proactive crisis management fosters a culture of ongoing learning and development. By evaluating incident reports and applying the knowledge to develop crisis management strategies, organizations may implement modifications, update systems, and raise overall preparation for future crises (Kane-Gill et al., 2019). Finally, proactive crisis management based on incidence reporting is critical for preventing adverse events, enabling timely response and intervention, reducing morbidity and mortality, optimizing resources and efficiency, improving patient and staff safety, enhancing organizational resilience, and encouraging continuous learning and improvement. By prioritizing proactive crisis management, healthcare institutions may protect patients' safety and improve overall care delivery.

Sub-theme No. 6: Safety Culture Assessment and Reporting System **-** Safety culture evaluation and reporting systems give a systematic method for measuring the safety culture inside healthcare organizations. By gathering data and input from healthcare professionals, these systems help identify areas of strength and areas that need improvement in increasing patient safety (Manser et al., 2019). Safety culture assessment and reporting systems aid in the development of a safe culture in healthcare organizations. These approaches emphasize open communication, reporting of accidents and near-misses, and learning from mistakes. They encourage healthcare practitioners to be proactive in improving patient safety (Hughes et al., 2019).

Respondent 1: "Feedbacks in incident reporting system helps in justifying and strengthening the effectiveness of corrective and preventive actions for incidents. These helps in rationalizing and evaluating the actions for future improvements."

Systematic examination and reporting of safety culture improves healthcare practitioners' understanding of patient safety risks. By participating in safety culture assessments and reporting occurrences, healthcare professionals have a better understanding of potential dangers and vulnerabilities in the care environment. This enhanced understanding enables more proactive steps to be taken to avert damage and improve patient safety (Manser et al., 2019). Quality improvement initiatives are built on assessment and reporting systems for safety culture. The data from these systems may be analyzed to find patterns, trends, and areas of concern. This information is used to guide the development and execution of targeted treatments to address systemic problems and improve patient safety outcomes (Hughes et al., 2019).

Respondent 3: "Feedback from incident reporting will make nurses more aware of their behavior and possibly reinforce themselves to have positive behavior in order to prevent errors."

Respondent 7: "Having a two-way communication gives us nurses a chance to hear professional insights outside of our echo chambers and it leads us into an action to make ourselves better for our patients. We are becoming more aware of our performance and we can also be able to hear observations that was already normalized within us but is deemed unnecessary or inappropriate in our practice."

Mechanisms for assessing and reporting safety culture promote accountability and openness within healthcare facilities. These systems establish an environment in which patient safety accountability is emphasized by providing a place for healthcare professionals to record incidents, express concerns, and recommend improvements. They also promote openness in the sharing of lessons learned and the results of quality improvement programs (Manser et al., 2019). This enables healthcare companies to benchmark their safety culture performance against others, discover best practices, and learn from one another in order to enhance patient safety outcomes (Hughes et al., 2019). Systems for monitoring and reporting on safety culture help healthcare companies achieve regulatory and accreditation requirements. These strategies demonstrate a commitment to continuously assessing and enhancing safety culture, which is commonly necessary for regulatory compliance and certification (Manser et al., 2019). Safety culture assessment and reporting systems, in general, are critical for identifying areas for improvement, promoting a culture of safety, increasing patient safety awareness, driving quality improvement initiatives, improving accountability and transparency, enabling benchmarking and comparative analysis, and meeting regulatory requirements. By appropriately integrating and exploiting these systems, healthcare organizations may foster a culture of safety, continuously enhance patient care, and raise overall patient safety.

Sub-theme No. 7: Interventional Feedback System of Incidence Reporting **-** The incident reporting interventional feedback mechanism is essential for promoting ongoing learning and development. By offering feedback on reported events, healthcare facilities can identify areas for improvement, execute targeted interventions, and assess the efficacy of implemented changes (Cooper et al., 2018). By highlighting the importance of reporting and its impact on patient safety, the interventional feedback system encourages incident reporting. Healthcare workers who give timely and constructive feedback are more likely to report accidents, resulting in a better understanding of safety dangers and opportunities for improvement (Scheepers et al., 2018).

Respondent 2: "One incident may contribute to remind nurses to carefully provide care to patients and to follow the health protocols and standard of the institution. Hence, a simple feedback may lead in a greater effect in reducing errors in providing care to patients."

Respondent 4: "Incident reporting can improve nurses' awareness of patient safety in a way correcting the not standard actions and following the standard protocol for each intervention.

Following the set standard intervention can prevent any potential error or error."

The interventional feedback system can be used by healthcare organizations to detect and resolve system-level faults that cause events. By examining reported events and providing comments, organizations may identify underlying causes and make necessary changes to prevent repeat occurrences (Hughes et al., 2019). The input supplied by the interventional feedback system aids individual and team learning. Healthcare professionals can reflect on their own practices to gain a better understanding of the factors that lead to accidents, allowing them to improve their skills, knowledge, and decision-making (Cooper et al., 2018).

Respondent 5: "Incident reporting in healthcare refers to collecting healthcare incident data with the goal to improve patient safety and care quality. If done well, it identifies safety hazards and guides the development of interventions to mitigate risks, thereby reducing harm"

Respondent 6: "Incident reporting helps us to re-understand the safety standards for each intervention."

The aforementioned feedback mechanism contributes to the development of a safe culture. It emphasizes the need of event learning, open communication, and proactive patient safety initiatives. This safety culture encourages healthcare workers to report incidents and contribute to continuous quality improvement programs (Scheepers et al., 2018). Employee engagement and contentment are increased when an interventional feedback system is used. Healthcare personnel feel empowered and recognized for their contributions to patient safety when they are actively participating in the process. Job satisfaction and retention rates improve as a result (Cooper et al., 2018).

Respondent 8: "Through reporting a potential error or error, it shows a sign of accountability, knowing there will be consequences for every wrong doing. It can be a foundation of good camaraderie in the unit, open to constructive criticism for the improvement of individual knowledge and skills"

Respondent 9: "Feedback from incident reporting plays the main role to have the positive outcome and reduce the reoccurrence of errors and improve the nurses' awareness. "

It has immediate implications for patient safety and quality improvement initiatives. By identifying areas for improvement and implementing targeted interventions, organizations may enhance patient outcomes, reduce adverse events, and improve overall quality of care (Hughes et al., 2019). Finally, the incident reporting interventional feedback system is critical for facilitating continuous learning and improvement, improving incident reporting culture, identifying system-level issues, supporting individual and team learning, promoting a safety culture, increasing staff engagement and satisfaction, and driving patient safety and quality improvement initiatives. Using such a system, healthcare institutions may create a safer and more effective care environment.

Sub-theme No. 8: Self-Involvement in Sustainable Learning - Participation in long-term learning through event reporting promotes personal growth and development among healthcare employees. Professionals that actively participate in the reporting process reflect on their own practice, identify areas for development, and learn new skills and knowledge (Fernandez et al., 2018). Self-reporting of incidents allows healthcare personnel to take ownership of patient safety. It encourages individuals to take an active role in identifying potential dangers, implementing safety solutions, and improving patient outcomes (González-Gil et al., 2020). Self-involvement in sustainable learning contributes to the development of a learning culture within healthcare organizations. By engaging in continuous learning and development through incident reporting, professionals create an environment that encourages continual education, cooperation, and the exchange of best practices (Fernandez et al., 2018).

Respondent 1: "Having an effective incident reporting will result in containment and corrective actions and possibly preventive actions which in effect will result in overall quality improvement

in patient care hence promoting a safe work environment for the patient and also the nurses."

Respondent 2: "This can contribute and continuously improve by reminding the nurses on what needs to be done and what should be done in order to have a quality of care to the patients."

Respondent 3: "It provides a way to monitor potential problems and their root causes in order for it not to occur."

Respondent 4: "It is one of the tool that can be used the establish protocols, procedures to improve for the benefit of patient safety. Also, it can be a basis to have a standardization of all skills nurses have."

Respondent 5: ": Incident reports can be used to track trends and identify patterns in workplace incidents. By analyzing this data, companies can identify potential hazards and take steps to mitigate them. This can help to prevent future incidents and improve overall safety in the workplace."

Respondent 6: "Incident reporting plays a vital role to identify or review protocols or policies especially for errors happened repeatedly."

Respondent 7: "Awareness of one's weakness and lapse can motivate nurses to perform better and focus on what we lack. We nurses have the drive to become better for our patents that is why the desire to not do it again propels us to performing excellent and quality care."

Incident self-reporting improves the quality and accuracy of reported occurrences. Professionals that actively participate in the reporting process are more likely to provide thorough and full information, which leads to a better understanding of the underlying causes and the opportunity for system adjustments (González-Gil et al., 2020). Participation in sustainable learning increases healthcare personnel's understanding of patient safety risks. By documenting and evaluating incidents, professionals get insight into potential dangers and weaknesses in the care environment. This increased awareness enables preventive measures to be adopted to avoid future incidences and improve patient safety (Fernandez et al., 2018).

Respondent 8: "Incident reporting is a good eye opening to nurses to validate their current knowledge and skills and for others to update and have a continuous professional development courses/classes or trainings."

Respondent 9: "Up to date knowledge and skills, knowing what's in and out, and identifying latest trends in healthcare can also count as results of proper incident report."

Correspondingly, participation in incident reporting by oneself, on the other hand, encourages continual professional growth. By engaging in reflective practice and actively exploring chances for learning and growth, professionals may increase their abilities, knowledge base, and critical thinking skills (González-Gil et al., 2020). Self-involvement in sustainable learning helps organizations learn and develop. Professionals contribute to the organization's collective knowledge by sharing lessons learned from incidents, supporting a learning culture, and advocating system-level innovations that promote patient safety (Fernandez et al., 2018). Thus, self-involvement in incident reporting is critical for personal growth and development, empowerment and ownership, cultivating a learning culture, improving incident reporting practices, raising patient safety awareness, supporting continuous professional development, and contributing to organizational learning. By actively participating in the reporting process and supporting self-involvement, healthcare personnel may create long-term learning and improve patient safety results.

Sub-theme No. 9: Standardized Incident Reporting Systems **-** Standardized incident reporting systems guarantee that incidents are recorded consistently and uniformly across healthcare facilities. Healthcare

practitioners can collect crucial information in a consistent manner by using a standardized approach that ensures events are reported uniformly (Devine et al., 2019). Standardized incident reporting systems make it possible to collect detailed incident data. These systems use defined categories and standardized data items to capture critical information such as the kind of occurrence, contributing variables, and patient outcomes. This meticulous data collection enables meaningful analysis and the detection of trends and patterns (Sari et al., 2018).

> *Respondent 1: "Incident reports identifies what went wrong? how it happened? Why it happened? And what can we do to prevent it from happening. With this nurses are given a reality in which they can reflect and apply actions to prevent incidents from happening to them in their work."*

Uniform incident reporting systems enable in-depth data analysis and learning. The consistent data from these systems may be gathered and evaluated to identify common causes of occurrences, areas for improvement, and successful solutions. This analysis leads to organizational learning as well as the development of targeted patient safety actions (Devine et al., 2019). Standardized incident reporting systems make it possible to compare and assess incidents across organizations. Using standardized reporting formats and data components, organizations may compare their event frequencies, types, and severity to national or global norms. This comparison allows for the identification of areas of strength and weakness (Sari et al., 2018).

> *Respondent 5: "Incident reporting helps us to be aware when and what we did wrong. This kind of documentation and the investigation helps us to protect from future errors of other nurses and ourselves too."*

> *Respondent 6: "This will help them identify or look back and set that lesson resulting in minimizing the occurrence of the same error."*

Structured incident reporting systems facilitate the identification of system-level issues that contribute to occurrences. By assessing reported events, organizations can identify underlying system failures, such as medication administration methods or communication breakdowns, and make targeted improvements to reduce repeat occurrences (Hughes et al., 2019). Standardized incident reporting systems promote openness and accountability in healthcare organizations. By establishing a systematic and consistent approach for reporting occurrences, these systems ensure that incidents are documented, examined, and relevant steps are taken. This fosters trust and accountability among healthcare providers and patients (Devine et al., 2019). Quality improvement efforts can be linked to pre-existing incident reporting systems. These systems' data may be utilized to support quality improvement initiatives, allowing organizations to prioritize areas for improvement and measure the impact of activities on patient safety outcomes (Sari et al., 2018). In summary, standardized incident reporting systems offer numerous benefits, including reporting consistency and uniformity, comprehensive data collection, improved data analysis and learning, comparison and benchmarking, identification of system-level issues, transparency and accountability, and integration with quality improvement initiatives. By using standardized systems, healthcare organizations may improve incident reporting procedures, develop a safety culture, and drive continuous improvement in patient safety.

Sub-theme No. 10: Empowering Staff Nurses to Sustainable Development - Allowing staff nurses to report occurrences fosters a sense of engagement and ownership in patient safety. When nurses actively participate in incident reporting, they are driven to assist improve patient care outcomes and take ownership of their role in safety promotion (Lee et al., 2019). Giving staff nurses the authority to report events fosters a healthy reporting culture. When nurses are encouraged to report incidents, voice concerns, and provide feedback, an environment that values open communication and learning from mistakes is created. This reporting culture enhances the overall quality and accuracy of incident reporting (Scheepers et al., 2018).

> *Respondent 2: "By reminding the nurses to provide quality of care always to the patients despite the struggles or the heavy workload they have."*

Respondent 3: "Incident reporting will help nurses to become assertive, practice honesty and humility, and also learn that incidents will not make them less of a nurse but will help them improve their skills, recognize their mistakes, and not do the same error twice."

Empowered staff nurses are more likely to recognize system-level issues that contribute to incidents. By actively participating in event reporting, nurses can uncover patterns, trends, and basic reasons of occurrences, leading to the discovery of underlying system faults. This understanding enables tailored therapies and modifications to improve patient safety (Lee et al., 2019). Allowing staff nurses to report occurrences encourages ongoing learning and growth. Nurses are urged to reflect on incidents, identify relevant variables, and participate in debriefing sessions or safety huddles as part of their continuous learning. This ongoing learning benefits their professional development and boosts their ability to avoid future blunders (Scheepers et al., 2018).

Respondent 4: "Incident reporting encourage nurses to reflect on their own practice and identify areas for improvement when they made an error through reflection to the situation and honing their knowledge and skills through evidence based practice that will lessen the occurrence of the error"

Respondent 7: ": Studies show that writing improves retention of information in the brain. The same principle also allows us to remember the introspected moment where we encountered an unusual landscape in our way of service to people. Also, incident reports are also somehow viewed as a badge of error, that way, we remember the mistakes for it to not be performed again."

Respondent 8: "Recommendation is one part of the incident reports. With this the nurses can know acknowledged their mistakes."

Respondent 9: "From what I stand for, there is an ongoing stigma about creating incident report. As mentioned earlier, we have this thought that incident report will be taken against us thus, making it a big deal in our profession. Relatively speaking, incident reports will make nurses look as if they weren't good enough or not putting their best foot forward to do their job."

Staff nurses who can report occurrences improve teamwork and interprofessional communication. Nurses are more willing to share information with other healthcare professionals when they feel empowered to report accidents, resulting in a more thorough understanding of patient safety risks. This collaboration enhances teamwork, communication, and patient outcomes (Lee et al., 2019). Empowered staff nurses play a critical role in supporting quality improvement programs. By actively engaging in incident reporting and sharing their thoughts, nurses help to the development and implementation of targeted therapies. Their involvement and input in quality improvement efforts leads to positive changes in patient safety procedures and outcomes (Scheepers et al., 2018). Empowerment in incident reporting has a favorable impact on professional satisfaction and retention. When staff nurses are able to contribute to patient safety, their job happiness, sense of professional fulfillment, and loyalty to their employer improve. Furthermore, empowering staff nurses in incident reporting is important for increasing engagement and ownership, improving reporting culture, identifying system-level issues, fostering collaboration and interprofessional communication, driving quality improvement initiatives, and promoting professional satisfaction and retention (Lee et al., 2019). By empowering staff nurses, healthcare organizations may foster a culture of safety and improve patient safety results.

Theme 2: Barriers of Incidence Reporting

Based on quantitative results regarding barriers in incidence reporting, clinical incidences was given the highest mean and concern therefore, the sub-themes generated under this focused on it linking risk assessment and prevention strategies, fostering transparency, accountability and improvement, establishing a culture of advocacy and volunteerism, responsible disclosure of errors and incidence, regular safety audits and assessments

and interconnecting trends and patterns for leverage system approach to address it by generating from the lived experiences of our respondents in the study. Patient safety is a top priority in healthcare, and incident reporting is a critical component for recognizing, treating, and preventing adverse occurrences. Despite its critical function, incident reporting remains a complex and difficult process, often hampered by a slew of hurdles that prevent healthcare personnel from reporting incidents honestly and regularly. These barriers, which include a wide range of interpersonal, organizational, and systemic variables, lead to a culture of underreporting, which obscures critical insights regarding patient safety hazards and opportunities for improvement.

Sub-theme No. 1: Risk Assessment and Prevention Strategies - Risk assessment and preventative activities may create a barrier to incident reporting due to the fear of fines. Healthcare workers may be hesitant to report incidents if they are afraid of repercussions such as disciplinary action or blame (Hofmann et al., 2018). Risk assessment and preventive strategies that do not support anonymity may hinder incident reporting. If healthcare professionals feel their identity or personal information has been stolen, they may be unwilling to report incidents, increasing concerns about privacy violations or retaliation (Fernandez et al., 2019).

> *Respondent 1: "An effective incident reporting system helps the nurses in identifying challenges regarding system failures by having a simple, organized, no-blame culture and systematic incident reporting protocol by which the nurses won't have a difficulty complying and reporting and also is monitored and evaluated for the effectiveness of its corrective actions. Nakakasakit ng brain cells eh. Hahaha".*

> *Respondent 2: "Effective incident reporting systems will contribute in leading to improvements in patient safety by addressing the cause and effect of such incident, identifying the gaps within the event, and doing a response with the said incident."*

If healthcare personnel perceive that risk assessment and prevention strategies are not adequately addressing reported incidents, this may discourage reporting. Professionals may doubt the relevance and efficacy of the reporting process when incidents are reported but no significant action or follow-up is made (Hofmann et al., 2018). Risk assessment and preventive techniques that place sole emphasis on attribution and punishment may discourage incident reporting. When healthcare workers are afraid of penalties for reporting incidents, they are less likely to contribute helpful information and insights (Fernandez et al., 2019).

> *Respondent 4: "Effective incident reporting system helps nurses to identify and report incident related to systems failure by taking this an initial action for the improvement of the current system, policies and protocol. Through incident reporting it will be the way to update and recheck all establish policies and check what is lacking or need to be improved"*

> *Respondent 5: "Incident reporting systems provide a reminder of possible hazards. Reporting them provides a way to monitor potential problems and root causes as they recur. The documentation of these problems and root causes increases the likelihood that repeating failures will be noticed and corrected before they develop into more serious incidents."*

> *Respondent 9: "Through incident reporting, all areas which are lacking of proper equipment to acquire baseline data for patients can request for new and innovative tools to avoid incidents."*

If risk assessment and preventative actions do not provide timely feedback and learning opportunities, incident reporting may be impeded. Healthcare professionals are more likely to report when they get feedback on reported occurrences, understand the results of their reports, and have opportunities for learning and growth (Hofmann et al., 2018). Risk assessment and preventative actions that place additional demands on healthcare personnel's time and effort may discourage incident reporting. When doctors are overloaded with routine tasks and responsibilities, they may prioritize urgent patient care above incident reporting (Fernandez et al., 2019). Inadequate risk assessment and preventative training and support may be a deterrent to reporting incidents. If

healthcare staff do not have the necessary knowledge, skills, and resources to correctly identify and report incidents, their ability and confidence to participate in the reporting process may suffer (Hofmann et al., 2018). Risk assessment and prevention strategies can act as barriers to incident reporting when there is a fear of repercussions, a perceived lack of confidentiality, an inadequate response, an overemphasis on blame and punishment, a lack of feedback and learning opportunities, time constraints and workload, and insufficient training and support. Understanding and addressing these roadblocks is crucial to creating a reporting environment that encourages incident reporting and promotes a safety culture.

Sub-theme No. 2: Fostering Transparency, Accountability & Improvement **-** Fostering transparency, accountability, and improvement may become a barrier to event reporting if there is a culture of blame and punishment. Healthcare workers may be hesitant to report incidents if they are afraid of disciplinary action or damage to their professional reputation (Perneger et al., 2018). To foster transparency, accountability, and growth inside an organization, a foundation of trust and psychological safety is required. If healthcare workers do not feel safe reporting incidents without fear of reprisal or criticism, their willingness to come forward and offer critical information is limited. If the reporting system is time-consuming or requires substantial paperwork, healthcare staff may be less likely to reveal events (Longo et al., 2018).

> *Respondent 3: "Incident reporting helps in identifying the areas of quality improvement. It fosters transparency among people who are directly involved in patient care and serves as a proper documentation."*

> *Respondent 6: "By this, we were able to recap the current policies, whether there is a need to revise or just reiterate those."*

Organizational culture has an impact on transparency, accountability, and growth. A lack of help, open communication, and a blame-free environment impede instance reporting. Fostering transparency, accountability, and improvement may be difficult if the event reporting system is overly complex or burdensome. Transparency, trust, and ongoing development need immediate feedback and learning from reported events. Healthcare professionals' incentive to participate in the reporting process is impaired if there is a lack of feedback or a failure to act on reported events (Perneger et al., 2018).

> *Respondent 7: "By submitting incident reports truthfully and completely, the trends and patterns that arise in the series of incident reports noted can be notices specifically incidents on the abovementioned list."*

> *Respondent 8: "Encouragement of incident reporting strengthens the idea that staff members' observations and concerns are appreciated while empowering them to actively contribute to the creation of a safe workplace"*

Honesty, responsibility, and continual progress need the support of leadership at all levels of the institution. The culture of transparency and accountability is compromised when leaders do not prioritize patient safety, do not provide adequate resources, and do not actively engage in learning and improvement initiatives (Perneger et al., 2018). To summarize, fostering transparency, accountability, and improvement can become a barrier in incident reporting when there is a fear of blame and punishment, a lack of trust and psychological safety, an unfavorable organizational culture, complex reporting systems, a lack of feedback and learning, resource constraints, and a lack of supportive leadership. Identifying and addressing these hurdles is crucial for creating an environment that promotes open and transparent event reporting and a culture of continuous improvement.

Sub-theme No.3: Establishing A Culture of Advocacy and Volunteerism **-** A culture of advocacy and volunteerism motivates healthcare workers to actively participate in incident reporting. It establishes an environment in which professionals feel comfortable raising concerns, speaking out about potential dangers, and reporting incidents. This gives patients a sense of ownership and responsibility for their own safety (Kim et al.,

2018). Creating an advocacy and volunteer atmosphere promotes open communication and collaboration among healthcare professionals. It promotes people to share information, ideas, and lessons learned from incidents, resulting in a better coordinated effort to improve patient safety. This collaborative strategy enhances incident reporting and enables learning from mistakes (Lekat et al., 2019).

> *Respondent 1: "One of the purpose of having an incident reporting system is for continuous improvement. Identifying the persons involved is accounted for and a no-blame culture should be promoted and emphasized within that system, this would encourage the nurses to report errors and won't hesitate due to fear of being held upon their reports"*

> *Respondent 4: "Incident reporting fosters a culture of transparency for the benefit of patient's safety and well-being to have a better outcome, having a same goal that benefit the patient will foster a culture of transparency to each nurse."*

> *Respondent 6: "Having the same goal that would benefit every patient will foster a culture of transparency to everyone."*

Patient-centered care is prioritized in an advocacy and volunteer culture. In an advocacy and volunteer culture, patient-centered treatment is valued. It urges healthcare workers to be patient advocates and to report circumstances that may endanger patient safety. It emphasizes the importance of incident reporting in delivering safe and high-quality care by adopting a patient-centered approach (Kim et al., 2018). In healthcare settings, creating a climate of advocacy and engagement encourages continual learning and development. It encourages healthcare workers to reflect on incidents, evaluate the circumstances that contributed to them, and participate in debriefing sessions or safety huddles. This continuing learning leads to improved incident reporting procedures and the implementation of targeted patient safety interventions (Lekat et al., 2019). A culture of advocacy and engagement reflects a company's commitment to patient safety. When healthcare organizations promote and value advocacy and participation, it shows a commitment to creating a safe environment for both patients and healthcare workers. This commitment improves the incident reporting process and its impact on patient safety outcomes (Kim et al., 2018). While establishing an advocacy and volunteerism culture is typically viewed as a facilitator rather than a barrier to incident reporting, it is critical to recognize the importance of this culture in promoting patient safety and encouraging healthcare professionals to actively participate in incident reporting.

Sub-theme No.4: Responsible Disclosure of Errors and Incidence **-** Responsible disclosure enables healthcare staff to openly discuss and learn from mistakes. It enables you to examine the root causes of occurrences, identify system weaknesses, and implement targeted solutions. By promoting a learning culture, responsible disclosure contributes to continuous quality improvement activities (Hughes et al., 2019). Responsible disclosure aids in the uncovering of system-level flaws that lead to mistakes and occurrences. Healthcare organizations can evaluate their systems, policies, and procedures by openly acknowledging and sharing information about incidents. This leads to system-level changes targeted at preventing similar incidents in the future, hence improving patient safety (Curtis et al., 2018).

> *Respondent 2: "Honestly Mam, what is said, and done in the incident."*

> *Respondent 3: "It teaches nurses to become accountable for their actions. Also to be assertive and not learn how to just get away with the errors of their work. As nurses, we should learn how to practice a culture of honesty."*

> *Respondent 5: "The development of a good safety culture inside a company depends on incident reporting. It is clear that employees' safety is a key priority when they feel free and encouraged to report events, near misses, or risks"*

Appropriate reporting fosters trust and transparency among healthcare practitioners, patients, and organizations. When errors and occurrences are correctly reported, a corporation demonstrates its commitment to

transparency and accountability. As a result, trust and confidence in the healthcare system grow (Hughes & Goldhaber-Fiebert, 2019). Responsible disclosure contributes to the development of a learning culture within healthcare institutions. It allows healthcare staff to freely address errors, share their experiences, and reflect on their practice. This transparent and self-reflective culture promotes continuous learning, personal and professional development, and, ultimately, improved patient care (Curtis et al., 2018).

> *Respondent 7: "It is quite the opposite of the ideal outcome of this situation. Fear sometimes cripple nurses to report everything honestly, but the assurance of managing and taking necessary actions are followed which do not jeopardize our patients' health."*

> *Respondent 9: "Oftentimes, nurses are having misconception once they were asked to write an incident report because they are taking this negatively. Nurses fail to realize that error is inevitable but what's worst is that errors are not being addressed to just because of "shame-culture" in any institution. Once you are asked to write an incident report, we have these thoughts that we aren't good enough, not skilled enough that we also neglect ourselves of the positive output we may benefit after the feedback has been disseminated. This traditional belief about incident reporting should totally be eradicated through positive approach system to avoid "shame culture" so nurses will foster trust and willingness to participate in doing incident reports."*

Patient-centered care standards are congruent with responsible disclosure. It emphasizes the need of open communication and decision-making collaboration between healthcare practitioners and patients. When healthcare providers report errors correctly, they emphasize patient well-being and actively include patients in the process of recognizing and fixing issues (Hughes et. al, 2019). Responsible disclosure acknowledges the impact of errors and accidents on the well-being of healthcare staff. Healthcare organizations realize the emotional toll that mistakes may have on people and provide a safe environment for disclosure. This help aids in satisfying the psychological needs of healthcare professionals and promotes their well-being (Curtis et al., 2018). While adequate disclosure of errors and incidents is typically considered as a facilitator rather than a disincentive to incident reporting, it is not without its limitations.

Sub-theme No.5: Regular Safety Audits and Assessments - Regular safety audits and reviews allow healthcare organizations to anticipate potential risks and hazards. By conducting systematic assessments of processes, systems, and surrounds, organizations can discover areas that may contribute to occurrences. This proactive technique allows for early intervention and the implementation of preventative measures to reduce incident frequency (Bradley & Mott, 2018). Safety audits and assessments assist healthcare organizations in cultivating a culture of continuous improvement. By assessing safety policies, regulations, and procedures on a regular basis, organizations may identify areas for improvement and make necessary adjustments. This continuous improvement technique encourages healthcare personnel to disclose issues in order to support necessary changes (Schwappach & Hochreutener, 2019).

> *Respondent 1: "Incident reports should be compiled and analyzed in a regular schedule. Given the specifications identified such as non-clinical vs clinical, involved departments, nature of complaints, medications errors. By doing such a pattern will be formed and a trend will be made. Having the said data will show in which area the department should focus on, effectiveness of corrective actions etc."*

> *Respondent 4: "When there is an error that is always recurring even after updating the protocol. It will call the attention of the management leading to a sit-down meeting and re-constructing a new protocol that will have a better outcome and will prevent the same error to occur."*

> *Respondent 6: "When an error occurs repeatedly, incident reporting would be the eye-opener for the managers to identify in which policy or protocol will be revised. To further know or look for*

different ways how to prevent that error happening."

Respondent 8: "Write the use of these reports, tallying of the said incidents can now be monitored."

Regular safety audits and assessments assist in detecting systemic flaws that contribute to disasters. By studying the underlying causes and patterns of events, organizations can uncover system-level weaknesses such as insufficient people, communication breakdowns, or equipment failures. This information enables more targeted interventions and system improvements to improve patient safety (Bradley & Mott, 2018). Employee involvement and participation are possible as a result of safety audits and assessments. Frontline healthcare workers are included in the auditing process to provide their perspectives on possible dangers and possibilities for improvement. This involvement fosters a sense of ownership and accountability, encouraging workers to actively participate in incident reporting (Schwappach & Hochreutener, 2019). Routine security assessments and evaluations assist healthcare organizations comply with legislation, regulations, and best practices. By conducting thorough reviews, organizations may identify gaps in compliance and take the necessary actions to meet regulatory responsibilities. This compliance not only improves patient safety but also develops an incident reporting culture (Bradley & Mott, 2018). While periodic safety audits and assessments are commonly seen as enablers, it is vital to address any concerns that may have an indirect impact on incident reporting. Among these barriers are the requirement for good communication, organizational support, and resources to fix recognized issues and actively involve healthcare staff in the reform process.

4. Conclusions and recommendations

In line to quantitative approach, incident reporting encompasses various dimensions. The study revealed that clinical incidents are the most commonly reported, followed by workplace, near-miss, and non-clinical incidents. This ranking provides a quantitative framework to prioritize interventions based on the prevalence of each incident type. While in terms of contributory factors, based on findings, local working conditions are attributed the highest significance, trailed by latent/external factors, active failures, and situational factors. It is noteworthy that latent/external factors are both highly regarded and ranked last in terms of their impact. This quantitative insight into the hierarchy of contributory factors guides us in tailoring interventions that address the most influential elements in incident reporting practices. The researcher adopted Giorgi's phenomenological approach in investigating the experiences of nine (9) ward nurses from selected hospitals in Lipa City.

Through interviews and subsequent transcription, ten (10) significant themes emerged under the contributory factors. These encompassed: Open and Non-Punitive Reporting Environment, Cultivation of Safety Culture in the Working Environment, Neutralizing Potential Patient Safety Risk, Nurse as Patient Advocates from Incidence, Managing Foreseeable Crisis Proactively, Safety Culture Assessment and Reporting System, Interventional Feedback System of Incidence Reporting, Self-Involvement in Sustainable Learning, Standardized Incident Reporting Systems and Empowering Staff Nurses to Sustainable Development. Correspondingly, under barriers the researcher generated six (6) themes namely: Risk Assessment and Prevention Strategies, Fostering Transparency, Accountability & Improvement, Establishing A Culture of Advocacy and Volunteerism, Responsible Disclosure of Errors and Incidence, Regular Safety Audits and Assessments and Interconnecting Trends and Patterns for Leverage System Approach. Correlating these findings, it is evident that while the quantitative approach provides a numerical understanding of incident types, the qualitative approach uncovers the intricate contributory factors and barriers that shape incident reporting behaviors. The quantitative insight into incident prevalence aligns with the themes identified in the qualitative approach. The researcher acquires a more complex and insightful view on incident reporting among ward nurses by integrating quantitative and qualitative findings. This enables to effectively design interventions, targeting significant sorts of events while addressing the underlying variables that drive reporting behaviors. The interaction of these techniques enables a comprehensive strategy to improving incident reporting, ultimately boosting patient safety and quality of treatment. Based on the study's findings, a recommended intervention program was developed.

Utilize the proposed program interventions. Developing a plan based from the findings for enhancing incident reporting among ward staff nurses is essential for improving patient safety and the overall quality of healthcare delivery. To elevate our incident reporting system, a multifaceted strategy is proposed. This entails collaborating with the IT department to develop an intuitive digital incident reporting platform, accompanied by a designated mobile number or email for smartphone and web submissions. Fairness, accessibility, and effectiveness are emphasized through a revamped incident reporting system, bolstered by clear guidelines and incident categorizations to enhance accuracy and consistency. Comprehensive education and training are pivotal. This involves workshops and webinars led by experienced nurses and quality improvement specialists on incident reporting protocols, complemented by accessible learning modules for ongoing knowledge refreshment. Effective communication and feedback are central to fostering a reporting culture. An automated acknowledgment system is recommended, along with a monthly report highlighting incidents, lessons learned, and actions taken. A structured feedback mechanism is proposed to provide timely responses to ward nurses who report incidents, and sharing aggregated incident data with nurses will enhance their understanding of patient safety risks and intervention effectiveness. Promoting the culture of reporting, a nursing department campaign is advocated. Recognition and celebration for exemplary reporting through awards and acknowledgments are suggested, accompanied by fostering interdisciplinary collaboration among healthcare professionals to collectively address incident reporting and patient safety. This approach, encompassing technological enhancements, education, communication, and culture building, sets the course to enhance our incident reporting system and elevate patient safety standards.

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