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Knowledge, Attitude and Barriers of Nurses to Incident Reporting in Al Dhafra Hospitals, Abu Dhabi, United Arab Emirates

Shakkeela Anilkumar*, Azmi Omar Al Horani, Mohammed Yousef Alkhraishi

Nursing Midwifery Clinical Education and Research Department, Al Dhafra Hospitals, Abudhabi, United Arab Emirates
Email: *shakkivlmr@gmail.com

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Abstract

Background: An incident in the health care system is unplanned and unfavourable which may be harmful or may cause potential harm to the patients, caregivers, and other individuals. Any risks in healthcare organizations can be detected by identifying and reporting incidents in a timely manner. Hospitals must ensure the delivery of safe and quality care through a proactive and patient-centered approach. **Aim:** The objective of the study is to assess the knowledge, attitude, and barriers to reporting incidents by the nurses working in Al Dhafra Hospitals. **Methodology:** A descriptive design was employed and the tool included four parts: a demographic outline, a self-structured questionnaire to evaluate the knowledge, a Likert scale to check the attitude, and a checklist to evaluate the perceived barriers. 168 nurses working in Al Dhafra Hospitals participated in the study. **Result:** 99.8% of nurses know what incident reporting is, and 92.9% of nurses agree that every incident is to be reported. Lack of time has been claimed by 69% of nurses as the major barrier to reporting incidents. While 56% of nurses report fear of legal action as a barrier,49.4% of nurses agree that fear of career and personal reputation is the common barrier for incident reporting. **Conclusion:** The incident-reporting system plays a critical role in fostering a safe health care environment. Developing and sustaining a non-punitive culture towards incident reporting encourages transparency, supports staff and ultimately leads to improved patient care and outcomes.

Keywords

Attitude, Barriers, Incident, Knowledge, Nurses

1. Introduction

Incident reporting in the health care system is crucial to improving patient safety

and quality of care. World Health Organization defines an incident as "any deviation from the usual care that poses a risk of harm or causes injury to a patient, it includes errors, preventable adverse events, and hazards". The objective of incident reporting is to identify and address adverse events, near misses, and other incidents related to the safety of patients and to implement corrective action plans to prevent the future recurrence of the incidents. Developing an atmosphere of safety culture in hospitals will motivate and encourage everyone to point out and report any deviation from normal. A non-punitive culture toward incident reporting in hospitals is essential for promoting patient safety, learning from mistakes, and improving the overall quality of care.

Nurses are the largest component of the hospital workforce and significantly influence patient safety and healthcare outcomes. Reporting errors fosters a culture of safety within healthcare organizations. Patient safety event reporting systems are widespread in healthcare organizations and are the backbone of detecting patient safety events and quality problems (Kapil & Anoopjit, 2020). The significance of reporting systems is situated in the ability to detect errors and risky situations, analyze root causes, and take corrective measures (Kaya et al., 2020). In a study conducted in Ethiopia, 73% of the nurses mentioned that any incident that will not cause harm to the patients will not be reported (Engeda, 2016). Errors can lead to an economic burden on the organization and cause additional costs because of re-hospitalization (World Health Organization, 2020). A non-punitive or just cultural atmosphere in hospitals will encourage the nurses to report any incidents without any hesitation. There should be a lack of blame for motivating people to be more engaged and be a part of the solution instead of fearing for their careers (Dekker, 2018). A well-explained and effectively communicated incident assists everyone in knowing the situations in which that incident occurred, learning the lesson from it, and preventing future occurrences. Nurses refrain from reporting medication errors, even though they detect them (Dirik et al., 2019). Each error offers a chance to learn. Whether it's an operational mistake or a product defect, understanding what went wrong provides insights into what needs to change or improve. This learning can lead to better practices and procedures in the future. In the context of continuous quality improvement, every error indeed presents an opportunity to improve (Hamed & Konstantinidis, 2022). Lack of time was identified as a main barrier to incident reporting, and the availability of report pathways was the proposed solution (Abeer et al., 2020).

Patient safety will be compromised if the errors are either not reported or underreported (Vrbnjak et al., 2016). Early detection of errors and corrective actions on time will help to prevent recurrences in the future (Heard et al., 2012; Ghorbanpour Diz et al., 2016). There are a lot of factors affecting the nurses to move away from reporting incidents, such as workload, heavy assignments, and lack of clarity about the system of reporting and the incident (Alrabadi et al., 2020; Ali et al., 2021).

Study Objective

The study is conducted to assess the knowledge, attitude, and barriers to reporting incidents among the nurses working in Al Dhafra hospitals.

2. Materials and Methods

2.1. Research Design

A descriptive design was employed to assess the knowledge, attitude, and perceived barriers among nurses to incident reporting.

2.2. Research Settings

The study took place in Al Dhafra Hospitals, Abu Dhabi, United Arab Emirates. The target population refers to the specific group that fits the researcher's predetermined criteria for inclusion in the study. The research study focused on nurses employed in Al Dhafra Hospitals as the target group.

2.3. Sample Size

The sample consisted of 168 nurses who are employed in Al Dhafra Hospitals. The researchers utilized convenience sampling to get the data from the nurses working in different units in Al Dhafra Hospitals. In the context of this study, the inclusion and exclusion criteria refer to the specific requirements that were used to determine which nurses were eligible to participate. All nurses who were accessible during the data collection period and willing to participate in the study are eligible for inclusion without any exclusion criteria.

The crucial element of doing research is the careful selection and development of tools that will enable the collection of relevant information. These tools are essential for obtaining the required data to address the research questions posed in the study. The tool was developed based on a literature review and with guidance from renowned professionals in the research and nursing domains. Additionally, the relevant areas of the tool were informally observed.

The tool is divided into four parts.

Part A: Demographic outline encompassing gender, age, total working experience, and the workplace in Al Dhafra Hospitals.

Part B: Self-structured questionnaire designed to assess the knowledge of the nurses.

Part C: Utilizing a Likert scale to check the attitude of the nurses.

Part D: Checklist for evaluating the perceived barriers among the nurses.

3. Results

3.1. Descriptive Statistics

Part A: Socio-demographic profile:

The sociodemographic profile of nurses at ADH facilities reveals a significant majority of female employees, comprising 78% of the workforce. This aligns with

the prevailing patterns observed in the healthcare sector as a whole. 48.8% of the employees are within the age range of 30 - 39 years, indicating a workforce that has the potential for both long-term retention and expansion. A noteworthy observation is that a considerable percentage (37.5%) of individuals have more than 16 years of professional experience, indicating the presence of a highly experienced and qualified staff group. Ghiathy Hospital functions as the primary workplace for almost half of the participants (43.5%), suggesting that the concentration of workers may have an influence on techniques for distributing resources. Descriptive Statistics of the socio-demographic profile of the study are shown in Table 1.

Table 1. Demographic profile results.

Variables	Socio-demographic profile	Frequency	Percentage
Gender	Male	37	22.0
	Female	131	78.0
Age	20 - 29 years	15	8.9
	30 - 39 years	82	48.8
	40 - 49 years	47	28.0
	50 years and above	24	14.3
Total working experience	1 - 5 years	25	14.9
	6 - 10 years	47	28.0
	11 - 15 years	33	19.6
	16 years and above	63	37.5
The facility of work in ADH (Workplace)	Madinat Zayed Hospital	12	7.1
	Ghiathy Hospital	73	43.5
	Mirfa Hospital	31	18.5
	Sila Hospital	11	6.5
	Liwa Hospital	21	12.5
	DFMC	4	2.4
	Sir Baniyas Clinic	1	.6
	Beda Mutawa Clinic	1	.6
	Abu Al Abyad Clinic	2	1.2
	Delma Hospital	12	7.1
	Total	168	100.0

Part B: Knowledge of nurses:

The dataset provides a detailed representation of several components of incident reporting as perceived by nurses, indicating comprehensive knowledge and adherence to protocols. Approximately 72.6% of individuals acknowledge that both medication errors and diagnostic delays are considered events, indicating a significant level of awareness regarding common occurrences in hospitals. More-

over, 98.8% of individuals fully comprehend the fundamental concept of incident reporting, which entails documenting atypical occurrences within the hospital environment. The responsibility for preparing the report is widely recognized, with 95.2% giving it to all staff, highlighting a communal approach to incident management. The main objective as determined by 97% of the participants is to enable essential modifications to avoid future occurrences, emphasizing a proactive approach to improving patient safety. Furthermore, the predominant category of occurrence, as indicated by 86.3% of the participants, encompasses both near misses and sentinel events, indicating a sophisticated comprehension of the range of incidents that can take place in healthcare environments. Descriptive Statistics of the knowledge of the nurses are shown in Table 2.

Table 2. Knowledge of the staff nurses.

Knowledge of the staff nurses	Response Option	Frequency	Percentage
What is considered as an incident?	Transfer/discharge of patient	1	0.6
	Fall/Medication error	39	23.2
	Delay/cancellation in any diagnostic test	6	3.6
	Both 2 & 3	122	72.6
Following is a type of incident?	Near miss	14	8.3
	Sentinel events	9	5.4
	Both 1 & 2	145	86.3
What is incident reporting?	Record of details of an unusual event in hospital	166	98.8
	Record of shift changes of staff nurses	1	0.6
	Record of previous hospitalization	1	0.6
What is included in incident report?	Date, time and location	2	1.2
	Detailed documentation of incident	15	8.9
	Both 1 & 3	151	89.9
Who is responsible for formulation of incident report?	All employees	160	95.2
	Supervisor	3	1.8
	Ward attendant	1	0.6
	Nurse in-charge	4	2.4
What is the intended goal of incident reporting?	Provide information in the medical report	1	0.6
	Identify changes needed to prevent re-occurrence	163	97.0
	Document actual injury in follow-up action	4	2.4
How can you recognize poorly written report?	Factual	6	3.6
	Judgmental towards others	137	81.5
	Short and to the point	19	11.3
	Location specific	6	3.6

Continued

What is the need to report an Incident?	To get appraisal	2	1.2
	To promote awareness	148	88.1
	To get others' opinion on incident	18	10.7
What is a "Near Miss"?	No harm to the patient	121	72.0
	Events that lead to harm to the patient	29	17.3
	A planned event that threatens human safety	11	6.5
	An unpreventable incident	7	4.2
What are the questions that must be answered while completing an incident report?	Where, when, and what happened to cause the incident	15	8.9
	All of the above	153	91.1
What are the key components of effective reporting?	Short and concise report	138	82.1
	Medical reports and scene safety	6	3.6
	Patients' personal information and type of incident	21	12.5
	Verbal reporting to the supervisor	3	1.8

Part C: Attitude of Nurses:

An examination of the attitudes of nurses about the reporting of adverse incidents demonstrates that the majority strongly advocate for open reporting standards. Specifically, 92.9% of the nurses endorse the reporting of every incident, indicating a robust dedication to enhancing patient safety through transparency. A majority of nurses (73.2%) dismiss the idea that reporting occurrences will harm their reputation, indicating a professional acknowledgment of reporting as an essential safety precaution. Moreover, a substantial proportion of individuals hold the belief that decreasing nurse-patient ratios (58.9%) and enhancing training in clinical processes (91.7%) are crucial for mitigating unpleasant events. There is widespread agreement among nurses regarding the significance of systemic enhancements and professional growth in improving patient care and safety. Descriptive statistics of the attitude of the nurses are shown in Table 3.

Table 3. Attitude of nurses.

Attitude of the Staff Nurses	Response Option	Frequency	Percent
Every incident should be reported	Agree	156	92.9%
	Uncertain	8	4.8%
	Disagree	4	2.4%
Reporting adverse incident will spoil my reputation	Agree	16	9.5%
	Uncertain	29	17.3%
	Disagree	123	73.2%

Continued

Reducing the nurse-patient ratio will reduce the adverse incidents	Agree	99	58.9%
	Uncertain	29	17.3%
	Disagree	40	23.8%
Better training in clinical procedures will reduce adverse incidents	Agree	154	91.7%
	Uncertain	9	5.4%
	Disagree	5	3.0%
Only those events should be reported which can be a learning for others	Agree	63	37.5%
	Uncertain	35	20.8%
	Disagree	70	41.7%
Reporting adverse incidents will make people accountable for their actions	Agree	77	45.8%
	Uncertain	31	18.5%
	Disagree	60	35.7%
Reporting incidents will lead to positive patient outcome	Agree	160	95.2%
	Uncertain	7	4.2%
	Disagree	1	0.6%
Reporting adverse incidents will expose your mistakes	Agree	38	22.6%
	Uncertain	43	25.6%
	Disagree	87	51.8%
Only serious adverse incident should be reported	Agree	19	11.3%
	Uncertain	20	11.9%
	Disagree	129	76.8%
Reporting adverse incidents will lead to punishment/written explanation	Agree	24	14.3%
	Uncertain	37	22.0%
	Disagree	107	63.7%
Reporting an incident will lead to analysis of that event by hospital committee	Agree	148	88.1%
	Uncertain	17	10.1%
	Disagree	3	1.8%
Reporting adverse incidents will lead to gossip among colleagues	Agree	22	13.1%
	Uncertain	41	24.4%
	Disagree	105	62.5%
Reporting an incident will lead to a risk of losing job	Agree	14	8.3%
	Uncertain	37	22.0%
	Disagree	117	69.6%
Reporting an incident is not required because we can't control their occurrence	Agree	16	9.5%
	Uncertain	11	6.5%
	Disagree	141	83.9%

Part D: Perceived Barriers among nurses:

The poll "Perceived Barriers" identifies various notable barriers that nurses encounter while reporting unfavourable situations. The primary barrier identified is time constraints, with 69% of nurses stating that they are excessively occupied or lack the time to report incidents competently. Additionally, 56% of respondents indicate a concern about fear of legal repercussions. Confidentiality concerns have a notable impact, affecting 45.8% of nurses. Additional significant obstacles include concerns over the influence on professional advancement and standing (49.4%), uncertainty on which instances should be disclosed (45.2%), and challenges in reporting occurrences involving higher-ranking personnel (44%). Other concerns encompass the disruption caused by the reporting process (32.1%), the overly long reporting documents (41.1%), and the absence of information on activities made in response to reports (25.6%). These barriers indicate specific places where enhancements could improve reporting practices and overall patient safety. Descriptive Statistics of the attitude of the nurses are shown in Table 4.

Table 4. Perceived barriers among nurses.

Perceived Barriers	Response Option	Frequency	Percentage
Lack of confidentiality	Yes	77	45.8%
	No	91	54.2%
Too busy/Lack of time	Yes	116	69.0%
	No	52	31.0%
Fear of legal actions	Yes	94	56.0%
	No	74	44.0%
Pointless nothing will be done about it	Yes	53	31.5%
	No	115	68.5%
Fear of career and personal reputation	Yes	83	49.4%
	No	85	50.6%
Lack of clarity about what to report	Yes	76	45.2%
	No	92	54.8%
Difficulty in reporting a more senior member of staff	Yes	74	44.0%
	No	94	56.0%
Never get any feedback on action taken	Yes	43	25.6%
	No	125	74.4%
Reporting interrupts the work process	Yes	54	32.1%
	No	114	67.9%
Everyone makes errors	Yes	76	45.2%
	No	92	54.8%
Form takes too long to complete	Yes	69	41.1%
	No	99	58.9%

3.2. Correlational Analysis of Variables

This analysis investigates the correlations among knowledge, attitudes, and perceived barriers among 168 nurses, who are working in Al Dhafra Hospitals. The analysis indicates a modest inverse connection between knowledge and attitudes ($r = -0.128$, $p = 0.098$), suggesting that as knowledge levels rise, attitudes may marginally decline. However, this correlation is not statistically significant. There is also a statistically significant, yet still weak, negative correlation between knowledge and perceived barriers ($r = -0.154$, $p = 0.046$), indicating that increased knowledge is associated with fewer perceived barriers. Additionally, there is a weak positive correlation between attitudes and perceived barriers ($r = 0.192$, $p = 0.013$), implying that more positive attitudes are linked to the perception of more barriers. The correlation coefficients are displayed in Table 5.

Table 5. Correlations result.

		Knowledge	Attitudes	Perceived Barriers
Knowledge	Pearson Correlation	1	−0.128	−0.154*
	Sig. (2-tailed)		0.098	0.046
	N	168	168	168
Attitudes	Pearson Correlation	−0.128	1	0.192*
	Sig. (2-tailed)	0.098		0.013
	N	168	168	168
Perceived Barriers	Pearson Correlation	−0.154*	0.192*	1
	Sig. (2-tailed)	0.046	0.013	
	N	168	168	168

*Correlation is significant at the 0.05 level (2-tailed).

3.3. Hypothesis Testing

Various hypotheses are generated according to the literature search performed at the beginning of this search.

H1: There is a significant relationship between nurses' knowledge of incident reporting procedures and their attitudes towards incident reporting.

H2: There is a significant relationship between the perceived barriers to incident reporting and nurses' attitudes towards incident reporting.

The regression model shows a very low R-square value of 0.016, indicating that knowledge explains only 1.6% of the variance in attitudes, suggesting a weak predictive power. The p-value is 0.098, which is above the conventional significance threshold of 0.05. Therefore, Hypothesis H1 is rejected, as the data does not support a significant relationship between nurses' knowledge and their attitudes towards incident reporting. On the other hand, the regression model for barriers shows a slightly higher, but still low, R-square of 0.037, explaining 3.7% of the variance in attitudes. However, p-value is 0.013, indicating statistical significance

at conventional levels. Therefore, Hypothesis H2 is accepted, supporting a significant relationship between perceived barriers and nurses' attitudes towards incident reporting. This result implies that addressing these barriers could be key to improving attitudes and practices around incident reporting in the hospital setting. The regression results are shown in the following Table 6.

This implies that nurses who identify more barriers may also perceive a higher significance in overcoming these barriers, maybe indicating a resilience or heightened understanding of the consequences of not reporting incidences. Although the model has statistical significance, its practical usefulness is limited. This suggests that other factors, such as organizational culture or support systems, which have not been explored, may have a crucial influence on attitudes toward incident reporting. This highlights the necessity of conducting a more comprehensive inquiry that includes other factors to properly comprehend and enhance incident-reporting methods in healthcare environments.

Table 6. Regression result.

Hypothesis	R	Beta	R Square	Adjusted R Square	Std. Error of the Estimate	Sig. F Change
H1	0.128a	−0.271	0.016	0.011	4.75429	0.098
H2	0.192b	0.289	0.037	0.031	4.70440	0.013

a. Predictors: (knowledge); b. Predictors: (perceived barriers).

4. Discussion

The current study reveals that the majority of nurses have moderate knowledge about what an incident is, the goal of reporting incidents, the types of incidents, the responsible person, and the key components of effective reporting. These results were consistent with Chen et al., which stated the high perception of nurses about incident reporting practices (Chen et al., 2018). While checking the attitude of nurses in the study, it is evident that 95.2% agree that reporting incidents will lead to positive patient outcomes. 92.9% of nurses reveal that every incident is to be reported and 91.7% state that better training in clinical procedures will reduce adverse incidents. On the other hand, 58.8% of participants think that reducing the nurse-patient ratio will decrease the adverse incidents and 45.8% points reporting adverse events will make people accountable for their actions. The enhancement of workload management by nurse managers and improved job satisfaction of nurses should be continued, which will be favourable to the safety practices that are executed.

In this study, the participants mentioned many barriers to reporting incidents. Lack of time has been claimed by 69% of nurses as the major barrier to reporting incidents. While 56% of nurses report fear of legal action as a barrier, 49.4% of nurses agree that fear of career and personal reputation is the common barrier for incident reporting. It aligns with a study in Saudi Arabia, where it was found that

one of the highest barriers to incident reporting is the nursing administrative response to the error (Mohammad, Aljasser, & Sasidhar, 2016). Taylor et al. (2007) claimed that the implementation of an anonymous reporting system could reduce the fear of legal action. Patient safety will be improved through an effective incident reporting system and reassuring the nurses to report an incident in a non-punitive manner, so their learning capacity will be enhanced regarding the causation of the incident, which will prevent it from recurring (Tatum & Kumar, 2021). A key step in improving the quality of care and enhancing the patients' safety is learning from their mistakes (Ellis & Abbott, 2019). Lack of confidentiality and lack of clarity about what to report have been reported by 45.8% and 45.2% of participants respectively. Musarezaie et al. (2013) proved in their study that fear of the unpleasant effects after reporting an error is the main factor for failure to report an adverse event (Musarezaie et al., 2013). The other barriers expressed by the nurses are fear of being blamed and lack of training about how to report incidents clearly and concisely. Being blamed is a major barrier because no one generally likes to be punished by superiors and does not wish to impede the career (Al-Mugheed et al., 2023). The results of Nouhi et al. (2015) and Amrollahi et al.'s (2017) studies have explored that the lack of support from colleagues can cause fear of being blamed and stigma of inefficiency, resulting in failure to detect and report errors (Nouhi, Mohamadi, & Abbaszadeh, 2015).

A study conducted by Bovis et al. (2018) stated that the nurses did not accept incident reporting as an effective tool to improve patient safety because they experienced that their concerns were not addressed and repeated incidents occurred that had already been reported. Non-punitive incident reporting systems will improve patient safety by assuring and enhancing the nurses' knowledge regarding the causes of the incident, which will prevent it from recurring. Efficient balancing of workload management and job satisfaction by nursing leadership is advantageous to the safety practices implemented (Chiang et al., 2019). Positive and effective communication between nurses and supervisors bestows for quality and assuring patients' safety (Al-Mugheed et al., 2023). Al Dhafra Hospitals has an intranet system called *UHC Safety Intelligence* for reporting incidents.

5. Conclusion

Every healthcare organization should have an efficient incident reporting system to ensure patient safety and assure quality care. The organizational leaders at the workplace should develop a conducive and positive environment so that the nurses will feel free to report any unsafe conditions sincerely without fear and anxiety. On the other hand, the nurses should be provided with adequate education and training on patient safety and incident reporting. Creating a non-punitive culture towards incident reporting by the nursing authorities and organization will provide positive reinforcement for the nurses in reporting adverse events and errors, ultimately leading to improved patient care and outcomes.

Limitations

The study was conducted in six peripheral hospitals under the umbrella of Al Dhafra Hospitals in Abu Dhabi, so the findings can be generalized. However, the sample size was limited. Therefore, we recommend conducting the study in different settings covering private and public sectors to gain a better understanding and get more representative samples from healthcare facilities. Hence, in our study, we have not covered all the factors affecting the nurses' intention to report incidents at their workplace. The authors highly recommend future research to explore many factors, such as psychological and environmental factors, that may influence the attitude of nurses when reporting incidents.

Ethical Considerations

The approval for the research study was obtained from Al Dhafra Hospitals Research Ethics Committee with unique reference no. **ADH-REC-698**.

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Conflicts of Interest

The authors of this study have nothing to disclose.

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