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Nurses Perception of Patient Safety Incident and The Impact of Workload in Ondo State, Nigeria

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Abstract

The study examined nurses' perception of patient safety incident and the impact of workload in Ondo State, Nigeria. In this study, perceptions of nurses in Ondo state, Nigeria regarding the patient safety incidents; the need for establishing patient safety incident, the processes of patient safety incident, and factors that can impede successful implementation of patient safety incident were examined. The study was a cross sectional descriptive survey that employed quantitative method. The study population comprised of 260 nurses working in the hospital. The researcher purposely selected 100 nurses as study participants. The questionnaire used was self-explanatory, researcher-developed and divided into nine sections. The instrument was subjected to face and content validity. Internal consistency method was used to determine the reliability of the instrument. The reliability index was calculated using Cronbach's Alpha which yielded reliability coefficient value of 0.798. Descriptive statistics was used to answer the research questions. The results of the study suggest that nurses perceive the culture in public hospitals of Nigeria to be castigatory and that individuals are not comfortable in reporting errors. Gynecology and maternity ward was most represented of the nurse respondent with 41%. The highest qualification obtained by the respondents was Master of Science in nursing (5%) while majority of the participants have Bachelor of Science in nursing (61%). The participants perceived that the culture of patient safety in public hospital should be a priority. Uncomfortable in reporting errors (62%), and that workload interferes with their ability to practice patient safety (62%). The barriers stated by the participants include; too much

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workload and stress is the top barrier to patient safety incident. Most nurse participants acknowledged the need for patient safety incident. Considering these obstacles to patient safety incident, a pragmatic approach is needed for successful establishment of patient safety incident.

Keywords: disclosure, patient safety, medical errors, workload, patient rights, nurses' perception,

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Introduction

Patient safety and access to high quality patient care are the top priorities for the healthcare system. Patient safety can be described as the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from health care processes. A patient safety incident is an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient (WHO, 2009). A patient safety culture can be described as an integrated pattern of individual and organizational behavior based on shared beliefs and values that continuously seek to minimize patient harm resulting from the processes of care delivery (Kizer, 1999). Error reporting is an important practice to ensure patient safety and to prevent adverse events in the hospital setting (Hughes, 2008). It is important to identify and understand adverse events in order to develop policies to reduce harm from medical care (Jha, 2008).

Multiple types of errors can commonly occur across hospital wards, leading to adverse events if not reported in a timely manner; this includes technical errors, medication and prescription errors, surgical planning errors, medical record errors, and surgical and post-operative errors (Jafree et al., 2017; Lewis et al., 2009; Rothschild et al., 2005). Though human medical practitioner errors are inevitable, their frequency and culmination to adverse events for the patient can be mitigated through better research, monitoring and training, and organizational culture (Jafree et al., 2017). According to the Canadian Adverse Events Study, approximately 7.5% of Canada's 2.5 million hospital patients experienced at least one adverse event in 2000 and up to 23,750 patients died as a result (Baker et al. 2004). One in 25 patient safety incidents will result in severe harm, including shortening of life expectancy, permanent injury, major loss of function or death (Panesar et al., 2016).

Nurses are integral front-line practitioners in the hospital setting. They have essential and significant knowledge of patient history, needs, and responses. Nurses are often exposed to patient safety incidents, and they frequently witness other medical professional's medical errors, and provide medical care for patients who have experienced patient safety incidents (Choi et al., 2019). Nurses have been evidenced to be the best practitioner to assess the climate of error reporting and the hospital culture regarding practices of patient safety (Jafree et al., 2017). Disclosure of patient safety incidents (DPSI) is a practical yet systematic policy that addresses methods of communication when a patient safety incident occurs (Perez et al., 2014). Comprehensive review of DPSI has shown that it can improve the relationships between physicians and patients increase the willingness of patients to visit again, and increase patients' overall rating for quality of care (Ock et al., 2017). Moreover, patient safety incident is important for ethical justification in terms of autonomy, transparency, trust, and professionalism (Choi et al., 2019; Simpson et al., 2012). Greater nursing workloads are associated with adverse patient outcomes (Hughes, 2008). Globally, researchers have used nurse-sensitive adverse patient outcomes to study the relationships between nurses' work environments, their workloads and patient outcomes (Cho et al., 2016). Despite growing evidence on the association between the workload of the nursing staff and patient safety in hospitals, there are still several gaps in the knowledge about this relation and its impact as a contributing factor to a good quality care. In the field of patient safety, much educational material comes from the narrative accounts of clinical staff reporting patient-safety incidents, and such accounts are a key component of many reporting systems (European Commission, 2014).

In view of the above, the study examines nurses' perception of patient safety incident and the impact of workload in Ondo State, Nigeria. The study specifically:

1. examined the culture of patient safety in public hospitals;
2. determined the advantages of inclusion of patient safety incident in health facility;
3. examined the process of implementation of patient safety incident;
4. examined the reasons why nurses should conduct patient safety incident;
5. investigated situations where nurses should conduct patient safety incident;
6. examined the impact of workload on patient safety;
7. determined nurses experience of level of harm severity in patient due to error; and
8. examined the barriers to patient safety incident.

Materials and Methods

The study was a cross sectional descriptive survey that employed quantitative method. This method was used to make accurate and systematic description of nurses' perception of patient safety incident and the impact of workload in Ondo State, Nigeria. The study was conducted at the State Specialist Hospital in Ikare Akoko, Ondo state. The hospital was divided into main wards such as obstetric and gynaecological department (O&G), medical and surgical wards and also Clinics such as medical outpatient (MOP), surgical outpatient (SOP), general outpatient department (GOPD), children's outpatient department (COPD), accident and emergency department, millennium eye centre, laboratory and histology department, National Health Insurance Scheme (NHIS) and mortuary. Each ward has 20 bed spaces in the main ward and 6 in the isolation and 4 in the side ward. Averagely about 300 clients show up in the hospital on a daily basis to utilize the medical infrastructure. There are 260 nurses working in the hospital with the average of 16 nurses per ward. The study population comprised of 260 nurses working in the hospital. The researcher purposely selected 100 nurses as study participants.

The questionnaire used was self-explanatory, researcher-developed and divided into nine sections which focused on socio-demographic, nurses' perception of DPSI using the principle of the "five W's and one H" method (who, what, where, when, why, and how), which was used as a framework in prior research that was conducted for physicians and the general public (Choi et al., 2019; Jafree et al., 2017), impact of workload, and experience of level of harm severity in patient due to error (Howell et al., 2017; Carayon and Alvarado, 2007). Anonymity of participants was assured by not taking any names of respondents.

The instrument was subjected to face and content validity. The items in the questionnaire were presented to experts in nursing science, test and measurement, for review, correction and appraisal after which necessary corrections were made. For the face validity, experts indicated that the items and the build-up of the instrument had facial relevance and acceptability to what it claims to measure. In ensuring the content validity, the experts ensured the appropriateness of the content of the instrument. Experts ensured that the items in the questionnaire represented adequately the concepts been measured. The experts also indicated that the items in the instruments adequately measured the subject matter it was designed to measure, thereby confirming its content validity.

Internal consistency method was used to determine the reliability of the instrument. To ensure the reliability of the instrument, 20 (20% of the sample size) nurses in general hospital Owo, Ondo State were used. The questionnaire was administered on nurses and the questionnaire was retrieved back immediately after completion. The reliability index was calculated using Cronbach's Alpha which yielded reliability coefficient value of 0.798.

Permission to do the study was obtained from the Head of Nursing Service of the hospital and the Ondo State Research Ethical Committee and from the Ethics Committee of the University of Medical Sciences, Akure Campus, Ondo State, Nigeria. Data collected were analysed to assess the unique perspectives and different views of the nurses on the phenomenon. The data collected were entered and analyzed using Statistical Product for Social Science (SPSS version 27). Descriptive statistics was used to answer the research questions.

Results

Socio-demographic characteristics of nurse

The characteristics of the nurse respondents in Table 1 shows age 20-29 years old were highest with 46%. Majority of the nurses (50%) have been married while 38% were yet to marry. The highest income in Naira (40%) was observed to be 50,000 to 100,000 Ninety percent of the nurse were Christian. Gynecology and maternity ward is most represented of the nurse respondent with 41%, followed by general medicine (16%). The highest qualification obtained by the respondents was Master of Science (M.Sc) in nursing (5%) and majority (61%) had Bachelor of Science (B.Sc) in nursing. Among the respondent, 21% were student, 48% were staff nurse, 14% were head nurse and 9% were nurse instructor or supervisor. The highest average number of patients attended to per duty period was found to be between 11- 25 patients (53%).

Table 1 Socio-demographic and employment characteristics of nurse respondents (n = 100)

Nurse characteristics	**Description of nurse respondents**			
Age (in years)	20-29	30-39	40-50	Above 50
	46%	26%	18%	9%
Marital status	Never married	Ever married	Divorced	Others
	38%	50%	0%	2%
Nurse income per month in thousand (Naira)	Less than 50	50-100	101-150	Above 150
	16%	40%	24%	16%
Religion	Islam	Christian	Traditional	Free-thinker
	8%	91%	0%	0%
Ward	Emergency	Gynecology and Maternity	Surgery	Primary health care
	8%	41%	8%	3%
	General Medicine	Cardiology	Internal Medicine	Others (Psychiatry, Orthopedics, Pediatric, etc)
	16%	3%	3%	15%
Nursing degree	Diploma	B.Sc. Nursing	M.Sc. Nursing	PhD. Nursing
	35%	61%	5%	0%
Nurse designation	Student	Staff nurse	Head nurse	Nurse instructor/ supervisor
	21%	48%	14%	9%

Government contract	Contractual	Permanent	Internship	Others
	4%	66%	6%	14%
Average number of patients attended to per duty period	Less than 10	11-25	26-40	Above 40
	34%	53%	9%	3%

Research Objective 1: Culture of patient safety in public hospitals as perceived by nurse
In Table 2, the nurse respondents perceived that the culture of patient safety in public hospital should be a priority (90%), averagely believe that they were supported for reporting medical errors (48%), uncomfortable in reporting errors (62%), their ward acted promptly on reported error (78%), they can openly communicate their opinions about patient safety (76%), averagely believe that their ward put blame on the individual that committed the error (48%) and that workload interferes with their ability to practice patient safety (62%).
Table 2: Culture of patient safety in public hospitals as perceived by nurse respondents (n = 100)

Construct	**Question/statement**	**True (%)**	**False (%)**
Priority	I have been communicated by hospital seniors that patient safety is a high priority	90	5
Support	Individuals are supported for reporting medical errors	48	46
Comfort	I feel comfortable reporting errors made by co-workers	31	62
Ward response	My ward acts on reported information related to errors to improve patient safety	74	18
Communication	I can openly communicate my opinions about patient care practices	76	17
Ward blame	My ward places blame on individuals when an error is reported	48	44
Workload	My workload interferes with my ability to practice patient safety	62	31

Research Objective 2: The advantages of inclusion of patient safety incident in health facility
Majority of the nurse respondents (76%) believe that patient safety incident should be included in all health facilities in the Ondo State, Nigeria. They provided the advantages of having patient safety incident as part of operation in all health facilities as shown in Table 3. Table 3b, shows the true representation of the respondent's perceptions of the advantages which they provided in Table 3a.
Table 3a: Advantages of why patient safety incident should be included in all health facility as perceived by nurse respondents (n = 100)

Description		**True (%)**	**False (%)**
DPSI should be included in all health facility		76	10
Advantages of inclusion of patient safety incident in all health facilities		**n (%)**	
1	To improves the quality of care to patients	15	
2	Prevent further exposure to or occurrence of error	13	
3	Prevent deterioration of the condition	12	

4	Ensures proper or credible care is rendered to patient	11
5	To make nurses conscious in their conducts	10
6	It helps in litigation or to avert incessant medical litigation	7
7	Prevent reoccurrence of the situation	5
8	To create patient awareness or advocate for patient's right	4
9	For auditing or evidential purpose or help in proper management	4
10	Reduce harm to patient	3
11	It will increase patient safety	3
12	To maintain high level of world best practice	3
13	It will prevent quackery, trial and error method of treatment, and improve competency of health workers	3
14	To improve nurse-patient relationship	2
15	Help to apply the ethics of the profession	2
16	Promote job satisfaction	1
17	It protects the patients	1
18	It makes hospital management liable	1
19	To improve positive image of health institution	1
20	To provide nurses with knowledge on patient safety incident	1

Table 3b: Why should patient safety incident be performed as perceived by nurse respondents (n = 100)

Question/Statement	**Agree (%)**	**Strongly Agree (%)**	**Disagree (%)**	**Strongly Disagree (%)**
Effective in reducing medical litigation	60	32	2	0
Improve the credibility of medical professionals.	47	46	3	2
It is one of nurses' role of advocating for the patients	45	49	3	0
Helps to keep and minimize errors	52	45	0	1
Helps to channel grievances appropriately	54	27	14	1
It is effective in professional justification	50	45	3	1

Research Objective 3: Nurses understanding of the process of implementation of patient safety incident

High percentage of nurse respondents (80%) believed that patient safety incident process should begin immediately after incident is identified and the staff involved has been notified (Table 4).

Table 4: The process of implementation of patient safety incident as perceived by nurse respondents (n = 100)

Questions	**Response (%)**
When should the patient safety incident process start?	
Immediately after incident is identified and the staff was notified	80
After approval from head of nursing unit	14

Waiting till the staff that committed the error is on duty	1
Watching if the patient will have adverse effect	0
Who should the information be given to?	
The patient	59
The patient's relative that is present in the hospital	37
The parent or children of the patient	5
The religious leader of the patient	1
Where patient safety incident should be conducted?	
In a multiple bed hospital room	29
When you see the patient along the street	6
In the office of the nurse or doctor	61
Through phone call or text message to the patient	2

Research Objective 4: Reason why nurses should conduct patient safety incident
As shown in Table 5, majority of the nurse respondents believed that they were exposed and in proximity to situation in which patient safety incident is needed (93%)., they frequently witness errors committed by another medical professional (82%).
Table 5: Reason why nurses should conduct patient safety incident as perceived by nurse respondents (n = 100)

Statement	True (%)	False (%)
Nurses are more likely to be exposed to situations in which DPSI is needed	93	3
Nurses frequently witness other medical professional's medical errors	82	14
Nurses face difficult situations most in which they continue to provide medical care for patients who have experienced patient safety incidents.	83	11

Research Objective 5: Situations where Nurses should conduct patient safety incident
Significant numbers of the respondents believe that patient safety incident should be conducted whether the patient is aware or not and whether if nurses are the one involved in the error or not (Table 6).
Table 6: Situations where nurses should conduct patient safety incident as perceived by nurse respondents (n = 100)

Statement	True (%)	False (%)
If the patient is aware of the error	68	28
If the patient is not aware of the error	68	27
If the nurses are the one involves in the error	79	18
If it is other health professionals that are the one involves in the error	66	29
Only If the patient safety incident caused severe harm to the patient	42	52

Research Objective 6: Impact of workload on patient safety

In Table 7, majority of the nurse respondents believed that heavy workload affects patient safety as a result of insufficient time, lack of motivation, continuous stress and burnout, and that it is evident in congestion in cognition, violation of rules and defect in quality of care rendered by health organization.

Table 7: Impact of workload on patient safety as perceived by nurse respondents (n = 100)

Mechanism	Description	True (%)	False (%)
Time	Nurses who have a heavy workload may not have sufficient time to perform tasks safely, apply safe practices, or monitor patients, and may reduce their communication with physicians and other providers.	89	7
Motivation	Nurses who have a heavy workload may be dissatisfied with their job, thus affecting their motivation for high-quality performance.	75	19
Stress and burnout	Nurses who have a heavy workload may experience stress and burnout, which can have a negative impact on their performance.	92	4
Errors in decision-making (attention)	High cognitive workload can contribute to errors, such as slips and lapses or mistakes.	87	7
Violations or work-a round	High workload conditions may make it more difficult for nurses to follow rules and guidelines, thus compromising the quality and safety of patient care.	69	26
Systemic/ organizational Impact	The heavy workload of a nurse, nurse manager, or another provider could affect the safety of care provided by another nurse.	68	25

Research Objective 7: Nurses experience of level of harm severity in patient due to error

The nurse respondents have prior knowledge of harm severity in patient due to error whether their practice or by proclamation within the organization or at workshop. Highest frequency was observed for mild harm severity followed by none, moderate, severe and death as given in Table 8.

Table 8: Nurses experience of level of harm severity in patient due to error as perceived by nurse respondents (n = 100)*

Descriptions of harm severity	Response Frequency
None Outcome was not symptomatic or no symptoms were detected and no treatment was required.	34
Mild Patient outcome was symptomatic, symptoms were mild, loss of function or harm was either minimal or intermediate but short-term and no intervention or only a minimal intervention, e.g. extra observation, investigation, review or minor treatment, was required.	36
Moderate	21

Patient outcome was symptomatic, required more than a minimal intervention, e.g. additional operative procedure or additional therapeutic treatment, and/or an increased length of stay and/or caused permanent or long-term harm or loss of function.	
Severe Patient outcome was symptomatic, required a life-saving or other major medical/surgical intervention, shortened life expectancy and/or caused major permanent or long-term harm or loss of function.	11
Death On balance of probabilities, death was caused or brought forward in the short-term by the incident.	5

* few of the nurse respondents have experiences in more than one level of harm severity in patient due to error.

Research Objective 8: The barriers to patient safety incident

The nurse respondents noted that too much workload and stress is the top barrier to patient safety incident, followed by inadequate hospital management policy about patient safety incident, lack of financial resources to support the process, no enough nurses and fear of penalty that can result from being identified as the culprit of error (Table 9).

Table 9: Barriers to patient safety incident as perceived by nurse respondents (n = 100)

	Description	**Response Frequency**
1	Too much workload and stress	26
2	(weak) hospital /management policy about patient safety incident	13
3	Lack of money or finance	12
4	Insufficient manpower	11
5	Fear of disciplinary action/ penalty or losing job	10
6	Language diversity	8
7	Lack of good communication system or policy	8
8	Lack of orientation or information or awareness about patient safety incident	8
9	Inadequate documentation or disclosure of error	7
10	Environmental factor or working environment	7
11	Medical and legal litigation	5
12	Blame by another co-worker	5
13	Poor nurse-nurse relationship	4
14	Interdisciplinary conflicts or unwillingness	3
15	Threat from patient or patient's relatives	3
16	Fear of threat from those that committed the error	3
17	Lack of infrastructures	2
18	Poor monitoring and evaluation	2
19	Insincerity by patient	2
20	Unawareness of patient safety incident	2
21	Poor knowledge on how, when and whom to report	2
22	Cultural background or attitude	2
23	Uncooperative ward managers	2

24	Lack of quality care control	2
25	Social factor	2
26	Affection for co-worker	1
27	Religion	1
28	Ineffective punishment	1
29	Late reporting	1
30	Political influence	1
31	Insecurity that might come after	1
32	Educational level of the patient	1
33	Ignorance on part of patient	1
34	Insurance	1
35	Lack of encouragement of nurses	1
36	Inexperience superior officer	1
37	Lack of priority for patient safety	1
38	Lack of teamwork	1

Discussion

The findings of the study revealed the nurse respondents perceived that the culture of patient safety in public hospital should be a priority while they averagely believe that they were supported for reporting medical errors, uncomfortable in reporting errors, their ward acted promptly on reported error, and they can openly communicate their opinions about patient safety. Most nurses admitted that patient safety incident is necessary to ensure quality care, for professionalism in practice, to protect the patient and to prevent quackery, trial and error method of treatment, and improve competency of health workers. Although the opinion that patient safety incident should be performed when a patient experienced harm was prevalent, the respondents expressed mixed opinions regarding the necessity of performing patient safety incident depending on the characteristics of the patient safety incident. Moreover, nurses conducted patient safety incident even when they were not responsible for the medical errors, and they also felt burdened (Choi et al., 2019).

The study revealed that majority of the nurse respondents believe that patient safety incident should be included in all health facilities in the Ondo State, Nigeria. Considering these obstacles to patient safety incident, a pragmatic approach is needed for successful establishment of patient safety incident, such as provision of patient safety incident guidelines on when and how to perform the patient safety incident, as well as continuous professional development training on patient safety incident for the nurses and other medical professionals within the hospital in order to improve the overall perception of and confidence in performing DPSI (Choi et al., 2019; Jafree et al., 2017; Lee et al., 2017; Ock et al., 2017). The sundry opinions of the nurse respondents about when, who and where to conduct patient safety incident was similar to that of previous studies (Choi et al., 2019; Ock et al., 2016).

The study also revealed that majority of the nurse respondents believed that patient safety incident process should begin immediately after incident is identified and the staff involved has been notified. The study further revealed that majority of the nurse respondents believed that they were exposed and in proximity to situation in which patient safety incident is needed and they frequently witness errors committed by another medical professional. The study revealed that patient safety incident should be conducted whether the patient is aware or not and whether if nurses are the one involved in the error or not. The results of the study

suggest that nurses perceive the culture in public hospitals of Nigeria to be castigatory and that individuals are not comfortable in reporting errors.

It was also revealed that majority of the nurse respondents believed that heavy workload affects patient safety as a result of insufficient time, lack of motivation, continuous stress and burnout, and that it is evident in congestion in cognition, violation of rules and defect in quality of care rendered by health organization. A heavy nursing workload has been found to be related to suboptimal patient care and lead to reduced patient satisfaction (Keijsers et al., 1995; Anderson and Maloney, 1998). According to the Systems Engineering Initiative for Patient Safety (SEIPS) model of work system and patient safety (Carayon et al., 2003, 2006; Carayon and Alvarado, 2007), structural/organizational characteristics of health care work systems, such as nursing workload, can affect quality of care and patient safety.

The study also revealed that the nurse respondents have prior knowledge of harm severity in patient due to error whether their practice or by proclamation within the organization or at workshop. Highest frequency was observed for mild harm severity followed by none, moderate, severe and death. The International Classification for Patient Safety (WHO, 2009), essentially enables the international and inter-specialty comparison of incidents. This classification system defines five degrees of harm severity, from no harm to death (Howell et al., 2017) and the results of this study indicate that the nurses understand level of harm severity in patient due to error. The results show that majority of the student nurses have similar perception to those of the staff. Though they may not have practical experience of error in clinical duties at their respective nursing school which may require patient safety standards.

It was lastly revealed that too much workload and stress is the top barrier to patient safety incident, followed by inadequate hospital management policy about patient safety incident, lack of financial resources to support the process, no enough nurses and fear of penalty that can result from being identified as the culprit of error. Study has shown that nurse job satisfaction was positively associated with a unit-level workload measure, staffing adequacy; burnout was negatively associated with unit-level staffing adequacy, and positively associated with task-level external demands, such as interruptions (Holden et al., 2011). Study has shown that job-level perceptions of heavy workloads and task-level interruptions had significant direct effects on patient and nurse outcomes, and that tasks left undone mediated the relationships between heavy workloads and nurse and patient outcomes; and between interruptions and nurse and patient outcomes (MacPhee et al., 2017).

Conclusion and Recommendations

In conclusion, this study determined that nurses in the State of Ondo in Nigeria perceived the need for patient safety incident in the hospitals. This study found that the advantages that the nurses envisage about the establishment of patient safety incident. However, this study discovered that they do not all clearly know how to perform patient safety incident, and that many barriers could impede the success of patient safety incident which include fear of penalty, heavy workload, inconsistent hospital policy, and lack of adequate health care fund. To facilitate communication of patient safety incidents for nurses, relevant guidelines organized by patient safety incident types need to be developed and implemented. Continuous professional development on patient safety incident should be mandated for principal nurses and medical professionals. Furthermore, improving the hospital organization atmosphere is essential to facilitate useful communication of patient safety incidents. In addition, post inauguration of patient safety incident process in the hospital should be

conducted to find the limitations and ways of improvement the standard of patient health care and hospital management.

References

Anderson FD, Maloney JP. (1998). A descriptive, correlational study of patient satisfaction, provider satisfaction, and provider workload at an Army medical center. *Mil Med*, 163(2), 90-4.

Baker, G.R., Norton P.G.,Flintoft V., Blais R., Brown A., Cox J., Etchells E., Ghali W.A., Hébert P., Majumdar S.R., O'Beirne M., Palacios-Derflingher L., Reid R.J., Sheps S. and Tamblyn R. (2004). The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada. *CMAJ,* 170(11), 1678–86.

Carayon P, Alvarado CJ, Brennan P, et al. (2003). Work system and patient safety. In: Luczak H, Zink KJ, eds. *Human factors in organizational design and management*. Santa Monica, CA: IEA Press; p. 583-589.

Carayon P, Alvarado CJ, Hundt AS, et al. (2006). Patient safety in outpatient surgery: the viewpoint of the healthcare providers. *Ergonomics,* 49, 470-85.

Carayon, P., Alvarado, C. J. (2007). Systems engineering initiative for patient, (SEIPS). Workload and patient safety among critical care nurses. *Critical Care Nursing Clinics of North America,* 19(2), 121–129.

Cho, E.; Chin, D.L.; Kim, S.; Hong, O. (2016). The Relationships of Nurse Staffing Level and Work Environment With Patient Adverse Events. *J. Nurs. Scholarsh*, 48, 74–82.

Choi EY, Pyo J, Ock M, Lee S. (2019). Nurses' Perceptions Regarding Disclosure of Patient Safety Incidents in Korea: A Qualitative Study. *Asian Nursing Research*, 1-9. https://doi.org/10.1016/j.anr.2019.05.002

European Commission (2014). Reporting and learning systems for patient safety incidents across Europe. Brussels.

Holden, R.J.; Scanlon, M.C.; Patel, N.R.; Kaushal, R.; Escoto, K.H.; Brown, R.L.; Alper, S.J.; Arnold, J.M.; Shalaby, T.M.; Murkowski, K. (2011). A human factors framework and study of the effect of nursing workload on patient safety and employee quality of working life. *BMJ Qual. Saf.* 20, 15–24.

Howell AM, Burns EM, Hull L, Mayer E, Sevdalis N, Darzi A. (2017). International recommendations for national patient safety incident reporting systems: an expert Delphi consensus-building process. *BMJ QualSaf,* 26(2), 150–163.

Hughes RG. (2008). Error reporting and disclosure. In: Hughes RG, editor. *Patient safety and quality: an evidence-based handbook for nurses*. Rockville, MD: Agency for Healthcare Research and Quality.

Hughes, R.G. (2008). *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Agency for Healthcare Research and Quality: Rockville, MD, USA,

Jafree SR, Zakar R, Zakar MZ and Fischer F. (2017). Assessing the patient safety culture and ward error reporting in public sector hospitals of Pakistan. *Safety in Health,* 3, 10-17

Jha A. (2008). World Health Organization; World Alliance for Patient Safety. Summary of the evidence of patient safety: implications for research. Geneva: World Health Organization.

Keijsers GJ, Schaufeli WB, LeBlanc PM, et al. (1995). Performance and burnout in intensive care units. *Work Stress,* 9:513-27.

Kizer KW. (1999) Large system change and culture of safety. Proceedings of enhancing patient safety and reducing errors in health care; November 8-10, 1998; Chicago, IL. National Patient Safety Foundation

Lee W, Choi EY, Pyo JH, Jang SG, Ock MS, Lee SI. (2017). Perception and effectiveness of education regarding disclosure of patient safety incidents: a preliminary study on nurses. *QualImprov Health Care,* 23 (2), 37e54.

Lewis PJ, Dornan T, Taylor D, Tully MP, Wass V, Ashcroft DM. (2009). Prevalence, incidence and nature of prescribing errors in hospital inpatients. *Drug Saf.* 32(5), 379–389

MacPhee M, Dahinten VS, Havaei F. (2017). The Impact of Heavy Perceived Nurse Workloads on Patient and Nurse Outcomes. *Adm. Sci.,* 7(7), 1-17. Doi: 10.3390/admsci7010007

Ock M, Kim HJ, Jo MW, Lee SI. (2016). Perceptions of the general public and physicians regarding open disclosure in Korea: a qualitative study. *BMC Med Ethics*, 17, 50.

Ock M, Lim SY, Jo MW, Lee SI. (2017). Frequency, expected effects, obstacles, and facilitators of disclosure of patient safety incidents: a systematic review. *J Prev Med Public Health*, 50(2), 68e82.

O'Connor E, Coates HM, Yardley IE, Wu AW. (2010) Disclosure of patient safety incidents: a comprehensive review. *Int J Qual Health Care*, 22(5), 371-379.

Panesar SS, Carson-Stevens A, Cresswell KM, Salvilla SA, Slight SP, Javad S, et al. (2016). How safe is primary care? A systematic review. *BMJ Quality & Safety*, 25(7), 544-553.

Perez B, Knych SA, Weaver SJ, Liberman A, Abel EM, Oetjen D, et al. (2014). Understanding the barriers to physician error reporting and disclosure: a systemic approach to a systemic problem. *J Patient Saf*, 10(1), 45-51.

Rothschild JM, Landrigan CP, Cronin JW, Kaushal R, Lockley SW, Burdick E, Stone PH, Lilly CM, Katz JT, Czeisler CA. (2005). The critical care safety study: the incidence and nature of adverse events and serious medical errors in intensive care. *Crit Care Med* 33(8), 1694–700.

Simpson C, Aubin D, Fillatre T. (2012). The ethics of disclosure of patient safety incidents. *Health Manag Forum*, 25(2), 120e5.

WHO (2002). Resolution WHA55. 18. Quality of care: patient safety. In: Fifty-fifth World Health Assembly, Geneva, 13–18 May 2002. Volume 1. Resolutions and decisions. Geneva: World Health Organization.

WHO (2009). The conceptual framework for the International Classification for Patient Safety. Version 1.1. Final technical report. Geneva: World Health Organization. Available from: http://www.who.int/patientsafety/taxonomy/icps_full_report.pdf [cited 2017 July 25].

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