Incident reporting in the nursing home sector: An interpretative phenomenological analysis study.

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Abstract

Introduction

Patient safety is a cause for concern across health-care systems worldwide with data suggesting that approximately 10% of patients experience harm whilst receiving care. Today, incident reporting systems are well established in the NHS in England and are used to identify risks so that clinical practice can be improved.

Background

In the NHS in England, there is a national incident reporting system to support the process, however despite there being more beds in the nursing home sector compared to the NHS, there are limited requirements for the care sector to report incidents, resulting in a wealth of data specific to the care sector not being collated.

A scoping review was conducted which highlighted limited studies in relation to the registered nurses' lived experience of incident reporting, particularly in the nursing home sector. Significantly, no studies were identified in the United Kingdom which explore the registered nurses' lived experience of incident reporting in the nursing home sector, indicating a substantial gap within the field.

Methods

Interpretative phenomenological analysis (IPA) was used to conduct the study. The use of IPA enabled the essence of the phenomenon to be exposed, with the interpretative element of IPA enabling a deeper, more holistic understanding of the phenomenon.

Results

Several themes were identified relating to three specific areas: system level facilitation, local engagement, and individual accountability. Furthermore, the researcher has questioned the accuracy of double hermeneutics, proposing that multiple hermeneutics is more reflective of the hermeneutic elements of IPA.

Covid Impact Statement

Coronavirus is a contagious disease caused by the severe acute respiratory syndrome coronavirus. The first case was identified in Wuhan, China, in December 2019, with the first case in the United Kingdom (UK) being identified in January 2020, and the first UK death occurring in March 2020. On March 11th, 2020, the World Health Organization (WHO) declared the novel coronavirus (Covid-19) outbreak a global pandemic. Since the pandemic was declared, over six hundred thousand people have died across the world due to the virus (WHO, 2022), and over 190, 000 people in the United Kingdom (Gov.uk, 2022), resulting in an unprecedented demand on health and social care services.

The following two years saw an unimaginable demand upon both NHS and social care services, due to the increased levels or morbidity and mortality experienced within the population, staff sickness and staff being required to isolate, as well as the need to deliver care differently in terms of the isolation of patients and the requirement to wear personal protective equipment. All of this has had a significant impact on capacity within NHS services, along with the emotional and psychological impact on all staff.

Although I work in a non-clinical role, the pressure caused by the pandemic affected all systems in the NHS, with roles and responsibilities changing due to the need to support the clinical services across both health and social care. Despite government guidance reporting a return to pre-pandemic working in April 2022, NHS and social care staff are still required to complete lateral flow device testing and to isolate if positive, which is continuing to have a significant impact on capacity. Since the start of the pandemic, my average working day has increased from 8-9 hours to 11-12 hours. Working extended hours has had a significant impact upon my ability to study.

Undertaking a research study during a pandemic has presented additional challenges. Due to the pandemic, I was not able to visit the nursing homes in person to discuss my research and to recruit participants. This made recruiting participants particularly difficult. I also feel that it was difficult to recruit participants as they were also working under extreme pressure, and to ask them to take part in a research study would have placed an additional impact on their time.

Due to the uncertainty of the virus, and the course timescales, it was not an option to delay the research. Although a six-month extension was offered, it was impossible to determine if the virus would have been contained and restrictions lifted within this six-

month window, therefore a decision was made to continue with the study by making the required adaptions to comply with Covid-19 requirements. Instead of visiting the homes to try and recruit participants, this took place over the phone. The initial plan for face-to-face interviews had to be adapted and they had to take place over the phone.

Although the pandemic has caused an additional challenge to undertaking the study and completing the required amount of academic study, following a few amendments to the initial study proposals to ensure compliance with the Covid-19 national guidance, the study has been completed, within the timescales.

Chapter 1

Introduction

Introduction

This report forms part of my Professional Doctorate in Health and Social Care and will present the research which has been conducted to explore incident reporting in the nursing home sector, using the methodology Interpretative Phenomenological Analysis (IPA).

A Professional Doctorate is a programme of study which requires the student to explore an area of professional practice through research. The Professional Doctorate integrates professional practice, with relevant academic theory and work-based problems (Maxwell, 2003) to produce a thesis which explores the issue in detail, making recommendations to improve practice along with identifying areas for further research. The overall purpose being to transform an area of professional practice (Fulton, Kuit, Sanders & Smith, 2012; Hochbein & Perry, 2013).

This following thesis will therefore demonstrate how an area of clinical practice has been explored in detail. A clear justification for the study will be provided, along with a discussion of how the application of academic theory has enabled a qualitative research study to be undertaken to highlight the issues in clinical practice. My role as a nurse-researcher will be evident throughout the study which will enable an in-depth analysis and interpretation of the findings, to illuminate new knowledge which can be implemented to transform practice.

The introduction provides background evidence in relation to incident reporting as a system to improve patient safety in healthcare. Nursing homes will be introduced, along with a rationale for their pivotal role within this research study. Incident reporting within the nursing home sector will be discussed and comparisons made with incident reporting systems and cultures within the National Health Service [NHS]. The Covid-19 pandemic will be discussed to highlight the impact it has had on the research study, but also to highlight inequalities between the NHS and the care sector. Finally, my personal interest in the research area will be explored.

Background

“Across the world, patients suffer harm in health care facilities and die unnecessarily” (World Health Organization [WHO], 2020, p.3). Patient safety is a cause for concern across health-care systems worldwide (Mahajan, 2010) with data suggesting that approximately 10% of patients experience harm whilst receiving health care (Vincent at el., 2008). The publication of “To Err is Human” (Kohn, Corrigan & Donaldson, 2000) and “Crossing the Quality Chasm” (Institute of Medicine, 2001) resulted in an increased focus on patient safety and learning from incidents. In 2001 the National Patient Safety Agency (NPSA) was established in England to introduce patient safety as a new discipline into the NHS, following which the National Reporting and Learning System (NRLS) – a national system to report incidents and to share learning was established in 2003 (NHS, 2014). However, there was little engagement with the care sector to share the learning, and despite the efforts of the last twenty years, patient safety incidents continue to occur.

Currently there are more nursing home beds in England than NHS beds (Care Quality Commission [CQC], 2020; Handler et al., 2006; Kings Fund, 2021). Nursing homes provide a significant contribution to the health economy by caring for patients with increasingly complex health care needs, yet they are a sector which is often overlooked (Cousins, Burrows, Cousins, Dunlop & Mitchell, 2016). They provide care for some of the most vulnerable patients within our society. The vulnerability and dependency of these patients places them at greater risk of harm; however, studies have highlighted under-reporting of incidents in the nursing home sector as an area of concern. Milligan, Krentz & Sinclair (2011) sought to analyse adverse drug incidents in the care home sector, relating to diabetes management in older people which were reported into the NRLS over a 5-year period, concluding that the number of incidents reported was low suggesting that under-reporting of incidents is common. Furthermore, they considered patients to potentially be at risk of harm from adverse drug events, but under-reporting means that there is limited information available to highlight the extent of the risk. Although all health care staff are encouraged to report incidents into the NRLS, Milligan et al. (2011, p.1540) suggest that the “inclusion of the care home setting within the National Reporting and Learning Service might serve to enhance patient safety”.

Patient safety remains high on the agenda in the NHS in England and in 2019 The NHS Patient Safety Strategy (NHS England & NHS Improvement [NHSE & I], 2019) was published. The strategy outlines the approach the NHS will take to improve patient

safety, part of which is a revised incident reporting system to replace the NRLS. However, despite nursing homes providing more beds than the NHS, there is little specific reference to the nursing home sector and how they can contribute to improvements in patient safety.

Today, incident reporting systems are well established in the NHS in England and used to identify risks so that clinical practice can be improved (Pham, Giradr & Pronovost, 2013). In 2003, a national database - the National Reporting and Learning System (NRLS) was established in England and Wales, to enable patient safety incidents to be reported. The scope for data collection was refined when the NRLS (n.d.) defined a patient safety incident as “any unintended or unexpected incident which could have or did lead to harm for one of more patients receiving NHS care”.

The NHS aims for complete transparency, making it clear that “both healthcare staff and the general public are encouraged to report any incidents, whether they result in harm or not, to the National Reporting and Learning System” (NHS Improvement, 2019a). The NRLS is the “world’s largest and most comprehensive patient safety incident reporting system and receives over two million reports each year” (NHS Improvement, 2018). Whilst NHS organisations report patient safety incidents into the NRLS, there are no contractual requirements for this. From discussions with NHS providers, the decision to report is one based on being open and transparent, and promoting a positive patient safety culture.

Incident reporting is essential to improve patient safety (NHSE & I 2019; Vrbnjak, Denieffe, O’Gorman, & Pajnkihar, 2016), yet under-reporting is common worldwide (Mansouri, Khaleghdoost, Adib, Lili, & Soodmand, 2019; Yung, Yu, Chu, Hou, & Tang, 2016,). The WHO (2020) claim that under-reporting of incidents is the norm. Despite an established incident reporting system in the NHS, the incident reporting rate in the United Kingdom is estimated to be between 22-39%, indicating that over 60% of incidents remain unreported (Public Accounts Committee, 2006). Low reporting rates require further exploration to identify what is preventing errors from being reported to improve reporting and most importantly improving patient safety (Mansouri et al. 2019; Yung et al. 2016,). Research in Acute Hospital Trusts in the United Kingdom has identified that as many as 11,000 lives per year are lost due to safety concerns, with older patients being affected the most (Hogan et al., 2012). In addition, the cost to provide additional treatment as a result of incidents costs in excess of 1 billion pounds per year.

Within healthcare, there are many differing professional groups who provide care to patients, for example doctors, nurses, pharmacists, radiographers, with nursing staff accounting for the largest group of professionally qualified staff in the NHS (26.9%) and medical staff accounting for 10.3% (NHS Digital, 2018). It is also reported that nursing staff have a higher rate of incident reporting than other professional groups such as doctors and pharmacists (Sarvadikar, Prescott & Williams, 2010). With nurses accounting for the largest group of health care professionals, it is argued that nurses are essential in promoting patient safety (Wagner, Harkness, & Gallagher, 2012) and that they are ideally placed to report incidents due to their role in working front line with patients daily (Chen, Wang, Redley, Chu, & Han, 2018).

Although under-reporting is common within the NHS and worldwide, NHS organisations still report a large number of incidents on a regular basis. The NRLS produce six monthly league tables to highlight the number of incidents reported by NHS organisations, but to date, these tables are not produced for private care providers, for example nursing homes. As such, a wealth of data in relation to incidents which occur in the private sector, is not collated, and analysed centrally, preventing opportunities to learn directly from data (trends, spikes, and anomalies) and respond in ways that improve patient care. Recent evidence indicates a “paucity of studies” exploring incident reporting in the nursing home sector, leaving a gap in understanding where prevention strategies are needed in nursing homes (Prang & Jelsness-Jorgensen, 2014, p.442).

Nursing Homes in England

Health and social care are often referred to collectively, as a single entity in the UK, however they are two completely different systems (Daly, 2020). Collaborative working between the two systems is essential to support the delivery of health and social care, however long-standing inequities are reported between the two (Daly, 2020; The Health Foundation, 2021).

Residential care homes in England provide 24-hour live-in accommodation for people requiring help with care and support needs. Residential care falls under the social care sector as opposed to health care. Nursing homes in England, are also classed as residential care, but differ from general residential homes in that a registered nurse is available on site 24 hours a day, to provide specific nursing care needs (Care to be

Different, 2019). Approximately 95% of nursing homes in England are private providers, provided by the independent sector (Competition and Markets Authority, 2017).

Funding of residential care is complex. Many residents are required to self-fund or part fund for the elements of social care. For those who do not have the funds the local authority will fund the placements. However, in nursing homes, the additional nursing element of a resident's care is funded by the NHS as part of the NHS commitment to "health care being free at the point of contact" (Competition and Markets Authority, 2017, p.28). This results in dual funding streams to fund one resident's placement. The registered nurse elements of a patient's care delivered in nursing home settings, is funded through the Registered Nurse Contribution to Care (RNCC) or Funded Nursing Care (FNC) as it is more commonly referred to today. FNC teams often sit within Clinical Commissioning Groups (CCG), commissioning organisations or commissioning support units. Occasionally they sit within provider organisations and have responsibility for assessing, planning, funding, and monitoring a patient's care. However, the contracting of the NHS funded care in residential care settings is not always straight forward. Local authorities, who have responsibility for the provision of social care, are often the lead commissioner of adult residential care, as they commission a significantly greater number of beds and fund the non-nursing element of a patient's residential care. Even in a nursing home, the local authority funds the non-nursing element of the care. This in turn causes an additional layer of complexity when working with nursing homes as often the local authorities will be the lead commissioner and manage the contractual requirements.

It also must be acknowledged that across the country there will be different operating models in relation to where FNC teams are located and how they operate with the local authorities.

Residential care homes (both with and without nursing) are essential in supporting the health and social care system within England, (Cousins et al., 2016), however they are often not the preferred place of work for registered nurses, leading to high vacancies and a high turnover of registered nursing staff (Skills for Care, 2021). Reasons proposed include lack of a career pathway, inequities in the quality and accessibility of training and increasing workloads (Cousins et al., 2016). The inequities between health and social care extend further than just staffing. Despite nursing homes providing NHS

funded care, nursing homes are often excluded from national NHS policy and quality improvement initiatives.

Although incident reporting was identified over 20 years ago as a process to support learning from mistakes, most of the experience relating to incident reporting systems in healthcare have been implemented in the NHS hospital sector (WHO, 2020). Incident reporting is well established in the NHS; however, Castle (2006) claims that nursing homes are generally much slower to adopt quality improvement initiatives. From personal experience of working with the nursing home sector, it is evident that a theory-practice gap exists; in the sense that contractual and regulatory requirements to report incidents of moderate harm or above exist, but in practice this does not reliably happen. Furthermore, incidents of low or no harm are often rarely reported, dependent upon the culture within the home. If a theory-practice gap exists, Rafferty, Allock & Lathean (1996) argue that concerted efforts should be made to reduce the gap. Contemporary data on nursing home engagement with quality improvements, such as incident reporting are difficult to access because only a few studies have been conducted, such as studies by Prang & Jelsness-Jorgensen (2014), Shmueli, Noy, Natan, & Ben-Israel. (2014), Wagner, Capezuti, Taylor, Sattin & Ouslander, (2005). Whilst research has been conducted in the hospital environment, Hughes & Lapane (2006) argue that the findings from hospital environments are not generalisable to the nursing home sector due to the differences in environment, purpose, and priorities of care, indicating that specific research may be necessary to understand incident reporting in the nursing home sector. In addition, none of the studies conducted in the nursing home sector have sought to explore the nurses' lived experience of incident reporting.

The size and significance of under-reporting in this sector requires emphasising in research-based literature. With an ageing population, living with multiple co-morbidities, and changes in policy, more care is being delivered outside the hospital environment, for example in patients' own homes or nursing homes. As a result, there are now far more nursing home beds than hospital beds (Handler et al., 2006), with an estimated 210,100 nursing home beds in England (Competition & Markets Authority, 2017) compared to approximately 141,000 hospital beds in England (Kings Fund, 2021). Due to the volume of beds in the nursing home sector, it is probable that patient safety incidents are a regular occurrence in nursing homes (Wagner et al., 2012). Incident reporting, which leads to learning and changes in practice, is an essential

aspect of a positive safety culture. Safety culture can be defined as the way in which patient safety is viewed, valued, and prioritised by an organisation (Bonner, Castle, Perera, & Handler, 2008) and encompasses numerous factors such as psychological safety, leadership, staffing levels (NHS Improvement, 2019b) and incident reporting.

There are suggestions that the culture of reporting, now well established in the NHS, needs to be adopted into nursing homes in England. Castle, Wagner, Perera, Ferguson & Handler (2010) argue that to encourage the reporting of incidents there needs to be a positive patient safety culture where there is a non-punitive approach to managing errors, however the literature supports the notion that the culture in nursing homes is punitive compared to the culture within NHS organisations (Bonner et al., 2008; Castle, 2006; Handler et al., 2006; Hughes & Lapane, 2006; Wagner, Castle & Handler, 2013).

Furthermore, unlike the NHS, a national organisation with corporate systems, the care sector is made up of predominantly independent small and medium size enterprises (Competitions and Markets Authority, 2017), all with differing internal systems and processes, including incident reporting systems. This means that between providers, it is probable that there is no consistency with regards to incident reporting processes which potentially contributes to inconsistencies with reporting across the care sector.

Despite the recognised benefits of incident reporting within the NHS, plans to extend national policy into the private sector are weak at best. A recent example is in relation to the NHS National Patient Safety Strategy released in 2019 (NHSE & I, 2019). The purpose of the strategy is to continuously improve patient safety, and a key driver in the strategy is learning from incidents. Within England, more NHS funded healthcare is provided by non-NHS organisations, an example of this is that there are more nursing home beds in England than in NHS hospitals (Handler et al., 2006; Kings Fund, 2021) and whilst the National Patient Safety Strategy (NHSE & I, 2019) does not exclude private providers of healthcare, such as nursing homes, from personal experience, there has been little activity by the NHS to engage with private providers compared to extensive support targeted at NHS organisations and commissioners.

Although Prang & Jelsness-Jorgensen (2014, p.442) report that there are a “paucity of studies” exploring incident reporting in the nursing home sector, it is necessary to perform a review of the literature to understand the current research position along with any potential divergence in practice.

Personal location.

As a registered nurse and a Specialist Practitioner in District Nursing, most of my clinical career has been based in the community, supporting patients to remain well within their own home or in care homes (both residential and nursing). I have worked with many care homes, providing support to improve the quality of patient care and patient experience. In addition, I have always been passionate about improving the quality of care and striving for high standards of nursing care. Harnessing my passion for quality improvement and to extend my skill set, I moved into a quality improvement role to further develop my skills and knowledge and to gain practical experience of large-scale quality improvement in practice.

Having worked in quality improvement for over two years, I moved into a Clinical Commissioning Group (CCG) as the Lead Nurse for Quality & Safety. Part of my role involved working with the nursing home sector, to monitor the standards of care and to seek assurance in relation to the quality of care provided in the nursing homes. I worked closely with the nursing home sector across the borough and networked with colleagues in similar roles across the Greater Manchester region. This is where my personal interest in patient safety, specifically incident reporting in the nursing home sector, developed. This experience afforded me first-hand experience of the patient safety and incident reporting culture within the nursing home sector, at a local and regional level. This also highlighted that there appeared to be a lack of incident reporting, apart from in relation to incidents where a resident suffered moderate or serious harm, which carried a regulatory or contractual requirement to report and investigate (Care Quality Commission, 2013), with no or low harm incidents, or near misses rarely being reported. This role also allowed insight into the management of incidents requiring a system wide approach and exposed the culture towards nursing homes. In my experience, when comparable incidents had occurred in both the NHS and a nursing home, the approach appeared to be inequitable and more punitive towards the nursing home than the NHS, which led me to believe that sometimes nursing homes were not treated fairly. Having worked in the NHS for many years this led me to question why the incident reporting culture was so different both within and towards the nursing home sector compared to the NHS.

The research which has been conducted adopted an IPA methodology and sought to address the following aim and objectives:

What are the lived experiences of registered nurses working in nursing homes in relation to the identification and reporting of incidents?

Furthermore, the objectives have been defined as:

- to determine what registered nurses in nursing homes, understand by the term "incident" in relation to incident reporting
- to explore incident reporting systems and processes in nursing homes
- to explore any barriers and enablers to incident reporting in nursing homes
- to explore any examples where nursing homes have successfully embedded incident reporting in practice

International Pandemic

Although background work for this study commenced in approximately 2017, it must be acknowledged that in March 2020 an international pandemic was declared relating to Covid-19

Covid-19 is a contagious disease caused by the severe acute respiratory syndrome coronavirus. The first case was identified in Wuhan, China, in December 2019, with the first case in the United Kingdom (UK) being identified in January 2020, and the first UK death occurring in March 2020. On March 11th, 2020, the World Health Organization (WHO) declared the novel coronavirus (Covid-19) outbreak a global pandemic. Over six hundred thousand people have died across the world due to the virus (WHO, 2022), and over 190, 000 people in the United Kingdom (Gov.uk, 2022), resulting in an unprecedented demand on health and social care services. Several vaccines have been developed and various countries have initiated mass vaccination campaigns, yet there are still high numbers of morbidity and deaths being reported across the world.

On the 23rd March 2020, the UK Prime Minister declared the first national lockdown due to the pandemic, which lasted for approximately four months. Only people who were deemed to provide an essential service, such as health and social care staff, staff working in food industries were allowed to go to work, the rest being ordered to work from home to minimise the spread. Within the UK, numerous additional measures were implemented to try and manage the spread of the disease such as social isolation,

maintaining a safe social distance from people, wearing face masks in public places and increased hand hygiene. Subsequent lockdowns have been implemented, both national and regional in response to the escalating spread of the disease.

Due to academic timetables, and the uncertainty of the disease trajectory due to the novel nature of the virus, it was not an option to delay the research by any significant time period. The research plans were therefore modified to ensure adherence to Covid-19 national guidance. This will be discussed in more detail in the methods section.

Covid-19 and inequity within Care Sector

Covid-19 has had a significant impact upon the health and social care systems within the UK, however the inequities between health and social care have been further compounded by national policies implemented to manage the pandemic

At the start of the pandemic, significant challenges were experienced in the NHS due to the sharp and sustained increase in acutely unwell patients due to the virus. Additional challenges experienced across both health and social care settings included access to personal protective equipment (PPE); essential for care givers to minimise the spread, and reduced staff numbers due to ill health or staff having to shield, which highlighted inequalities between the NHS and the care sector.

Prior to the pandemic, the care sector could be described as in a fragile state, due to longstanding workforce challenges and years of underfunding (Daly, 2020; The Nuffield Trust, 2021), however it was the NHS, which was presented as vulnerable, with national slogans such as “Stay at Home – Protect the NHS – Save Lives” being released by the Government (Daly, 2020, p. 995.) At the start of the pandemic, large numbers of patients were discharged to residential facilities, often without Covid-19 testing, to free up capacity within NHS hospitals (Daly, 2020; Rajan, Comas-Herrera & McKee, 2020; The Nuffield Trust, 2021) without due consideration as to whether the facilities had the appropriate staffing, skills, and resources to manage the patient’s needs. In addition, residential facilities experienced significant delays in accessing essential PPE supplies, with supplies being prioritised for the NHS, and delays in implementing testing systems across the care sector, both of which potentially contributed to excess deaths within the sector. This resulted in large scale Covid-19 outbreaks across residential care settings and an extraordinary number of excess deaths among care home residents (The Nuffield Trust, 2021). It is estimated that

approximately 46% of all Covid-19 deaths occurred in the care sector (Rajan et al., 2020), yet despite the inequities discussed above, the Government blamed the care sector for failing to follow procedures (Walker, Proctor and Syal, 2020).

Further inequalities were evidenced when in summer 2021, it was announced that all care home staff were required to be vaccinated against the Covid-19 virus by November 2021 (Department of Health and Social Care, 2021), a requirement not placed upon NHS staff, and a decision likely to have a further negative impact upon staffing levels within an already extremely fragile sector.

Chapter Summary.

This chapter has provided a background to the importance of incident reporting in relation to promoting patient safety. Incident reporting is essential to learning from mistakes to reduce harm to patients, improve patient experience whilst also reducing the financial burden associated with patient safety incidents.

With more beds in the nursing home sector than the NHS and with the patient group being at higher risk of patient safety incidents due to living with multiple co-morbidities, there needs to be a greater understanding of incident reporting within the nursing home sector. Nurses in nursing homes are ideally placed to support incident reporting as their role is to oversee and manage a patient's care. Furthermore, it has been reported that nurses have a higher incident reporting rate than other health care professionals.

Despite the NHS having an established incident reporting system, under-reporting remains an issue, with under-reporting also being highlighted as an issue worldwide. However, whilst there is a national reporting system in England to support the process, there are no requirements for the care sector to report unlike the NHS, resulting in a wealth of data specific to the care sector not being collated and reflecting inequity between the NHS and the care sector.

The international pandemic, Covid-19, has also been discussed to highlight the challenges this has posed in relation to the research study, and to further evidence the inequalities between the NHS and the care sector.

Whilst there has been significant research in relation to incident reporting within the NHS, there are a paucity of studies exploring incident reporting in the nursing home sector. To develop a broader understanding of incident reporting, a review of the

literature was conducted to inform this study. The following chapter will detail the review of the literature to understand the current context of incident reporting in the wider context of healthcare.

Chapter 2

Scoping Review

Introduction

The aim of this chapter is to present a scoping review which has been conducted to identify, collate, and review the relevant literature in the field. The rationale for choosing a scoping review will be discussed along with the framework used. The findings from the scoping review will be presented and any gaps in the current literature will be considered in relation to the formulation of the research question.

Rationale for a Scoping Review

Smith, Flowers & Larkin (2009) suggest that the aim of Interpretative Phenomenological Analysis (IPA) research is to adopt a flexible approach to enable the exploration of an area of interest, not to test a pre-determined hypothesis generated following an in-depth review of the literature. As such a literature review is not essential or recommended by phenomenologists when conducting IPA research (Finlay, 2011; Fry, Scammell & Barker, 2017). Phenomenologists suggest that a detailed literature search may suppress the innovation of the researcher (Finlay, 2011) and that the findings of previous studies may limit the scope of the study and the themes identified (Fry et al., 2017). Phenomenologists also argue that in phenomenological research the researcher is seeking to elicit the “lived experience” of individuals involved in the study, not to simply theorise about what the previous literature claims (Finlay, 2011). It is therefore argued that a conventional review of the literature is not necessarily required when undertaking IPA research. However, a review of the literature has been conducted as I was keen to understand the current position in relation to the existing research in the field. I was keen to ensure that the principles of phenomenology were followed and that I was not overtly influenced by existing studies (Finlay, 2011), therefore the purpose of the review was to develop a broad understanding of the context of incident reporting within the nursing home sector and wider healthcare systems.

In the last couple of decades there has been a significant increase in the number of literature reviews taking place. As such, multiple review types exist, enabling researchers to select the most appropriate type of review suited to their specific study. In 2009, Grant & Booth carried out a search to determine the most used reviews in health and social care, resulting in 14 types of review being identified. However, whilst there may be multiple types of review, with different names, Arksey & O'Malley (2005) suggest that despite the differing names, the reviews share similar key characteristics in terms of collection, evaluation, and presentation of the data. Arksey & O'Malley (2005, p. 20) further contend whilst the differing approaches to literature reviews present a suite of tools to guide the process, that there is no "ideal type" of literature review.

Having appraised the different types of reviews available, their intended purpose, and considering the views of phenomenologists in relation to IPA research and literature reviews, a scoping review has been deemed appropriate to meet the needs of this study. Scoping review and scoping study are sometimes used interchangeably in the literature (Colquhoun et al., 2014; Daudt, Mossel & Scott, 2013) so for the purpose of this study, scoping review will be used.

Scoping reviews are conducted to "identify and map the available evidence" (Munn et al., 2018, p.2) and are used to search the literature where a broad understanding of the subject matter is required as opposed to answering a specific research question, as is the case with systematic reviews. Scoping reviews aim to examine the amount, breadth, and type of conceptual research in a broad topic area (Jesus, Bright, Kayes & Cott, 2016) and in recent years, scoping reviews have become an increasingly popular approach to searching for relevant literature (Colquhoun et al., 2014; Daudt et al., 2013; Gartshore, Waring & Timmins, 2017; Munn et al., 2018). However, scoping reviews are considered to be a relatively new methodology (Peters et al., 2015). Arksey & O'Malley (2005) were among the first scholars to develop a framework for a scoping review and their framework is the most widely used framework for conducting scoping reviews (Colquhoun et al., 2014). Arksey & O'Malley's (2005) framework will therefore be used to guide this scoping review.

Similar definitions of scoping reviews exist in the literature, but the one used by Arksey & O'Malley (2005) was adopted from May, Roberts & Popay's (2001, p.194) definition of a scoping review:

> *"to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as standalone projects in their own right, especially where the area is complex, or has not been reviewed comprehensively before"*

Four criteria were identified for conducting a scoping review which can be seen in table 1 (Arksey & O'Malley, 2005). Munn et al. (2018) confirm that scoping reviews are an ideal approach to determine the scope of literature within a given field. However, despite the clear criteria for conducting a scoping review proposed by Arksey & O'Malley (2005), Munn et al. (2018) argue that there is a lack of clarity regarding the rationale for conducting a scoping review as opposed to an alternative type of review. Based on the criteria proposed by Arksey & O'Malley (2005), I believe that for the purpose of this study, the justification for undertaking a scoping review is clear. As previously discussed, the research being undertaken is IPA, therefore the aim of the scoping review is to develop a broad understanding of the extent and range of literature in the field, to determine if any similar studies in the area have been carried out and to identify any research gaps in the existing literature.

Table 1 – Criteria for undertaking a scoping review (Arksey & O'Malley, 2005, p. 21.)

1	To examine the extent, range, and nature of research activity: this type of rapid review might not describe research findings in any detail, but it is a useful way of mapping fields of study where it is difficult to visualise the range of material that might be available
2	To determine the value of undertaking a full systematic review; in these cases, a preliminary mapping of the literature might be undertaken to identify whether or not a full systematic review is feasible or relevant.
3	To summarise and disseminate research findings: this kind of scoping review might describe in more detail the findings and range of research in particular areas of study
4	To identify research gaps in the existing literature: this type of scoping study takes the process of dissemination one step further by drawing conclusions from existing literature regarding the overall state of research activity. Specifically designed to identify gaps in the evidence base where no research has been conducted

Arksey & O'Malley (2005) believe that a scoping review should be subject to the same rigour and transparency as a systematic review and that accurate and comprehensive documentation of the process is paramount to ensure that the study can be replicated if required. To facilitate a comprehensive review, and to support methodological rigour,

Arksey & O'Malley (2005) developed a framework for conducting a scoping review, consisting of five stages:

1. identifying the research question
2. identifying relevant studies
3. study selection
4. charting the data and collating
5. summarising and reporting the results

As with most approaches to searching the literature, there are some criticisms of this approach. Scoping reviews do not formally appraise the quality of the literature (Arksey & O'Malley, 2005), which means that studies of poor quality may be included within the review. However, Thomas & Harden (2008) argue that there is little empirical evidence to support the exclusion of studies from a review and that quality appraisals often exclude studies which do not provide a clear answer to the research question (Thomas & Harden, 2008). Furthermore, this scoping review seeks to explore the scope of literature within the field, rather than answer a specific question. In addition, whilst a scoping review does not attempt to synthesise the findings (Arksey & O'Malley, 2005) as in a systematic review, the findings are presented as a descriptive or narrative account to enable the reader to develop a general understanding of the scope of the literature in the field. Some suggest that there is a lack of consensus in relation to the terminology and methods used in relation to scoping reviews (Colquhoun et al., 2014; Tricco et al., 2016) which is possibly because the methodology is in its infancy. Due to the differing terminology and methods, it could be argued that the application of different approaches to the same research questions could render different results (Tricco et al., 2016). However, to counter this I will be using Arksey & O'Malley's (2005) framework, so that a clear and documented approach is used.

This scoping review was undertaken utilising the five stages of Arksey & O'Malley's (2005) framework as described above.

Stage 1 – Identifying the research (search) question

The first stage of Arksey & O'Malley's (2005) framework is to identify the research question. However, a criticism of Arksey & O'Malley's (2005) framework is that the

initial stage should be to define the search question rather than the research question. The research question can only be truly defined once the literature has been reviewed to explore the current scope of available literature, exploring what the existing knowledge base is and where the gaps are in relation to the knowledge. Therefore, adopting a slight variation from Arksey & O'Malley's (2005) framework, my first stage was to identify the search question.

Like a systematic review, the key to any successful review of the literature lies in the ability to propose a precise and specific problem to be addressed. (Beecroft, Booth & Rees, 2015). Defining the search parameters is key to a successful search and Arksey & O'Malley (2005) suggest adopting a wide approach to generate a breadth of knowledge. The initial scoping review focused specifically on the nursing home environment and only identified three published studies. This outcome was critically considered, and it was identified that the search terms were too narrow. In response, a new strategy was implemented to broaden the search to explore the wider context of incident reporting in other health care settings. Therefore, when undertaking the main scoping review, the search terms were broadened to explore incident reporting in the wider context of healthcare rather than just in the nursing home environment.

The Population Exposure Outcome (PEO) model is widely used in qualitative health care research to assist with formulating and refining the search area (Bettany-Saltikov & McSherry 2016; Khan, Kunz, Kleijnen, & Antes, 2003); therefore, as the study is adopting an interpretative phenomenological approach, a qualitative methodology, the PEO model was used. Table 2 illustrates how the PEO model was used to direct the scoping review, listing the relevant synonyms aiming to keep the parameters broad across the wider healthcare context. Determining the synonyms was an iterative process which was continually reviewed dependent upon the search findings, before determining the final search terms. Patient safety was considered as a concept to explore, however whilst reviewing literature in relation to patient safety it was determined that the concept was too broad. Incident reporting is only one element of patient safety, and it was considered that searching for "patient safety" would yield too many non-relevant studies.

Table 2 – PEO model

PEO model	**Population**	**Exposure**	**Outcome**
Keywords	Registered Nurses (working in a) nursing home (or) healthcare environment	Incidents	Experience
Boolean operator ***(AND)***	A N D	A N D	
Boolean operators ***(OR)***	***OR***	***OR***	***OR***
Synonyms / Alternative phrases	• Nursing home • Care home • Care sector • Long-term care facility • Rest home • Retirement home • Hospital • NHS • National Health Service • Healthcare	• Accident • Adverse event • Act • Omission • Hazard • Concern • Error • Near miss	• Report • Notification • Register • Statement • Record • Barrier • Facilitator • Enabler • Intention • Prevention • Challenges • Opportunities

Using prior knowledge obtained from working within the NHS and with the nursing home sector, the scope and aims of the scoping review were determined; to understand incident reporting, including the barriers and facilitators of reporting, in the nursing home environment and the wider healthcare environment, and to understand the registered nurses' experiences of incidents and incident reporting. Jesus et al. (2016, p.3) claim that the search question is critical as it provides "the overall rationale for decision-making about later study selection and data extraction". Consequently, the search question this scoping review will seek to answer is:

What is known from the existing literature in relation to the registered nurses' experience, including the barriers and enablers, of incident reporting in the nursing home sector as well as the wider healthcare environment?

Stage 2 – Identifying the relevant studies

The second stage of the framework proposed by Arksey & O'Malley (2005) is to identify the relevant studies. Using the search parameters listed above, identified using the PEO model, comprehensive and iterative searches were undertaken in the following databases: Cumulative Index of Nursing and Allied Health Literature (Cinahl), Medline, and the British Nursing Index. These databases were chosen as being relevant to the subject area and therefore increasing the likelihood of identifying relevant papers (Beecroft et al., 2015). The key words identified using the PEO model were searched for individually, using wild cards to extend the search fields to ensure all relevant information was captured (Bettany-Saltikov & McSherry, 2016). Boolean operators "OR" and "AND" were then used to combine and focus the individual searches to the specific subject area (Aveyard, 2014). The search strategy was then reproduced in each listed database.

NHS Evidence and the Cochrane Library were also searched to identify any further studies not identified in the previous searches. To identify all relevant studies, grey literature was also searched. Grey literature can be defined as literature that is not formally published, such as in books or journals (Cochrane Collaboration, 2011). Finally, hand-searching was undertaken. Searching grey literature and hand searching is necessary to ensure that key papers are not omitted from the search (Armstrong, Jackson, Doyle, Waters, and Howes, 2005).

Stage 3 – Study selection

When performing a search of the literature it is important to note that papers that make a fleeting reference to a specific search term will be highlighted but may not necessarily be relevant to the specific subject area (Beecroft et al., 2015). It is also possible for searches to return a large number of irrelevant studies (Arksey & O'Malley, 2005). It is therefore essential to determine search limits to ensure that any evidence retrieved is specific and relevant to the subject area (Brettle & Grant, 2004) and enable studies that do not address the research question to be eliminated (Arksey & O'Malley, 2005). Search limits, sometimes also referred to as inclusion and exclusion criteria (Aveyard, 2014) were therefore applied which are listed in table 3.

Table 3 – Scoping Review - inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
• Research limited to studies post 2010 • Studies conducted in care homes where nursing care was provided • Studies conducted in healthcare organisations • Registered nurses' views and experiences • International studies • English language studies • Grey literature • Primary research methodologies	• Research studies pre-2010 • Views and experiences of non-nursing staff • Non- English language studies • Studies relating to the types of incidents reported • Studies relating to the causes of incidents • Studies relating to the disclosure of incidents to family members or other parties • Studies relating to the prevention of incidents • Studies relating to the prevalence of incidents • Studies relating to learning from incidents • Secondary research data, for example systematic reviews

Initially the plan was to only include UK studies so that the findings would be more relevant due to similar commissioning arrangements and polices. It was also considered that leadership and cultural issues relevant to incident reporting may differ in international studies, making it difficult to apply the findings locally. However, due to the limited number of UK studies retrieved, the search was expanded to include international studies.

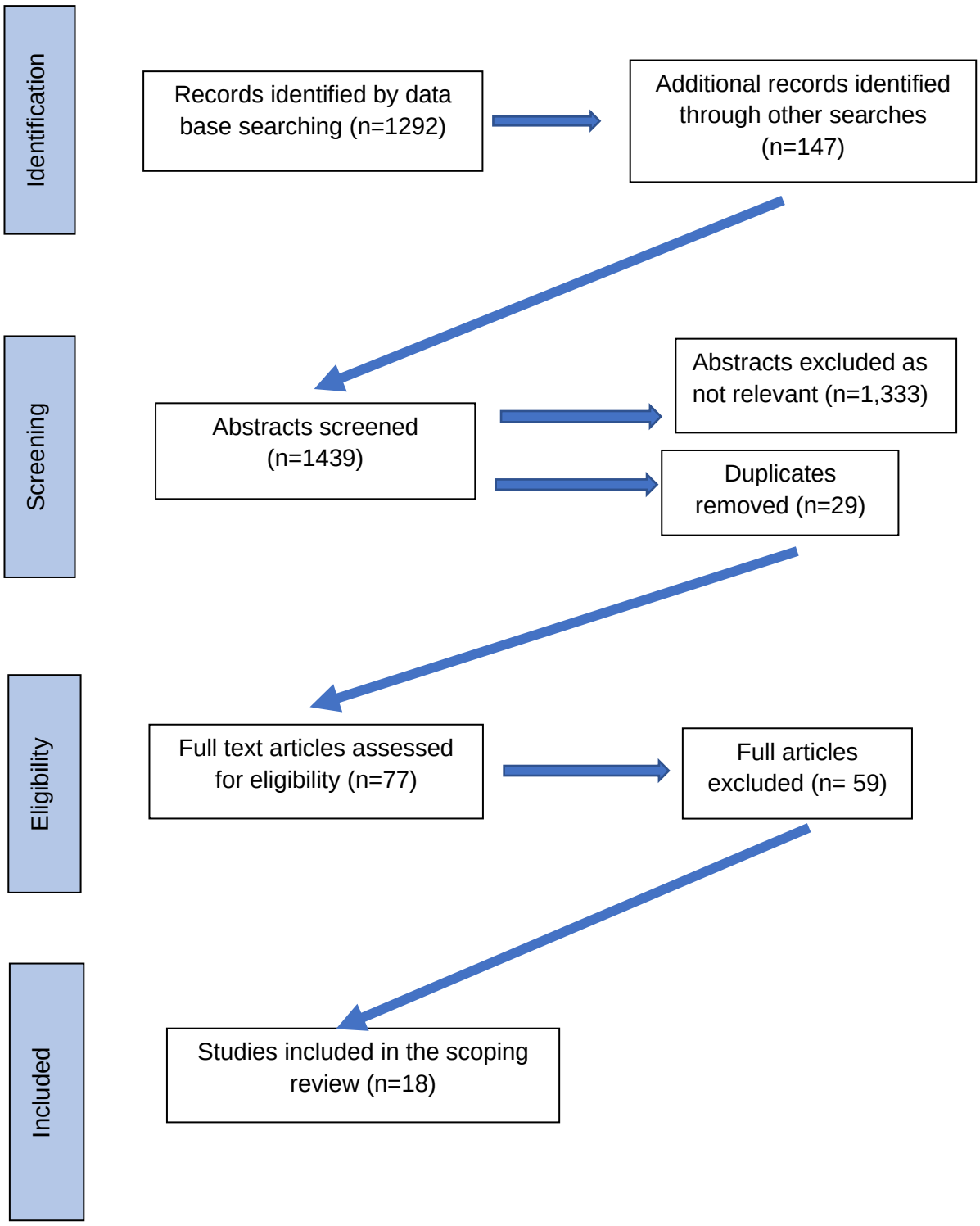
A total of 1439 papers were identified through the data base and additional searching, of which 29 were duplicates. All titles and abstracts were reviewed against the inclusion and exclusion criteria to determine the relevance to the subject area, following which

18 papers were selected for inclusion in the scoping review. Figure 1 shows the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analysis) flow diagram of the search process, identifying the number of records identified, along with the inclusions and exclusions. Although the PRISMA diagram is more commonly associated with systematic and meta-analysis reviews, the flow diagram is a useful tool to chart the search process supporting the openness and transparency of the search (Prisma). Therefore, although not specific to a scoping review, for transparency a PRISMA flow diagram has been included – see figure 1.

It is worth noting that within each database several articles that were not deemed relevant to the subject area and therefore excluded, appeared more than once, falsely inflating the total number of identified articles initially. In addition, although the search terms were carefully considered and deemed to be appropriate to the specific area, some of the search terms used could apply to multiple different situations resulting in a high number or articles being identified that bore no relevance to the subject area. An example of this is in relation to the search term “act”. Whilst “act” was included as a term in relation to an “act” being committed which may warrant being reported as an incident, a high number of articles were returned which related specifically to the Mental Capacity Act but were of no relevance to this specific study.

Also, several of the studies related to various health care professionals such as doctors and pharmacists, rather than just registered nurses, so were excluded from the review. Finally, “incident reporting” is a broad subject area. The specific focus of this search was in relation to the registered nurses’ experience of incident reporting, looking at barriers and facilitators to incident reporting, however a significant number of the articles returned focused on types of incidents, or preventative or causative factors of incidents, which were not relevant to this specific scoping review.

Figure 1 - PRISMA diagram



Stage 4 – Charting the data

The fourth stage of the process is charting the data, which involves "charting" key information obtained from the included studies. The purpose of charting the data is to provide a broad view about the context of each study. The following criteria, proposed by Arksey & O'Malley (2005, p.27) were used to chart the data:

- Author(s), year of publication, study location
- Intervention type, and comparator (if any); duration of the intervention
- Study populations
- Aims of the study
- Methodology
- Important results

Having reviewed the studies identified in stage 3 of the framework, it was felt that the above criteria were appropriate to extract the key information and findings of the studies and was therefore used to chart the data. The data identified from the search has been presented in a table in appendix 1.

Reflections 1

When I decided to undertake my research into the area of incident reporting in the nursing home, I knew that this was an area where I had a significant understanding due to my time spent working closely with the nursing homes for several years. Completing a scoping review highlighted limited research in the area, specific to nursing homes especially in the United Kingdom.

When I undertook the scoping review, I was not surprised by the lack of information in relation to incident reporting in the nursing home sector. I was disappointed that more had not been undertaken but feel the lack of research in this sector also reflected the commitment to the sector as a whole within health and social care policy within the UK. There are currently more care home beds in the UK than NHS beds. Care homes, including nursing homes, care for some of our most complex, vulnerable, and challenging patients (whilst differentiating from the complexity of acutely unwell patents). However, nursing homes remain in the private sector, with fees being paid falling significantly below a comparable NHS bed. As care home beds are predominantly in the private sector, there is often limited access to training and staff are often paid significantly less that staff in the NHS doing similar jobs.

Stage 5 – Collating, summarising, and reporting the results.

The final stage of the framework involves collating, summarising, and reporting the results. In contrast to a systematic review, where only some of the studies identified are included within the final report, in a scoping review all studies are included. In a scoping review there is no attempt to synthesise the data, instead a narrative account is presented which offers no weighting to the included studies due to the absence of a quality appraisal (Arksey & O'Malley, 2005).

Arksey & O'Malley (2005) suggest presenting the findings in two ways, first to categorise the studies in relation to factors such as geography and research methods adopted. Secondly, the findings need to be presented thematically. Whilst Arksey & O'Malley (2005) suggest presenting the data thematically, they do not propose a specific framework to facilitate this. Therefore, the results extracted will initially be presented under conceptual categories such as general study information, research methodology and methods, study population and research aim, following which the findings will be presented thematically along with a discussion of the results (Peters et al., 2015).

Framework optional stage – Consultation exercise

Arksey & O'Malley (2005) propose an optional stage to their framework, a consultation exercise. Whilst they report that the stage is optional, they also suggest that there are benefits to performing this stage, indicating that the work can be enhanced and improved when practitioners are permitted to contribute to the review. However, given that this scoping review was conducted for an academic piece of research, and given the time and funding restraints, the final optional stage was not included.

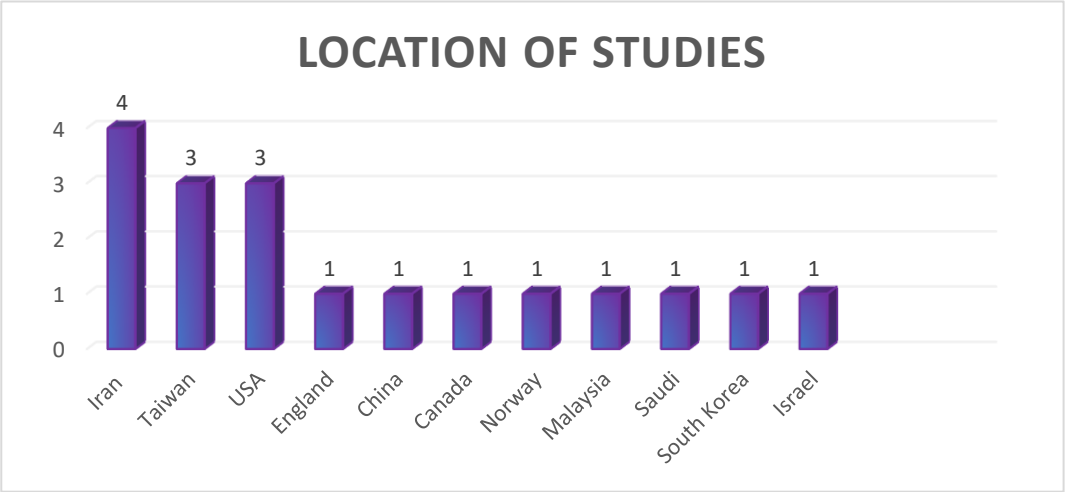
Results

A total of 18 studies were identified and included within the review based upon the search question and the inclusion and exclusion criteria. All studies were reviewed, and data extracted as per the criteria in the charting table (appendix 1).

Overview of the studies

In reviewing the studies by location, it was identified that of the 18 studies included within the review, only one study was conducted in England (Haw, Stubbs & Dickens, 2014). This was surprising, as the nursing workforce account for the largest professional group of staff within the NHS (NHS Digital, 2018). Despite the National Reporting and Learning System (NRLS) being established in England in 2003 to support incident reporting, only one study was identified which specifically explored the registered nurses' experience of incident reporting (Haw et al., 2014). The remainder of the studies were conducted internationally with the highest number of studies being conducted in Iran (n=4) and Taiwan (n=3). It is reported that there is a high incidence of medical errors in Iranian hospitals (Chegini, Kakeman, Jafarabadi & Janati, 2020), particularly in Iranian Accident and Emergency departments (Vazin, Zamani & Hatam, 2014) which may explain the higher number of research studies being carried out to try and understand incident reporting with a view to improving practice and learning from errors. Also, in Taiwan, whilst the reporting of medical errors is not mandatory (Chen et al., 2018), the Taiwan Joint Commission on Hospital Accreditation (TJCHA) report that less than half of all errors are reported (TJCHA, 2009). As Taiwan moves towards a system of mandatory reporting of incidents (Chen et al., 2018), it is possible that a national acknowledgement of the under-reporting has led to measures to increase incident reporting, leading to research being conducted to explore how to facilitate this. See figure 2 for the full breakdown of the studies by location.

Figure 2 – Location of studies



Of the 18 studies, 14 were conducted in the hospital setting and 4 studies were conducted in the nursing home environment (Farag, Vogeismeier, Knox, Perkhounkova & Burrant, 2020; Prang & Jelsness-Jorgensen, 2014; Wagner et al., 2012; Wagner et al., 2013).

Despite nurses accounting for the largest professional clinical group of staff employed within the NHS (NHS Digital, 2018), the small number of studies identified suggests that there is a gap in relation to the study of registered nurses' experience of incident reporting. In particular, the small number of studies conducted in the nursing home environment has identified that there is a significant research gap specifically relating to the registered nurses' experience of incident reporting in the nursing home sector. This finding is supported by Prang & Jelsness-Jorgensen (2014, p.442) who highlighted that there is a "paucity of studies" which had explored the barriers to incident reporting in the nursing home sector. Identification of the paucity of studies that explore incident reporting in the nursing home sector demonstrates the value of conducting the scoping review – that being to identify any gaps in the literature as per Arksey & O'Malley's (2005) scoping review criteria, which also provides justification for conducting the research study.

Research methodology and methods

The scoping review revealed that most of the studies undertaken were quantitative (n=15), with only three studies adopting a qualitative methodology (Dyab, Elkalmi, Bux & Jamshed, 2018; Haw et al., 2014; Prang & Jeslness-Jorgensen, 2014). No rationale is provided for the chosen methodologies; however, it is possible that an initially quantitative focus was adopted due to quantitative data in relation to patient safety in clinical practice being available from audit and governance departments. Therefore, as quantitative data has evolved from clinical practice, this may have led to quantitative research to try and understand the data, before considering qualitative research to further explore participants' experiences of incidents. This highlights that not only is there limited research exploring the registered nurses' experience of incident reporting, but a significant gap in relation to qualitative research in the field of incident reporting, reaffirming the need for this study.

Surveys/questionnaires were the dominant data collection approach (n=14) in the quantitative studies with the qualitative studies using semi-structured interviews to

collate the data. One study conducted a retrospective review of completed incident reports.

Study population

The scoping review sought to identify studies which explored the registered nurses' experience of incident reporting was evident; therefore, it was essential that all participants included within the studies were registered nurses.

Research aims

The aims of the included studies can be divided into two broad areas; either barriers to reporting incidents, or factors which influence the reporting of incidents, with some of the studies exploring both barriers and facilitators to incident reporting. In addition, three of the studies examined the patient safety culture in the working environment to determine what impact this had on incident reporting. Finally, three studies also explored the characteristics of nurses such as age and length of time qualified, to determine if there was any correlation to reporting incidents. Notably, of the included studies, 11 of the studies focused specifically on the reporting of medication errors, rather than incident reporting in general. This will be explored later in the chapter in the discussion section.

Exploration of key themes

Although a combination of both quantitative and qualitative studies was included within the review, the data will be presented thematically in a narrative and descriptive format as recommended by Arksey & O'Malley's (2008) scoping studies framework. The thematic analysis of data can be defined as "a method for identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2008, p.79). Braun & Clarke (2008) developed a five-stage process to support the thematic analysis of data, the five stages being: familiarising yourself with the data, generating initial codes, searching for themes, reviewing the themes, and defining and naming the themes. Although this model is generally used for the thematic analysis of primary data, the model has been used previously to support the thematic analysis of data in scoping reviews (Jesus et al., 2016). Arksey & O'Malley (2008) do not advocate a specific

methodological approach for conducting the thematic analysis, however, to ensure a robust approach to the analysis Braun & Clarke's model will be used to support the process.

Generating the themes is often considered to be the most difficult stage of the process as this depends upon the interpretation and insights of the reviewer (Thomas & Harden, 2008). After reviewing the data, initial codes were determined. A code can be described as a "label for a feature that is relevant to the study" (Braun & Clarke, 2013, p.61). For example, fear and criticism were used as initial codes as a number of the studies highlighted that participants were reluctant to report incidents due to the risk of disciplinary action, their managers' response and even the response of colleagues. Following which themes were then constructed.

A theme can be described as representing important information in relation to the search question which also reflects some degree of pattern within the data (Braun & Clarke, 2006). An inductive approach to thematic analysis was used in that there were no pre-determined themes, instead themes were constructed by the process of reviewing and familiarising oneself with the data and the initial codes as they were generated. For example, psychological safety was one of the first themes constructed which encompassed the initial codes of fear, criticism, and embarrassment. The thematic analysis was an iterative process where the data, codes and sub-themes were reviewed to determine the most appropriate theme. As other themes began to be constructed, such as leadership and openness, it was then considered that these three themes would be more appropriate as subthemes under the overarching theme of patient safety culture. These three themes collectively constitute key elements of a patient safety culture (NHS Improvement, 2019b) so it was considered appropriate to classify these as subthemes under the main theme of patient safety culture. Table 4 provides an overview of the constructed themes from the scoping review.

Table 4 – Themes from the scoping review

Theme	Subtheme	Studies
Patient Safety Culture	1. Psychological safety	Boyazidi et al (2012); Chegini et al. (2020); Chen et al. (2018); Dyab et al. (2018); Farag et al. (2020); Hammoudi, Ismail & Yahya, (2018); Haw et al. (2014); Hong & Li (2017); Hung, Lee, Liang & Chu, (2016); Lee, (2017); Mansouri et al. (2020); Mostafaei et al. (2014); Prang & Jelsness-Jorgensen (2014); Rutledge, Retrosi, & Ostrowski (2018);

		Wagner et al. (2012); Wagner et al. (2013); Yung et al. (2016).
	2. Good leadership	Chegini et al. (2020); Farag et al. (2020); Hammoudi et al. (2018); Hong & Li (2017); Hung et al. (2016); Lee (2017); Mansouri et al. (2020); Mostafaei et al. (2014); Prang & Jelsness-Jorgensen (2014); Wagner et al. (2012); Yung et al. (2016).
	3. Openness and support for learning	Chegini et al. (2020); Farag et al. (2020); Lee (2017); Prang & Jelsness-Jorgensen (2014); Rutledge et al. (2018); Wagner et al. (2013).
Procedural	1. Unclear guidelines/processes	Haw et al. (2014); Hong & Li (2017); Prang & Jelsness-Jorgensen (2014); Rutledge et al. (2018); Wagner et al. (2013); Yung et al. (2016).
	2. Lack of knowledge	Chen et al. (2018), Hammoudi et al. (2018), Haw et al. (2014), Hong & Li (2017), Lee (2017), Mostafaei et al. (2014), Rutledge et al. (2018), Wagner et al. (2012), Wagner et al. (2013), Yung et al. (2016).
	3. Reporting process	Chen et al. (2018); Farag et al. (2020); Hong & Li (2017); Mostafaei et al. (2014), Prang & Jelsness-Jorgensen (2014); Rutledge et al. (2018); Wagner et al. (2013) Yung et al. (2016).
Time	(No subthemes)	Boyazidi et al. (2012); Chen et al. (2018); Dyab et al. (2018); Hammoudi et al. (2018); Haw et al. (2014); Hong & Li (2017); Lee (2017); Prang & Jelsness-Jorgensen (2014); Rutledge et al. (2018); Wagner et al. (2013); Yung et al. (2016).
Level of harm	(No subthemes)	Boyazidi et al. (2012); Dyab et al. (2018); Haw et al. (2014); Hammoudi et al. (2018); Lee, (2017); Mostafaei et al. (2014); Rutledge et al. (2018); Yung et al. (2016).
Confidentiality	(No subthemes)	Boyazidi et al. (2012); Dyab et al. (2018); Hung et al. (2016); Rutledge et al. (2018); Yung et al. (2016).
Nurse characteristics	(No subthemes)	Chegini et al. (2020); Chen et al. (2018); Prang & Jelsness-Jorgensen (2014); Shmueli et al. (2014); Wagner et al. (2012).

Patient Safety Culture

Patient safety culture was constructed as a key theme. Three additional subthemes were categorised under patient safety culture, these being: psychological safety, leadership and openness and support for learning

Psychological Safety

From the scoping review it was identified that factors that fall under patient safety culture were most commonly reported as barriers to reporting incidents. Fear was reported as the main barrier to incident reporting in many of the studies with different elements of fear being identified. For example, fear of disciplinary action and being blamed if an incident occurred were ranked as a key barrier (Boyazidi et al., 2012; Chegini et al., 2020; Chen et al., 2018; Dyab et al. 2018; Farag et al., 2020; Hammoudi, et al., 2018; Haw et al., 2014; Lee, 2017; Mansouri et al., 2020; Mostafaei et al., 2014; Prang & Jelsness-Jorgensen, 2014; Rutledge et al. (2018); Wagner et al., 2012; Wagner et al., 2013; Yung et al., 2016). Several studies also identified that participants reported concerns associated with being criticised by colleagues, feeling inadequate or embarrassed if they made a mistake and losing the respect of their colleagues along with fear of being blamed by colleagues (Boyazidi et al., 2012; Chegini et al., 2020; Chen et al., 2018; Dyab et al., 2018; Hammoudi et al., 2018; Lee, 2017; Mansouri et al., 2020; Wagner et al., 2013). Dyab et al. (2018) highlighted that if the blame culture was removed then reporting incidents would improve. Prang & Jelsness-Jorgenson (2014) also identified that if a participant had experienced a previous adverse response to reporting an incident, then they would be less likely to report subsequent errors. Hung et al. (2016) identified that participants with a positive attitude towards incident reporting were more likely to report, although no explanation was offered as to how participants developed a positive attitude.

Leadership

Compassionate leadership is another essential element of a positive patient safety culture and key for reporting incidents. Numerous studies identified that staff were more likely to report incidents if they worked in an environment with strong and supportive leadership (Boyazidi et al., 2012; Chegini et al., 2020; Farag et al., 2020; Hammoudi, et al., 2018; Hung et al., 2016; Lee, 2018; Mansouri et al., 2020; Mostafaei et al., 2014; Yung et al., 2016). They identified that participants were less likely to report incidents if managers apportioned individual blame rather than looking at the

whole system. Staff who didn't feel supported were less likely to report incidents (Prang & Jelsness-Jorgensen, 2014) and Wagner et al. (2012) also reported that only 38% of participants reported that they were provided with adequate support after reporting an incident, suggesting that the nursing homes where they worked failed to acknowledge the stress that staff experienced when reporting an incident.

Openness and Support for Learning

Multiple studies identified that participants were less likely to report an incident if there was limited follow up and learning post-incident (Chegini et al., 2020; Lee, 2018; Rutledge et al., 2018; Wagner et al., 2012). Farag et al. (2020) identified that participants were more likely to report an incident if they received feedback from an incident and felt that there was learning from the event. Lack of follow up and learning post incident could lead to participants believing that incident reporting was a waste of time and result in them being less likely to report.

Procedural

Procedural issues were identified as another theme with a few subthemes; unclear guidelines/processes, a lack of knowledge and the reporting process.

Unclear guidelines/processes

Rutledge et al. (2018) and Yung et al. (2016) reported that a lack of clarity in relation to who was responsible for reporting an incident resulted in incidents often being unreported. Being unclear about what and when to report was identified as an issue by Haw et al. (2014); Hong & Li (2017); Lee (2018); and Prang & Jelsness-Jorgensen (2014) with participants reporting that the systems are not clearly established. Wagner et al. (2013) also identified that reporting could be improved if there was more guidance and education on how to report.

Lack of knowledge

Linked to the previous subtheme is a lack of knowledge in relation to incident reporting. A few studies identified a lack of knowledge as a reason why incidents may not be reported (Chen et al., 2018; Wagner et al., 2012; Wagner et al., 2013). Chen et al. (2018) and Hong & Li (2017) identified that participants had a limited experience of incidents and that education in the area could serve to increase the recognition of incidents which may subsequently improve reporting. Furthermore, confusion as to

what constituted an incident was reported by several participants (Hammoudi et al., 2018; Haw et al., 2014; Mostafaei et al., 2014; Rutledge et al., 2018; Yung et al., 2016). Wagner et al. (2013) reported that there was a general lack of knowledge about incident reporting which prevented incidents being reported, whilst Wagner et al. (2012) also concluded that more education would raise awareness about what constituted an incident and therefore encourage incident reporting.

Reporting process

Farag et al. (2020) and Yung et al. (2016) identified that participants were more likely to report an incident if they were familiar with the reporting process. Chen et al. (2018) and Hong & Li (2017) identified that incident reporting systems are often too complex and time consuming and that to simplify the process would help to encourage incident reporting. Some participants reported that electronic systems had made the process of reporting incidents more difficult, stating that the previous paper systems were much easier to use (Prang & Jelsness-Jorgensen, 2014), however Rutledge et al. (2018) identified that often the paper forms were not readily available which resulted in incidents going unreported. Wagner et al. (2012) identified that whilst most of their participants (94%) agreed that reporting incidents is key to improving the quality of care within the home, less than half (49%) felt that the current reporting system within the nursing home was adequate. However, lack of an adequate reporting system was ranked as the least important barrier in relation to incident reporting in their study.

Time

A lack of time was reported in several studies as to why incidents may not be reported. Chen et al. (2018) and Prang & Jelsness-Jorgenson (2014) identified that nurses already have a heavy workload and that completing an incident report placed additional pressures on an already demanding workload. Dyab et al. (2018) identified that the time taken to undertake an investigation post incident deters nurses from reporting. It was also identified that incident reporting forms can be time consuming to complete and posed as a further barrier (Boyazidi et al., 2012; Hammoudi et al., 2018; Haw et al., 2014; Hong & Li, 2017; Lee, 2018; Rutledge et al., 2018; Wagner et al., 2013; Yung et al., 2016).

Level of harm

A number of studies (Boyazidi et al., 2012; Dyab et al., 2018; Hammoudi et al., 2018; Haw et al., 2014; Lee, 2017; Mostafaei et al. 2014; Rutledge et al., 2018; Yung et al., 2016), identified that the reporting of incidents depended upon the level of harm to the patient. If the patient suffered no harm as a result of the incident, then the incident would often go unreported with participants failing to see the benefit of reporting. This theme could link to the “lack of knowledge” sub-theme as if participants were clear about what constituted an error, then the level of harm would be irrelevant to the decision as to whether to report.

Confidentiality

Most reporting systems required the reporter to provide details such as their name, however participants in a number of studies reported that they would be more likely to report incidents if they could do so anonymously (Boyazidi et al., 2012; Dyab et al., 2018; Hung et al., 2016; Rutledge et al., 2018; Yung et al., 2016). This theme links to the sub theme of psychological safety, under the theme patient safety culture, as if participants felt safe to report then they may feel confident to provide their name.

Characteristics of the Nursing Staff

A number of the studies included within the scoping review explored the characteristics of the nursing staff to determine which nursing staff were more likely to report incidents. Chegini et al. (2020) identified that nurses with higher qualifications such as Bachelor or Master’s degree, were less likely to report than nurses with an Associate’s degree (a lesser course of 1-2 years) although no rationale was provided for this finding. However, this finding was in direct contrast to other studies who identified that nurses with higher levels of qualifications were more likely to report incidents (Chen et al., 2018; Shmueli et al., 2014; Wagner et al., 2012). Chen et al. (2018) further identified that more experienced nurses and nurses in senior roles were more likely to report incidents and attributed this to being more likely to identify that an incident had occurred. In addition, nurses in senior roles were more likely to have a greater understanding of organisational systems and be considered a role model, therefore expected to take a lead in areas such as incident reporting (Chen et al., 2018).

Shmueli et al. (2014) and Wagner et al. (2012) also identified that significantly more incidents were reported by registered nurses than registered practical/licenced nurses (nurses who have undertaken a 1-2 year course as opposed to a 3 year course) and attribute this to the extensive professional training programme which registered nurses undertake. Hong & Li (2017) also suggested that experienced nurses were more likely to detect an error but did not identify if they were more likely to report an error than less experienced nurses.

Wagner et al. (2012) also identified that registered nurses are more likely to report an incident if they have had previous experience of incident reporting. Wagner et al. (2012) concluded that a registered nurse's personal experience of incident reporting and level of education were more important in relation to incident reporting than the organisational culture where they work.

Discussion

Patient Safety Culture was constructed as a key theme in relation to incident reporting with almost all studies identifying elements in this area. Recent guidance from NHS Improvement (NHSI, 2019b) states that the key features of an organisation who demonstrate a positive safety culture are "staff who feel psychologically safe; valuing and respecting diversity; a compelling vision; good leadership at all levels; a sense of teamwork; openness and support for learning".

Fear of punitive action, of being criticised by colleagues or feeing incompetent, was identified in many of the included studies. These findings suggest a lack of psychological safety within the workplace. Current guidance indicates that one of the key elements of a patient safety culture is that staff feel psychologically safe, which is where staff feel supported within the workplace by both managers and colleagues, believe that they will be treated fairly if things go wrong and have the confidence to raise concerns (NHSI, 2019b). It is also documented that a positive patient safety culture involves a non-punitive approach to incident reporting (Castle et al., 2010; Bonner et al., 2008).

For staff to report incidents, they need to feel supported in the workplace and believe that they will be treated fairly by their managers. Several of the studies identified that staff were more likely to report incidents where there was strong and supportive leadership. This is also acknowledged in national guidance which suggests that

compassionate leadership is key to facilitating psychological safety and a supportive working environment (NHSI, 2019b) which in turn will encourage the reporting of incidents. Furthermore, it is argued that leaders have an influential role in determining the culture within an organisation (NHSI, 2019b; White & Kettring, 2001). This is congruent with the findings of one of the studies which identified that only 38% of staff who reported an incident felt supported post incident (Wagner et al., 2012). Lack of support will inevitably affect the culture within a workplace and may lead to staff under-reporting incidents. Organisations with compassionate leadership demonstrate a positive safety culture which acknowledges and encourages the reporting of incidents. They are open to learning from errors rather than taking punitive actions against colleagues (NHSI, 2019b).

Linked to the patient safety culture theme, is the theme of confidentiality. Several of the studies reported that participants would be more inclined to report incidents if they could do so anonymously. However, if the participants worked in an area with a positive patient safety culture it could be argued that participants would feel more confident to report and provide their details. Providing details is often required in case any additional information is required regarding the incidents, but also to provide feedback and learning to the reporter. If incidents are reported anonymously, it can prevent key information from being obtained to enable a comprehensive review of the incident.

The findings from the included studies do not reflect a positive patient safety culture and could be perceived as demonstrating a blame culture in relation to reporting incidents, with a lack of management support and learning from incidents, which is considered incongruous to an incident reporting culture (Castle et al., 2010).

However, a patient safety culture was only one of the themes constructed. Although it was the most reported theme, addressing the patient safety culture alone will not resolve the issues relating to incident reporting as a number of other logistical themes were identified such as procedural issues and time. Procedural issues such as unclear guidelines, a lack of knowledge in relation to what constitutes an incident and a poor reporting system were all cited as issues which could either deter participants from reporting incidents or if improved, could facilitate the reporting process.

A patient safety incident is defined by the National Reporting and Learning System (NRLS, n.d.) as “any unintended or unexpected incident which could have or did lead to harm for one of more patients receiving NHS care”. This suggests that a patient does not need to be harmed for an incident to have occurred, however level of harm

to the patient was identified as a theme, which could also link into the sub themes of unclear guidelines and lack of knowledge. If staff are unclear as to what needs to be reported, it could be perceived that only incidents which cause harm need to be reported. However, it is widely documented (NHSE & I, 2019; Pham, et al., 2013; Vrbnjak et al., 2016), that key learning occurs from near misses and that the learning from near misses should not be underestimated. Providing clarity about what types of incidents need to be reported, regardless of the level of harm, and a clear reporting process may help to improve incident reporting.

Time was also constructed as a theme which prevents incidents from being reported. A combination of time to complete the incident report and time to undertake the investigation were cited as barriers to reporting incidents. Participants reported often having to work additional hours with a heavy workload, and that the time taken to complete the incident reporting forms was too time consuming, often resulting in incidents not being reported.

Of the 18 studies included within the review, 11 studies focused specifically on factors affecting the reporting of medication errors. Medication errors are one of the most common types of incidents reported in the NHS today which can often lead to harm for patients. A recent study has identified that an estimated 237 million medication errors occur in the NHS in England every year (Elliott et al., 2018). In addition, a study conducted in the care home sector found that 7 out of 10 residents were exposed to at least one medication error (Alldred et al., 2008), indicating that nationally, significantly more than 237 million medication errors occur every year. Medication errors can have a significant effect on a patient's morbidity and mortality, as well as additional organisational costs (Mostafaei et al., 2014).

The fact that a high number of studies specific to medication error reporting were identified in the scoping review was therefore not surprising. However, despite a specific focus being on reporting medication errors, the themes identified from these studies were consistent with the themes identified in the studies which explored incident reporting in general, suggesting that it is not the type or error that is important, but the process of reporting and the nurses' experience of reporting that needs further exploration.

The final theme constructed was in relation to the characteristics of the nursing staff who participated in the studies, exploring factors such as length of time qualified, type of qualification, seniority, and experience. Five studies considered the characteristics

of the participants; however, the findings were contradictory. Whilst Chegini et al. (2020) found that participants with higher levels of qualifications were less likely to report, other studies found that the higher the level of qualification the more likely the participant was to report an incident (Chen et al., 2018; Shmueli et al., 2014; Wagner et al., 2012). Chen et al. (2018) and Wagner et al. (2012) also identified that having previous experience of incident reporting would result in the reporting of future incidents. However, this could be related to having a better understanding of the process rather than just prior experience as if a participant had suffered an adverse experience this could deter them from reporting incidents in the future.

The scoping review identified 18 studies exploring incident reporting in the wider healthcare context. Several themes were constructed which all require further exploration in clinical practice to promote incident reporting. Whilst some themes were reported more frequently, it is clear from reviewing the findings that several of the themes interlink and that no one theme can be considered in isolation. For example, whilst patent safety culture was reported in most of the studies, addressing the patient safety culture alone, will not resolve the logistical issues such as time and a poor reporting system (Rutledge et al., 2018), which were also identified as barriers to reporting. However, it is important to note that the scoping review failed to elicit any studies conducted in the United Kingdom which explore the registered nurses' experience of incident reporting in the nursing home sector, indicating a significant gap within the field and providing a clear justification for this research study.

Over the last two decades the quality and safety of healthcare has been afforded increased significance in relation to international health policy and research (Waring, Allen, Braithwaite & Sandall, 2016). The publication of "To Err is Human" (Kohn et al., 2000) and "Crossing the Quality Chasm" (Institute of Medicine, 2001) resulted in an increased focus on patient safety and learning from incidents. However, almost twenty years later patient safety incidents continue to occur, and under-reporting of incidents continues to present a significant problem (Mahajan, 2010).

Conclusion and defining the research question

Despite the increased focus on improving patient safety, of which incident reporting and learning from incidents is key, this scoping review has highlighted that there is limited research exploring the registered nurses' experience of incident reporting,

particularly in nursing homes in the UK. Prang & Jelsness-Jorgensen (2014, p.442) have previously highlighted that there is a “paucity of studies” exploring incident reporting in the nursing home sector. Six years on, this scoping review has highlighted that this continues to be an issue, with only one additional study being identified in this scoping review (Farag et al., 2020) specific to the nursing home sector. However, the study by Farag et al. (2020) focused specifically on the reporting of medication errors in nursing homes rather than incident reporting in general. The limited published research studies in relation to the registered nurses’ experience of incident reporting, particularly in nursing homes, indicates that this aspect of patient safety has not yet been translated into research in the nursing home sector. The purpose of this research is to address that gap, and to explore the registered nurses’ lived experience of incident reporting.

Understanding the registered nurses’ experience is essential to improve incident reporting in the nursing home sector to reduce patient harms. Using knowledge obtained from conducting the scoping review and prior knowledge obtained from working with the nursing home sector, the aims of the research study were determined; to understand incident reporting in the nursing home environment and to understand the registered nurses’ lived experiences of incidents and incident reporting. Consequently, the question this research study will seek to answer is:

What are the lived experiences of registered nurses working in nursing homes in relation to the identification and reporting of incidents?

Furthermore, the objectives have been defined as:

- to determine what registered nurses in nursing homes, understand by the term “incident” in relation to incident reporting
- to explore incident reporting systems and processes in nursing homes
- to explore any barriers and enablers to incident reporting in nursing homes
- to explore any examples where nursing homes have successfully embedded incident reporting in practice

Chapter Summary

The scoping review sought to obtain relevant literature to enable a broad understanding of the research that has been published relating to the registered nurses' lived experience of incident reporting in the nursing home sector, as well as the wider healthcare environment. The review highlighted that there are limited studies in relation to registered nurses' lived experience of incident reporting, particularly in the nursing home sector in the United Kingdom, but also internationally with only 18 studies being identified. Of significance, no studies were identified in the United Kingdom which explore the registered nurses' lived experience of incident reporting in the nursing home sector, indicating a substantial gap within the field. Six key themes were identified which prevented nurses from reporting incidents, and conversely a number of factors which may also serve to facilitate and encourage incident reporting. However, no studies were identified which sought to explore the registered nurses' lived experience of incident reporting, highlighting a significant gap in the research field. Understanding the registered nurses' experience is essential to improve incident reporting in the nursing home sector to reduce patient harms, this being the focus of this study.

The next chapter will explore the theoretical assumptions of ontology and epistemology which will underpin the research paradigm along with a discussion about the research methodology selected to guide the study. My personal location in relation to the study will also be considered.

Chapter 3

Methodology

Introduction

The following chapter will discuss the philosophical assumptions of ontology and epistemology which underpin the research paradigm of this study. The research methodology chosen to undertake the research study will be explored, along with a rationale for choice. To provide a balanced discussion some criticisms of the approach will also be discussed. My personal location in relation to the study, to understand how my experiences may influence the research, will also be discussed.

Philosophical assumptions

Creswell & Poth (2018) claim that in the conceptualisation of a research study, researchers need to identify the philosophical assumptions, including ontology, epistemology, and methodology, along with their own personal beliefs which will then guide and structure the research study. These assumptions collectively are referred to as a paradigm which Guba (1990, p.17) defines as “a basic set of beliefs that guides action.” These philosophical assumptions will be explored below, before considering the overarching research paradigm and the methods that will be used to support the study.

Ontology

Ontology is described as the study of being (Crotty, 2003) and is concerned with how reality is constituted. Ontology explores whether reality exists regardless of social influence or whether reality is constructed dependent upon people’s perception and experiences. Braun & Clarke (2013) suggest that there are many variations of ontology that can be described as sitting along a continuum. At one end of the continuum, there is an approach referred to as realism where reality is viewed as being independent of human perceptions, to the other end of the continuum, referred to as relativism, where reality is dependent upon human construction and interpretation. Realism is often associated with quantitative research, with relativism being associated with qualitative research.

Relativism is a philosophical term whereby multiple realities exist. Relativists believe that the world is created by the human mind and that there is no absolute truth (Holloway, 2008). In relativism, reality is subjective and will differ from one person to the next. All concepts are considered valid and are based upon the relative ideas and assumptions of the individual who proposed it. The concepts are often based upon social contexts, assumptions, and experiences. In relation to this research, as the aim is to explore the registered nurses' lived experience of incident reporting, it is probable that multiple different realities will be elicited, therefore a relativist position will be adopted, where the concepts proposed will be the individual registered nurses' experiences of incident reporting. The concepts will seek to expose the unique essence of the experience, as reported by the research participants, based upon their own personal and social experiences drawn upon to construct their beliefs and theories.

Having considered the ontology there also need to consideration of the epistemology as Crotty (1998, p.10.) claims that ontology and epistemology often "emerge together" suggesting that they are interlinked and entwined when considering a research approach.

Epistemology

Epistemology refers to the nature of knowledge, looking at both the origins and nature of knowledge (Creswell & Poth, 2018; Holloway, 2008). Epistemology explores what we know and how we obtain knowledge, for example knowledge can either be discovered or created. Crotty (2003) suggests that there are three main approaches to epistemology: objectivism, constructionism, and subjectivism. Objectivism holds the belief that reality exists regardless of any type of conscious thought. In constructionism reality does not simply exist to be discovered but is instead constructed, accepting that different realities about the same phenomenon might be constructed by different people. Finally, in subjectivism meaning is present without any interaction or relationship between the subject and the object.

Of the three main epistemologies described by Crotty (2003), constructionism is the epistemology generally adopted by qualitative researchers (Crotty, 2003) and will be used to underpin this study. However, it must be noted that the terms social constructionism and constructivism are often used interchangeably in texts (Franklin,

1995), and whilst there are similarities, there are also specific distinctions which set the two approaches apart. Both approaches highlight the need for human agency, which describes how people think and act to shape their experiences, and both also believe that reality is socially constructed. In addition, both necessitate the need for human interaction and a relationship between the individual and their social environment (Rodwell, 1998). However, the main difference between social constructionism and constructivism is in relation to how reality is constructed, this is where the two theories diverge. In social constructionism, language and cultural systems are key factors in determining and constructing reality, whereas, in constructivism reality is constructed with the use of cognitive structures. Rodwell (1998) has produced a table which highlights the differences between constructivism and constructionism and can be seen in table 5.

In table 5, I have highlighted in ***bold italic*** the elements which I believe are aligned to this study, for example participants' experiences will be elicited through conversations and will be constructed based upon the participants' experiences. It will be acknowledged that participants' experiences will be socially constructed and may change in different situations.

Whilst some of the elements sit under constructivism, most sit under constructionism reflecting the overlap between the two terms and possibly indicating why the two terms are used interchangeably in texts. Although some of the elements sit under constructivism, they are not exclusive to the constructivist approach, instead they relate to qualitative research. Therefore, for the purpose of this research, social constructionism will be used as this approach is more aligned to the aims and objectives of the study.

Social constructionism has its origins in sociology and is concerned with the nature of reality (Walker, 2015) and how people apply meaning to life experiences. Social constructionism seeks to understand what events mean to individuals and how individuals construct meaning of a phenomenon (Creswell & Plano Clark, 2007). In addition, social phenomena are not constant, but will continually evolve dependent upon individual experiences and social interactions.

Table 5 - Constructivism versus Constructionism (Rodwell, 1998).

Constructivism	Constructionism
Nature of knowledge	
Cognitive schemas	***Linguistic negotiation (conversation)***
A construction of the subject's experience and action	Generated between individuals who judge and correct
An invention of new interpretive frameworks or structures	Agreement regarding meaning
Evolutionary to more comprehensive interpretations	Product of claims-making, labelling and other constitutive definitional processes
Human Beings	
Proactive, goal directed, and purposive organism	***Personality and identity socially constructed and potentially changing from situation to situation***
Human Interaction	
Structured coupling – fitting together structures and coordinating behaviours of self-organised systems	***Linguistic coupling – negotiating meaning across cognitive, social, and moral structures***
Processes relevant to Constructivist Research	
Schemas for analysis	***Discourse analysis stories***
Purposeful questioning	***Problems understood within the social network or context***
Managing paradox	***Circular questioning and emergent processes***
Experiential data collection	***Narrative reconstructions***
Restructuring of cognitive meaning	***Opening spaces for conversation***
Conceptual frameworks	
Hearing multiple voices	

Crotty (2003) states that in social constructionism meaning is created through interaction with the world and that different people may construct multiple different meanings and descriptions of the same phenomenon, dependent upon their individual

experiences. In essence, “different ways of understanding the world co-exist in parallel” (Burr, 2015, p.223). With social constructionism no one single truth exists, it is not about seeking a generalised understanding of a given phenomenon; instead, a unique and personal application of meaning and understanding.

In relation to the study, the aim is to explore the registered nurses’ lived experience of incident reporting; by adopting the principles of social constructionism it is expected that multiple different experiences will be reported by participants about the same phenomena. All participants in the study will be registered nurses, registered with the Nursing & Midwifery Council [NMC], the statutory body for registered nurses in the United Kingdom. As such, all participants will be bound by the same code of practice (NMC, 2018), however, work environments, experiences and relationships will vary. It is anticipated that through engaging with participants, to explore their individual experiences of incident reporting, multiple differing interpretations and socially constructed beliefs will be proposed based upon their own personal unique and social experiences.

Having considered the ontological and epistemological position, this study will adopt the relativist ontology along with a social constructionism epistemology. This ontology and this epistemology clearly align with the interpretivist paradigm of the study.

Research Paradigm

A research paradigm is “a basic set of beliefs that guides action”, (Guba, 1990, p.17). They are constructed of philosophical assumptions, which link to specific paradigms and reflect the views of the researcher. Scotland (2012) suggests that a paradigm consists of its own ontological and epistemological assumptions which in turn influence the methodology and research methods.

In considering a paradigm, along with the ontological and epistemological assumptions, those being relativism and social constructionism, there needs to be consideration of the aims and objectives of the study. The study aims to explore the lived experiences of registered nurses working in nursing homes in relation to the identification and reporting of incidents. A scoping review identified that whilst quantitative studies have been conducted to examine incident reporting in nursing homes (Shmueli et al., 2014; Wagner et al., 2013), the purpose of the studies was not to explore the lived experience of nurses in relation to incident reporting and therefore

did not provide any insight into what this meant for the nurses involved in the study. To enable the lived experience to be explored, an appropriate investigation needed to be conducted which not only explored the lived experiences of nurses but sought to understand and interpret the meaning of the individual experiences. To achieve the aims of the study, an in-depth exploration and interpretation of the phenomenon in question, an interpretative paradigm was adopted. The philosophical approaches of relativism and social constructionism are closely aligned to the interpretivist paradigm (Scotland, 2012, Denzin & Lincoln, 2018).

The interpretivist paradigm is an approach in social science concerned with human beings and the unique way in which they make sense of their surroundings and experiences (Holloway, 2008). Interpretivists believe that the world we live in is continually being constructed and interpreted by human beings, and that to understand human behaviour it must be considered within the context in which it takes place. Interpretivism is subjective and is concerned with individual experiences and how meaning is co-constructed by the participant and the researcher (Scotland, 2012), furthermore the meanings constructed are not fixed, but continue to evolve.

Denzin & Lincoln (2018) have argued that in the last decade the boundaries between the differing paradigms have begun to blur. Lincoln, Lynham & Guba (2018, p.108) talk about “paradigmatic controversies, contradictions, and emerging confluences” to describe how paradigms are no longer clearly delineated, instead elements of the differing paradigms are described as starting to “interbreed” and evince confluence. Therefore, although Scotland (2012) suggests that paradigms consist of their own philosophical assumptions, the recognised contradictions and emerging confluence means that the paradigms are not as clearly differentiated as previously considered. Scotland (2012) further claims that philosophical assumptions are simply conjecture, opinion, meaning that the underpinnings beliefs that shape each paradigm can never actually be proven.

Having identified the paradigm, which was used to guide the study, the research methodology also needed to be considered along with how this aligned with the aims and objectives of the study.

Methodology

A methodology is an approach adopted to generate the knowledge required to answer a research question. Creswell (2009a) claims that when determining a research design, a key consideration should be in relation to what the actual research problem is. Creswell (2009b) defines a research problem as an issue that needs to be explored. He further suggests that when the research problem relates to a phenomenon that needs to be understood, then a qualitative methodology is the most appropriate due to the exploratory nature of qualitative research. Noble & Smith (2014) describe qualitative research as an approach to understanding the meaning within a situation, which can be either interpretative or explanatory, as well as exploring how people feel about a situation to enable practitioners to develop their practice (Lee, 2006; Ryan, Coughlan & Cronin, 2007). In this study, the aim is to explore and understand the registered nurses' lived experience of incident reporting in nursing homes and will therefore require a qualitative methodology to enable the experience to be explored.

The methodology chosen should also be guided by the ontological and epistemological views of the researcher and the research aims and objectives. For example, as previously discussed, relativism is the ontological approach which was used to underpin the study and is an approach associated with qualitative research (Braun & Clarke, 2013). Creswell & Poth (2018) identify five main qualitative approaches, all five approaches were considered in detail to ensure the most appropriate methodology was selected. A summary of the five approaches can be seen in table 6.

Having reviewed and considered the different approaches to qualitative research, the qualitative methodology selected to conduct the study sits within the phenomenological domain. The goal of phenomenological research is not to seek a consensus opinion, or to develop a theory (Balls, 2009), but to accurately describe in depth an individual's lived experience of the phenomenon being studied.

Phenomenology is often considered to be a philosophical movement, indicating that the seminal concepts have remained unchanged, but have been developed further or diversified by successive scholars (Lopez & Wills, 2004) and has evolved considerably since its inception (Patton, 2019). Phenomenology is a key tenet of Interpretative Phenomenological Analysis (IPA), a relatively new research approach, first proposed by Smith in 1996 and is an approach closely aligned with nursing research (Patton, 2019).

Table 6– Approaches to qualitative research.

Approach	Description	References
Narrative Research	The focus is on exploring an individual's life, collecting stories told by research participants about their experiences. This approach explores how participants make sense of what happened, through narratives, as stories that are being told often have a purpose to them.	Braun & Clarke (2013); Bryman (2016); Creswell & Poth (2018).
Phenomenological Research	A philosophical and a methodological approach. The focus is on understanding the essence of an experience, which aims to identify the meaning of the lived experiences of research participants. Phenomenology is about understanding the experience from the individual's perspective.	Creswell & Poth (2018); Crotty (2003); Denzin & Lincoln (2018).
Grounded Theory Research	The purpose is to progress from understanding and description to the discovery or generation of a theory. Grounded theory adopts a systematic approach to synthesise data resulting in a new theory. Often involves larger numbers of participants where the data is systematically reviewed, patterns observed, enabling theories to emerge	Charmaz (2003); Creswell & Poth (2018); Crotty (2003); Holloway (2008).
Ethnographic Research	Is an approach to explore the cultures, subcultures, or social groups within their natural setting. Ethnography uses a fieldwork approach which takes place in the natural setting. Through participant observation the researcher seeks to immerse themselves in the day to day lives of the participants to observe behaviours and listen to what is said, to develop an understanding of the behaviours, language, and culture within the group.	Bryman (2016); Creswell & Poth (2018); Denzin & Lincoln (2018); Holloway (2008); Parahoo (2014).
Case Study Research	The in-depth study, often over a prolonged period of time, of an individual case, a particular event, or process within a real-life setting. Case study research aims to explore the complexities of a particular issue and to explore a particular phenomenon within its natural context.	Bryman (2016); Creswell (2009b); Creswell & Poth (2018); Denzin & Lincoln (2018).

Smith (1996) claims that IPA is "concerned with the detailed examination of human lived experience, the meaning of experience to participants and how participants make sense of that experience" (Smith, 2011, p.9). IPA differs from other qualitative methodologies in that the participants experience is interpreted by both the participant and the researcher to achieve a deeper understanding of the phenomenon being investigated. IPA was chosen as the research methodology to conduct this study and will be explored in more detail below.

Interpretative Phenomenological Analysis (IPA)

The approach adopted to undertake this research study was Interpretative Phenomenological Analysis (IPA), as the aim was to elicit a rich and deep description of the phenomena as it is experienced and interpreted by the participants (Jaromahum & Fowler, 2010). IPA is a phenomenological approach which seeks to both understand and interpret the participant's experience, acknowledging the unique contribution of each participant's experiences (Tuohy, Cooney, Dowling, Murphy & Sixmith, 2013) and differs from pure phenomenology in that IPA has a strong focus on the hermeneutic interpretation of the data. Although previous studies have been conducted to explore incident reporting in the nursing home sector, no studies have sought to explore the lived experience of the nurses who work in the sector, resulting in a gap in the knowledge base. Smith (1996) suggests that IPA studies can be used to enrich the data in an area which may have only been studied using quantitative research methods, which may in turn enable this existing theory gap to be addressed.

Whilst the origins of IPA research are rooted in mainstream psychology, other disciplines such as health and social care have started to realise the benefits and the application of IPA as a research approach due to its qualitative and interpretative nature (Finlay, 2011; Patton, 2019; Smith, 2009). Although a relatively new approach, IPA is described as a "dominant qualitative research methodology" (Tuffour, 2017, p.1). In a literature review conducted by Smith (2011) he identified an upward trend in the number of IPA studies being conducted, particularly in the field of health (Smith, 2011), from one study (his own) in 1996 to approximately 70 studies in 2008.

IPA includes elements of both Husserl's and Heidegger's beliefs of phenomenology (Patton, 2019) and is an approach to qualitative research which is constructed of three key areas of philosophy: phenomenology, hermeneutics and idiography.

Phenomenology

Phenomenology, developed by Husserl in the early 1900s, started as a philosophical movement which focused on the nature of experience from the perspective of the individual experiencing the phenomena (Connelly, 2010). Phenomenology as a philosophical approach seeks to study experience by focusing on an individual's conscious experience (Langdridge, 2007), such as their emotions and perceptions;

and considers humans to be embodied beings, meaning that life experiences are realised through their physical bodies (Connelly, 2010).

Husserl's focus was on achieving a pure description of the phenomenon as it was experienced in the consciousness of an individual; he described this as a lived experience. He believed when the mind becomes conscious of something, it reaches out to that something to explore it further and he uses the term intentionality to describe this process (Crotty, 2003). Husserl claimed that an individual's lived experience was not easily accessible as many life events are taken for granted (Koch, 1995). To be phenomenological, through intentionality, an individual needed to be able to focus on the taken for granted elements of the experience rather than focusing on the actual activity, to be able to elicit the raw essence of the lived experience. Husserl considered phenomenology to be a way of reaching the true meaning of an experience by delving deep into the reality of an individual's lived experience (Sloan & Bowe, 2014).

As well as a philosophy, phenomenology is also a research method used predominantly in psychology, education, and health (Balls, 2009; Connelly, 2010). In relation to research, the goal of phenomenological research is not to generate a theory or develop a new model but to accurately describe a person's lived experience of the phenomena being studied (Balls, 2010). Phenomenological inquiry begins by exploring the meaning or nature of a particular phenomenon. It then seeks to investigate the phenomenon from the perspective of the individual who encountered it. The findings of a phenomenological study are usually a collection of interpretations of meanings for individuals of their lived experiences of the phenomena (Cresswell & Plano Clark, 2007), with the interpretations often appearing as written phrases or statements offered by the individual to describe their experience (Smith et al., 2009).

Phenomenology has been used to conduct nursing research for many years (Koch, 1995; Balls, 2009; Flood, 2010). Nursing adopts a holistic approach to care and values the individuality of each patient and their own experiences. Similarly, phenomenology considers the person as a whole whilst acknowledging their individual values and beliefs (Balls, 2009; Reiners, 2012). Oiler (1982) suggests that phenomenology as a research methodology is appropriate in nursing practice as it is the nurses' reverence for patients' experiences which aligns nursing with phenomenology. Furthermore, some of the key skills required in nursing; observation, interpersonal skills, empathy, and interviewing are also the key skills required by a phenomenological researcher (Koch, 1995). In relation to nursing research, phenomenology is used to investigate

experiences, to elicit the hidden meaning so that the new knowledge acquired can be used to improve practice and care (Matua & Van Der Wal, 2015).

Although phenomenology is a key element of IPA, when considering phenomenology as a research approach, it is believed that there are two main approaches to phenomenological investigation: descriptive phenomenology, and interpretative phenomenology (Balls, 2009; Connelly 2010; Flood, 2010; Patton, 2019; Wojnar & Swanson, 2007). Whilst both approaches stemmed from Husserlian phenomenology (Sloan & Bowe, 2014), there are distinct differences between the two approaches, mainly in how the findings are generated. The two types will be explored below in more detail.

Descriptive Phenomenology

Husserl is considered to be the founder of phenomenology as a philosophy and also of the descriptive approach to inquiry (Wojnar & Swanson, 2007). Descriptive phenomenology, sometimes also referred to as transcendental or eidetic, is an approach whereby the researcher seeks to explore and describe the meaning of a lived experience, as it was experienced by an individual. Husserl believed that phenomenology involves examining human experience and that it is concerned with "an individual's personal perception or account of an object or an event (Smith, 1996, p. 263). Husserl was keen to find an approach which highlighted how an individual came to understand their own experience of a given phenomenon, which elicited the key elements, or the essence of the experience. He believed that individuals needed to step outside of the everyday experience, which Husserl described as our natural attitude, to allow us to explore the experience in greater detail. Husserl's aim was to reveal the content of the conscious experience, to elicit what lies at the very core of the subjective experience – the essence of the experience. Husserl did not believe that experiences were affected by external factors such as society and culture, instead he proposed that the essence of an experience would transcend individual circumstances and illuminate the essence of a particular experience for others too (Smith et al., 2009).

In descriptive phenomenology, through discussion, attentive listening and careful questioning, the researcher seeks to create a new description of the essence of the lived experience, as described by the individual, but in more detail than was previously known (Koch, 1995). To achieve this, Husserl introduced the concept of transcendental subjectivity, where the researcher is able to set aside their own experiences and pre-conceptions, to enable them to focus on the pure essence of the lived experiences of

those being studied (Wojnar & Swanson, 2007). Husserl discusses the use of bracketing, whereby the researcher is able to bracket off all existing knowledge and experiences about a phenomenon so as not to bias or influence their understanding of the phenomenon as it is relayed by the individual. Husserl believed that by bracketing knowledge and experience that he was not denying their existence, instead temporarily disconnecting from them, which then allowed the phenomenon to be considered with no preconceived ideas, allowing the essence of the phenomenon to be extracted in its purest form (Koch, 1995). Husserl believed that by using bracketing, phenomenology as a research method would be more rigorous and help to maintain objectivity (Lopez & Willis, 2004).

Although an acclaimed research approach, descriptive phenomenology is not without its criticisms. Todres (2005) believes that one of the key criticisms of descriptive phenomenology is that all descriptions are in fact interpretations, and that it is not possible to simply describe an experience as there will always be an element of interpretation that underpins a description. Furthermore, some may argue that it is not possible for the researcher to bracket their own experiences so as not to influence their understanding of the phenomenon as it is described by the participant. These are both elements which are linked to interpretative phenomenology which will be discussed below.

Interpretative Phenomenology

Heidegger, a student of Husserl, critiqued his work and went on to develop his own approach to phenomenology. Heidegger developed interpretive phenomenology, sometimes referred to as existential phenomenology, by including hermeneutics, the philosophy of interpretation (Wojnar & Swanson, 2007). Hermeneutic inquiry focuses on human experience as opposed to what a person consciously knows (Lopez & Willis, 2004). When considering human experience, hermeneutics searches for the meanings rooted within everyday experiences, rather than just considering the core concepts (Lopez & Willis, 2004) of the person's consciousness.

In interpretative inquiry, Heidegger's focus is on the understanding of being, and interpreting human experience, rather than simply focusing on the lived experience as it is presented. Heidegger uses the term pre-understanding (or fore conception) to explain how our culture and background experiences form a key element of our being in the world. He believed that individuals are influenced by their backgrounds and their different social, political, and cultural contexts. He suggested that individuals cannot

exist in isolation of these concepts (Smith, Flowers & Larkin, 2009) and stressed the importance of “the indissoluble unity between the person and the world” (Koch, 1995, p. 831). Heidegger introduced the concept of daesin (the way in which a human exists within the world), from the word sein ‘to be’ to highlight that human beings are unable to disengage from the various peripheral factors which influence their choices and help them to understand and interpret their experiences (Wojnar & Swanson, 2007).

This is a key difference between descriptive (Husserl) and interpretative (Heidegger) phenomenology. Husserl believed that the context and wider influencing factors were of little or no importance when seeking to understand a phenomenon, believing that individuals will share the same understanding of the essence of an experience. Whereas for Heidegger, context was a pivotal factor and responsible for the uniqueness of the individual interpretations of the same phenomenon.

In direct contrast to descriptive phenomenologists, interpretative phenomenologists are of the opinion that it is impossible to set aside any fore conceptions or experiences related to the phenomenon under investigation and approach the subject in a completely objective manner (Balls, 2009). Heidegger dismissed the notion of bracketing and developed his theory to extend beyond simply describing an experience, believing that both the researcher and participant are key to the interpretation of the phenomenon. This is a belief which I share and is linked to both my ontological and epistemological assumptions. In interpretative phenomenology, the researcher uses their own fore conceptions to assist them in interpreting the phenomenon as shared with them by an individual. However, it is common practice in hermeneutic inquiry for the researcher to make explicit their fore conceptions to evidence how they may be influencing the interpretation of the phenomenon (Lopez & Willis, 2004); this is achieved through reflexivity and describing a researchers’ personal position in relation to the study. My personal location and reflexivity will be discussed later in the chapter to highlight my position in relation to the study.

Whilst there are two main approaches to phenomenology, for the purpose of this study and to achieve the aims and objectives of the study, the interpretative phenomenological approach is necessary to enable a deeper understanding of the lived experience to be elicited and interpreted.

Hermeneutics

The second philosophical element of IPA is hermeneutics. Hermeneutics is defined as the theory and practice of the interpretation of the meaning of texts (Rennie, 2012). Although hermeneutics was originally developed to support the interpretation of biblical texts, the focus has shifted to facilitate the interpretation of a wider range of texts (Smith et al., 2009). IPA researchers do not simply engage in a single interpretation but a process of double hermeneutics, explained as when the researcher is trying to understand the participant, who is trying to understand their own experience of the phenomenon (Smith et al., 2009). So not only does the participant have to try and understand and generate meaning of their experience of the phenomenon, but the researcher must also understand the participant's interpretation of their experience. Furthermore, the process is considered to be cyclical and is referred to as the hermeneutic cycle (Smith et al., 2009) in that the participant is questioned, meaning is uncovered and constructed which results in further questioning to obtain a deeper understanding of the phenomenon being studied.

The hermeneutic element of IPA (Smith,1996) is derived from the theoretical perspectives of three hermeneutic theorists: Schleiermacher, Heidegger and Gadamer (Smith et al., 2009). Schleiermacher was one of the first to write about hermeneutics and was concerned with both the "exact and objective textual meaning" along with the "individuality of the author" (Smith et al., 2009, p. 22). He felt that part of the aim of hermeneutics was to understand the author as well as the text and believed that the techniques adopted by writers may reveal their intentions. Therefore, the examination and interpretation of the text, not only what was said, but how it was said, would result in a deeper and more holistic understanding of the phenomenon in question and also the author.

Heidegger believed that phenomenology was concerned with the examination of "something which may be latent or disguised, as it emerges into the light" (Smith et al., 2009. p24.). Heidegger (1967) further believed that our understanding of the world and the meaning we apply to objects is accessed through interpretation, which is influenced by our prior experiences and assumptions. Whilst some aspects of the phenomenon under investigation have visible meanings; many can also have hidden or concealed explanations which require deeper exploration and analysis, which can be achieved through the process of interpretation. However, Heidegger acknowledged that when something is interpreted, the interpretation will be based upon the fore conceptions,

described as prior experiences and knowledge, of the interpreter. This suggests that any new situations or experiences may be viewed considering the interpreter's own experience, although it is probable that these fore conceptions may not be known until the data starts to emerge through the interview process (Cassidy, Reynolds, Naylor & De Souza, 2011).

Gadamer's beliefs were very closely aligned to Heidegger's in that he also believed that the lived experience of the interpreter is essential to the interpretation of the text. Gadamer also believed that through interpretation of the lived experience, the researcher's fore conceptions are adjusted, creating new meanings, and understanding and resulting in further questioning (Cassidy et al., 2010), reflecting the double hermeneutics associated with IPA research.

However, this approach is not without criticism. Heidegger identifies that the process of interpretation is often built upon the interpreter's previous experiences and existing knowledge, which he describes as fore conceptions. However, although the interpretation of any new experiences will be influenced by the researcher's fore conceptions, those fore conceptions can actually pose as a barrier to interpretation as the focus should be on the object itself, to enable the generation of new knowledge (Smith et al., 2009). To avoid this, the researcher needs to be alert to their own biases, be open and transparent, and through reflexivity be able to highlight to the reader their prior experiences and knowledge in relation to the phenomenon being investigated.

The hermeneutic cycle highlights the interpretative process involved in IPA and furthermore highlights the relevance of the relationship between the individual parts and the whole. The hermeneutic cycle requires a non-linear approach to data analysis and reflects the interactive relationship between the part and the whole (Smith, 2007).

Idiography

The final element of IPA is idiography (Smith, 1996). Idiography refers to the specific experiences of particular people and the contexts in which the experiences take place (Cassidy et al., 2011). In direct contrast to nomothetic research, criticised by Smith (2004) for its approach to making group level claims, IPA seeks to identify what is important or relevant to the individual, acknowledging that this is unique and may not be generalisable (Holloway, 2008) or transferable to other individuals. Smith (2004) states that idiography is at the heart of IPA, the detailed analysis of the phenomenon

under investigation where the researcher seeks to understand as much as possible about the first case before moving onto the next case. Smith (2004) even encourages researchers to be bold and advocates the use of single case studies to elicit detailed information. Throughout the research study, particular attention will be made to each participant's unique experience, using the interview as an opportunity to explore factors specific to the participant, which may have influenced how they interpret the phenomena. It is recommended that only when all transcripts have been analysed, that the data be looked at collectively to identify any themes and to look for any convergence or divergence of the data.

IPA does not aim to produce results which are generalisable but instead focuses on the potential transferability of findings from one group or context to another (Hefferon & Gil-Rodriguez, 2011). This has been termed "theoretical generalisability" and involves encouraging the reader to adopt an active role, drawing on their existing knowledge and experience, to judge the applicability of the findings and the possible implications for their own practice (Smith et al., 2009).

It is acknowledged that the findings of this study will reflect the individual experiences which are specific to the participants who took part. However, it is hoped that due to the similarity in participants, achieved by purposive sampling, the findings will be able to contribute to the knowledge base of the lived experience of registered nurses in nursing homes in relation to incident reporting.

Rationale for IPA

IPA is a valuable approach when exploring an area which has previously not been extensively researched (Reid, Flowers & Larkin, 2005). This is of particular relevance as this IPA study aimed to explore the registered nurses' lived experience of incident reporting in the nursing home sector, an area which has not been researched before, evidenced by the scoping review. Whilst incident reporting is well established within NHS organisations, incident reporting in nursing homes remains largely unchartered territory; suggesting that patient safety is far less than optimised (Lafton & Fagerstrom, 2011).

Smith & Osbourne (2003) suggest that people can sometimes struggle to express their feelings, possibly due to a lack of clarity or understanding, or simply because they may not wish to disclose certain elements. For the purpose of this research, the "latent or

disguised" will be the nurse's experience of incident reporting which may be unknown due to a lack of knowledge or understanding about incident reporting, or possibly due to the culture within their working environment. It may even lie in the nurse's subconscious. If a nurse has previously had a negative experience of incident reporting, for example if they have tried to report an incident but their concerns have been dismissed, or when reporting an incident, they have been reprimanded or witnessed adverse outcomes personally or with colleagues, they may have subconsciously suppressed their experiences and emotions relating to the incident. By using IPA, it was anticipated that through questioning, the discussion would enable the nurse's unique and subjective experience to emerge, be reflected upon and interpreted by both the nurse and the researcher, to construct meaning. IPA also adopts an inductive approach, meaning that the purpose is to generate new ideas and theories relating to the topic under investigation. Therefore, this approach will allow for unique ideas to be presented and constructed through the interaction between the participant and the researcher, and the hermeneutic cycle used to interpret the experiences.

It is possible that multiple differing meanings will be identified throughout the research, unique to each participant and generated through a combination of social interactions. This supports both the ontological and epistemological beliefs that multiple realities exist that are socially constructed.

IPA is appropriately aligned to the proposed research question with its focus on being to enable the understanding and interpretation of the registered nurses' lived experience of incident reporting and achieving the aims and objectives of the study. This methodology is appropriate because it generates knowledge that supports both the understanding and interpretation of the meanings of the phenomenon being investigated (Crist & Tanner, 2003), that being the registered nurses' lived experience of incident reporting.

Criticisms of IPA

Although IPA has been described as a "dominant qualitative research methodology" (Tuffour, 2017, p.1), IPA as an approach is not without its criticisms. Van Manen (2017) a fellow phenomenologist, has criticised Smith's approach of IPA suggesting that the approach is more aligned to a therapy orientated research methodology rather than a phenomenological approach. Van Manen (2017) suggests that in IPA participants are

encouraged to try and make sense of an experience and argues that this is a therapeutic approach. Smith (2018) refutes Van Manen's claims and suggests that in encouraging participants to share their experiences with the researcher, who in turn seeks to understand and interpret their experience, is what aligns IPA to Heidegger's interpretation of hermeneutic phenomenology.

A further criticism is whether IPA can elicit the actual experiences and meanings of the experiences of a phenomenon rather than an opinion of the experience (Tuffour, 2017). However, IPA is not used to elicit an experience, but an interpretation of an experience, as recalled and interpreted by the participant. IPA as a research approach encourages participants to explore their experience of a phenomenon, recalling this through questioning and discussion with the researcher.

It is claimed that IPA does not attempt to explore how and why people experience phenomena, instead the focus is on eliciting and understanding individual perceptions of the phenomena (Willig, 2013). The lack of explanation about how a phenomenon has been experienced may limit our understanding of the phenomena and be considered a weakness of the method. Finally, IPA is an approach which requires both the participant and the researcher to be able to interpret. Not only does the outcome depend upon the ability of the participant to reflect and interpret their experiences but it is also dependent upon the researcher being able to reflect, analyse and interpret the data (Brocki & Wearden, 2006). Although as a novice researcher this was an area of concern for me, I hoped that following the theoretical frameworks would support my data analysis and interpretation. In addition, by being reflexive and with support from my supervisors I would be able to complete the interpretative analysis.

Personal Location

In relation to IPA research the personal location of the researcher is essential as the researcher's prior knowledge and experiences are used to support the double hermeneutics, where the researcher interprets what the participant is presenting as their experience of the phenomenon.

As a researcher I have extensive knowledge and experience of incident reporting in the nursing home sector. This could have influenced or inhibited the discussion with participants along with the analysis of the data and affected the interpreted meaning of the experience. Therefore, to avoid researcher bias, careful consideration was

needed in relation to my fore conceptions. I needed to be open and receptive to any data which may have conflicted with my fore conceptions (Gyollai, 2020). Through questioning I needed to pursue these lines of enquiry rather than closing them down as incongruous with my own beliefs to ensure more was learned so that I could truly explore the phenomenon under investigation from the participants' perspective. Being reflexive and positioning myself in relation to the study can help to reduce researcher bias and ensure the trustworthiness of the study (Barratt, Kajamaa & Johnston, 2020). Therefore, as a researcher, I have declared my experiences, values, and beliefs below and acknowledge how this may influence the interpretation and data construction.

In a previous role as Head of Quality in an NHS Clinical Commissioning Group (CCG), one aspect of my role involved supporting the strategic development of the care sector and ensuring that expectations in relation to the quality of care were clearly communicated and embedded in the contract. This involved communication, negotiation, and collaborative working with both the care sector and also the local authority to set achievable targets to promote the ongoing improvements in the quality of care being delivered. As a Registered Nurse with a background in district nursing, and more recently working as a Lead Nurse for quality in a CCG, I have always had a connection with the care sector as a large proportion of my portfolio has involved working with residents in the care sector or working with the care sector in a quality improvement role.

The care sector has been referred to as the Cinderella service of nursing (Houchin, 2016) and from working closely with the care sector I have first-hand experience of what often felt like inequity between the care sector and the NHS. The care sector often experiences significant staffing difficulties, greater financial pressures and from my own personal experience, what feels like disproportionate safeguarding referrals reported against them.

These perceived inequalities feel like injustice, against a service caring for some of the most vulnerable people in our society, and this resonated with my moral compass. I believe in fairness and equality, and I was therefore keen to work with the care sector to understand more about how they worked and their internal processes, particularly in relation to quality within the homes. Moustakas (1994) suggests that the initial interest in research stems from a subject area that the researcher feels passionate about which leads to the development of the research question.

Although Houchin (2016) suggests that the care sector is no longer viewed as the Cinderella service, concerns raised during the current Covid-19 pandemic indicate that the care sector may be continuing to experience inequalities in comparison to the NHS and is still considered to be a sector which is overlooked (Cousins et al., 2016). During the pandemic it has been reported that Government support for the care sector was too slow and limited, resulting in insufficient protection for both the services users and those providing care (Dunn, Allen, Humphries & Alderwick, 2021).

Chapter Summary

This chapter has explored the philosophical assumptions of ontology and epistemology that underpin the study, those being relativism and social constructionism. The interpretivist paradigm was chosen, as this is aligned to the relativist ontology and social constructionism epistemology. A qualitative methodology was chosen, specifically IPA which was used to explore the lived experience of the research participants. Not only does IPA seek to elicit the essence of the phenomenon, but the interpretative element of IPA enables a deeper and more holistic understanding of the phenomenon in question to be realised, which could not be achieved by a purely phenomenological approach. A clear rationale for the chosen methodology has been described; to address the current gap in the knowledge base related to the registered nurses' lived experience of incident reporting in the nursing home sector, along with some criticisms of the approach. My personal location has been shared and the need for reflexivity has been identified, highlighting my prior knowledge and experience in the field.

The research methods chosen to conduct the study will be discussed in the next chapter and will address sampling, sample size, inclusion and exclusion criteria, and recruitment. Data construction will be discussed along with the framework to support data analysis. Reflexivity will be introduced and finally the ethical implications of the study will be presented.

Chapter 4

Research Methods

Introduction

This chapter will describe in detail the methods adopted to undertake the research study and includes sampling, inclusion and exclusion criteria, sample size and recruitment. Data construction (collection) will be explored, looking at methods aligned to the principles of IPA research which will include a discussion of the tools chosen to collect and construct the data. The impact of the international Covid-19 pandemic will be discussed to highlight the impact this has had on the research and how plans had to be modified. Data analysis will be discussed, including the framework used to support the data analysis. Reflexivity will be explored in relation to the data analysis and how this was addressed to ensure research credibility. Finally, the ethical implications of the study will also be presented.

Research Design

The research design has been guided by the philosophical principles of relativism, social constructionism, and the research methodology IPA. As discussed in the previous chapter, IPA is an approach used to determine how individuals think and feel about certain situations they have experienced, and to explore the meaning of their individual experiences. Smith & Osborn (2003) describe a framework to guide IPA studies which involves the following stages: constructing a question, selecting a sample, collecting data and data analysis. This framework has been used to guide the study. The first stage, constructing a question, has been discussed in detail in chapter 2, therefore the question that the research study will seek to answer is:

What are the lived experiences of registered nurses working in nursing homes in relation to the identification and reporting of incidents?

Furthermore, the objectives have been defined as:

- to determine what registered nurses in nursing homes, understand by the term "incident" in relation to incident reporting
- to explore incident reporting systems and processes in nursing homes
- to explore any barriers and enablers to incident reporting in nursing homes
- to explore any examples where nursing homes have successfully embedded incident reporting in practice

The next three stages, selecting a sample, collecting data and data analysis will be discussed below.

Sampling

In relation to research, sampling is an approach used to select a specific group of individuals within a population to take part in the research study (Holloway, 2008). In IPA research, the subject area being studied determines the boundaries of the required sample (Smith & Osborn, 2003) as it is imperative that the participants selected have all experienced the phenomenon in question (Creswell & Poth, 2018).

Smith et al. (2009) suggest that, in IPA research, samples must be purposively selected; therefore, in keeping with the principles of IPA purposive sampling was used. Purposive sampling is a non-probability type of sampling, whereby participants are purposively selected as they are able to offer an insight into the specific phenomenon being investigated (Offredy & Vickers, 2010; Parahoo, 2014). Smith et al. (2009) further suggest that in IPA research a relatively homogeneous sample, defined as "sharing similar characteristics" (Parahoo, 2014, p. 260) needs to be selected, to ensure that the research question is meaningful to them. Although it must be acknowledged that due to variables such as age and gender a truly homogenous sample may not be achievable (Parahoo, 2014). Furthermore, although all participants will have similarities in that they are registered nurses working within a nursing home, the similarities may not extend any deeper. It is possible that all will have very differing backgrounds and experiences, rendering a homogenous sample difficult to achieve. Purposive sampling was therefore used to select a partially homogenous sample,

acknowledging the nuances of age and gender as suggested by Parahoo (2014) along with the wider social and cultural differences.

For this study, the homogenous aspects of the sample relate to registered nurses working in the nursing home sector. Ritchie & Lewis (2003) argue that once a broad participant population area has been identified, this needs to be refined further by determining specific selection criteria, which also supports the concept of a homogenous sample required in IPA research. Selection criteria need to be aligned to the aims and objectives of the research, and in IPA research it is imperative that all research participants have direct experience of the phenomenon being studied (Creswell, 2013). It is anticipated that in using a purposive sample, a partially homogeneous sample will be identified. Adopting an idiopathic approach when examining the data, will ensure that the participants' unique perspectives are elicited, which may then demonstrate both convergence and divergence across the data set, reflecting the differing perspectives of the participants in relation to the phenomenon being investigated.

To create a partially homogeneous sample, to ensure the participants were suitable to take part in the study, and had direct experience of incident reporting in the nursing home sector, the following criteria were determined to select research participants for the study:

Inclusion Criteria

- Registered nurse
- Worked in a nursing home for at least 12 months (to enable an understanding of the nursing home environment and procedures)
- Currently working and directly employed by a nursing home

Exclusion criteria

- Care staff
- Registered nurses who have worked for less than 12 months in a nursing home environment
- Working in a managerial role of either Home Manager or Deputy Home Manager
- Registered nurses employed by an agency

One geographical locality was chosen as opposed to a cross section of nursing homes from different geographical areas to ensure all nursing homes were bound by the same contractual and reporting requirements of the CCG and the local authority. All ten nursing homes commissioned by one NHS Clinical Commissioning Group (CCG) in one geographical locality were contacted and invited to take part in the study.

Recruitment

Participants were recruited from nursing homes commissioned by one CCG. The CCG chosen, commissioned care with all ten nursing homes based in a geographical boundary and is an area where I have previously worked. Although I have previously worked in the area, given the reported high turnover rates of staff within the nursing home sector (Castle & Engberg, 2005, Care to be Different, 2019), it was probable that many of the nursing staff were no longer employed within the same home. If some of the same nursing staff were employed there would have been the risk that staff may have felt pressured into taking part in the study due to our previous relationship but may not have been truly willing participants. This may have resulted in bias which could have affected the rigour of the study. None of the participants who volunteered to take part in the research had previously been known to me in any capacity.

Recruitment is a complex process and considered by some to be the most difficult part of a research study (Blanton et al., 2006), however there is little information in relation to recruitment strategies to support researchers in recruiting participants. To facilitate the recruitment of participants, the CCG were contacted to seek their support and a formal introduction to the nursing homes they commissioned care from. It was felt that an initial introduction by the CCG may help to secure engagement with the study rather than simply cold calling the homes. The CCG agreed to share information regarding the study with the nursing home managers and arranged for my attendance (via Microsoft Teams) at one of the nursing home managers' meetings to introduce myself and present a brief overview of the study. Initially the plan was to hold a project advisory group, consisting of the nursing home managers, to develop an understanding of the local systems and processes for incident reporting, along with the contractual and regulatory requirements in the nursing home sector, so I was keen to meet with the nursing home managers.

Challenges faced and resolution

Although an initial meeting was arranged by the CCG, due to a lack of capacity and pressures caused by the Covid-19 pandemic, the meeting was cancelled at short notice. The CCG did explain that since the pandemic started, a number of meetings had been cancelled due to capacity.

A few days after the meeting had been cancelled, the CCG called all nursing home managers, as part of their routine CCG business and used this opportunity to discuss the research to try and facilitate engagement with the study. The following weeks, I called all homes to speak to the managers to discuss a project advisory group. Consensus from a few of the nursing home mangers who I spoke to was that it would be difficult to arrange a mutually agreeable time to convene to form a project advisory group, however a number of managers agreed to have a telephone conversation with me as an alternative to a project advisory group and agreed to share the participant information in their homes.

After four weeks of multiple phone calls attempting to make contact with all the nursing home managers, seven of the ten nursing home managers agreed to a telephone call with me and subsequently agreed to discuss the study and share the participant information sheet with the registered nurses in their home. Making telephone calls to potential participants who have not responded has been identified as a key strategy for improving participant recruitment (Newington & Metcalfe, 2014). However, there were three nursing home managers who did not engage, despite phone calls being made to the nursing homes on three separate occasions and messages left asking them to contact me regarding the study. This was in addition to information being shared by the CCG initially and a follow up phone call by the CCG requesting that the participant information was shared with the registered nurses in the home.

It is acknowledged that the registered nurses within these three homes may not have received the participant information sheet and therefore may have been unable to access the study. However, due to General Data Protection Regulations (GDPR) (Information Commissioner's Office, 2018) it was not possible to access a list of the registered nurses who work in the homes to send the research information to direct. Therefore, information was shared with the nursing home managers with a request for them to share information about the study with the registered nurses in their home. It is accepted that the nursing home managers were gatekeepers to the study and that gatekeepers can control access to staff within a study (Wanat, 2008). Some

gatekeepers may even deny potential participants access to the study by withholding information about the study or by selectively sharing the information. Singh & Wassenaar (2016) suggest that researchers need to anticipate the concerns of gatekeepers, such as the risk of harm to participants or organisational reputation and provide assurance in relation to mitigating actions. To mitigate any concerns that the nursing home managers and nurses may have held relating to the study, information relating to the study along with background information was shared with all nursing home managers initially by the CCG, so even the homes where the manager did not engage in the telephone conversations with the researcher would have received this information.

Seven out of the ten nursing home managers agreed to take part in the project advisory conversations and agreed to share the participant information with the registered nurses. Participant information sheets should be provided to all prospective participants and should contain easy to understand information relating to the research study along with what is expected of the participants (University of Salford, 2017). Participant information sheets are considered to be best practice and often a pre-requisite of ethics applications. The participant information letter (appendix 2) and information sheet (appendix 3) were shared with all participants at least one week before the interviews took place, allowing sufficient time to enable them to read the information and make an informed decision about taking part in the research (University of Kent, 2017). At the start of the interviews, all participants were asked to confirm that they had read the participant information sheet and asked if they had any questions in relation to the content, or the research study.

It was hoped that by the CCG introducing the research study to the nursing homes managers, that this may have helped facilitate engagement with the study. It is acknowledged that some nursing homes may have been reluctant to take part in the research study as findings may be interpreted as reflecting poor practice within the home, which may have a negative effect upon their reputation (Wagner et al., 2013). To address this and to try and alleviate any fears, all nursing home managers were provided with brief information relating to the study and assured that the findings would be reported anonymously. Nursing home managers were also given the opportunity to contact me directly to ask any questions about the study. In the homes where I was able to speak to the nursing home manager, they agreed to talk with me and share the information with the nurses in their home. Unfortunately, despite leaving telephone

messages and emailing information about the study I was unable to make contact with three of the nursing home managers. However, information was shared with the nursing homes via the CCG, so it may be possible that the information was shared with the registered nurses in the home

Regardless of how information about the study was accessed, all registered nurses working in the ten homes, based upon the inclusion and exclusion criteria, were eligible to take part in the study. It is possible that registered nurses in one home may have shared information with colleagues in other homes. As accountable practitioners within their own right (NMC, 2018) all registered nurses would have been able to decide if they wanted to take part in the research, as findings will be reported anonymously so as not to identify either the individual or their place of employment.

Following the initial conversations that I had with the nursing home managers, due to a lack of interest from potential participants, emails were sent to all home managers after two weeks, requesting that the research study was further promoted within their home to facilitate engagement and to try and recruit participants. After another couple of weeks, again due to a lack of interest, to improve recruitment (Newington & Metcalfe, 2014) I also phoned the nursing home managers to ask if any interest had been expressed. A few of the managers advised that they had shared the information with the nursing staff and discussed the study, but no-one had expressed an interest. However, a few of the managers explained that some of their nurses had expressed an interest and were surprised that they hadn't contacted me directly. To try and facilitate engagement and recruit participants to the study I asked the nursing managers if the nurses were on duty and if it would be possible to talk to the nurses directly. Speaking to the nurses directly gave me an opportunity to engage them with the study. By sharing my passion about improving care in the nursing home sector and explaining how their experiences would support the research study, I was able to recruit four registered nurses to take part in the study. It is believed that one of the main reasons why people agree to take part in research is due to altruism, the selfless concern and wellbeing of others (Newington & Metcalfe, 2014). By taking part in the research, the nurses would be able to support the research study within their area of work, but also to help a fellow nurse – the researcher. Following which, four registered nurses from three homes volunteered to take part in the research.

Of the four registered nurses who I was able to speak to, I asked all of them to share the information with colleagues and friends who work in the nursing home sector in an

attempt to recruit more participants, but no other nurses contacted me to express an interest.

Whilst altruism has been identified as a reason for participants engaging with a research study (Newington & Metcalfe, 2014), logistical issues have been highlighted as a reason why people decline (Blanton et al., 2006). I personally feel that being unable to visit the homes, due to the Covid-19 pandemic, to speak to the nurses in person, not only to promote the research but also to allay any fears in relation to the research, did have an adverse effect on participant recruitment. I also feel that the timing of the research, during the pandemic, may have had a negative impact on recruitment as nursing staff in the care sector had been under immense pressure during the pandemic. Pressure on care home staff has been extensive and sustained, caused by the excess death of care home residents and staff shortages along with trying to work within a fragmented and complex health and social care system (Dunn et al., 2021). At a time when staff are already under immense pressure, being asked to take part in a research study may have been too much to contend with.

Reflections 2

Despite the large number of beds in the care sector, research and support with quality improvement initiatives rarely reach this sector. Lack of research in the field may also be a contributory factor in relation to the difficulties I had in recruiting participants. If research is not something the nurses are familiar with, they may feel threatened or intimidated by it, resulting in a lack of interest or agreement to take part. Interestingly, 3 of the nurses who agreed to speak to me had all had previous NHS experience. Only one nurse had only ever worked in a nursing home since qualifying.

Four registered nurses agreed to take part in the study, from three nursing homes, see table 7 for information relating to the homes. One participant volunteered from nursing home 1, a smaller home with fewer than 35 beds, independent and not part of a national care group provider. In nursing home 1, a paper system is in place for incident reporting and all incidents are managed within the home by the home manager. One participant volunteered from nursing home 2, a slightly larger home with between 36 and 80 beds. This home is part of a national care group provider and has an electronic incident reporting system in place. Incidents are managed by the home manager, but there is also senior oversight from the corporate teams. Finally, two participants volunteered from nursing home 3, a large home with over 80 beds. They also have an

electronic incident reporting system and as in nursing home 2, incidents are managed by the home manager, but there is also senior oversight from the corporate teams.

Table 7 – Information relating to participants place of work

Nursing Home	Number of research participants	Number of beds	Care home group or single home	Incident reporting system
1	1	35 or fewer	Single home	Paper
2	1	36-80	National care home group	Electronic
3	2	81 +	National care home group	Electronic

Sample Size

In qualitative research, the quality of the data is considered more important than quantity, to allow the deep exploration of the complex human phenomenon under investigation (Smith et al., 2009). Due to the often complex and in-depth nature of IPA studies, they are generally conducted on small samples (Cassidy et al., 2011; Smith & Osborn, 2003) to enable a detailed analysis to take place (Koch, 1998; Smith et al., 2009). To reflect the idiographic nature of IPA, studies are sometimes conducted with just one participant (Brocki & Weardon, 2006; Creswell & Poth, 2018; Smith, 2009). Although IPA studies consisting of just one participant have been encouraged (Smith et al., 2009; Smith & Eatough, 2012), a review of health-related IPA studies was conducted to explore the differing sample sizes. The sample size ranged between 1 and 35, a sample of eight being the average size (Brocki & Weardon, 2006) with studies published since then continuing to follow the same trend in relation to sample size (Cassidy et al., 2011).

In IPA, a small sample is deemed acceptable (Creswell & Poth, 2018; Tuffour, 2017; Vance, Talley, Azuero, Pearce & Christian, 2013) and whilst there is no definitive guidance as what an ideal sample size would be, Bryman (2016) argues that there needs to be a balance between the sample size and other considerations such as time and financial implications. Smith & Osborn (2003) further suggest that the sample size will be determined by the number of participants who are willing to take part in the study. Experience of the researcher is also a factor in determining the sample size with

Smith & Osborn (2003, p. 57) suggesting that for a first-time researcher a sample of three is sufficient to allow for the required in-depth analysis, whilst also enabling “a detailed examination of the similarity and difference, convergence and divergence.”

In some qualitative research, the aim is to achieve data saturation, defined as when the researcher repeatedly encounters the same responses indicating that all evidence has been identified (Roberts & Priest, 2010). However, in IPA research this is not the case. The aim is to achieve in depth analysis of individual cases, acknowledging that unique views may be elicited rather than seeking data convergence. This reflects the idiographic nature of IPA research, in that the focus is on the individual rather than groups of individuals or seeking generalisable claims.

Smith et al. (2009) suggest that 3-6 participants is considered a reasonable sample for a student undertaking IPA and that furthermore in Professional Doctoral studies, samples of between 4 and 10 participants are adopted. Once participants have been recruited, the data construction then commences. Due to the in-depth nature of IPA studies, it would be impractical to interview and analyse data from a large sample, therefore adopting the principles of IPA research and acknowledging the inexperience of the researcher, the plan was to initially recruit between 6-8 participants. Factoring in that some participants may drop out of the study; the aim was to achieve between 3-6 participants in total to take part in the study to ensure sufficient data to allow the phenomenon to be explored. Four nurses in total agreed to take part in the study and although at the lower end of the target sample size, four participants are considered an appropriate sample size in IPA research.

Data collection/construction

Data collection is a process to gather data from a relevant sample which will enable the research question to be answered (Bryman, 2016; Creswell & Poth, 2018). Data collection is the term used for most types of research, both quantitative and qualitative. However, in IPA research data is not merely collected, instead it is constructed by an interactive relationship between the participant and the researcher. Therefore, for the purpose of this study, data construction will be used as the term to refer to how data was constructed to inform the study.

Selecting an appropriate data construction approach is key to the success of a research study. Smith et al. (2009, pp.56) suggest that for IPA studies, an approach is

required which “invites participants to offer a rich, detailed, first-person account of their experience.” Rich data can be described as when participants are afforded the opportunity to speak at length, to recall their stories, to reflect and to develop their ideas in a way that reflects the complexities of the phenomenon being studied (Given, 2008; Smith et al., 2009). This type of approach reflects the idiographic nature of IPA research in that the aim is to elicit the individual and unique nature of the data, from the individual’s perspective. It is also during the data construction process where the first element of the hermeneutic cycle occurs. During the interviews, the dynamic relationship between the researcher and participant to explore the participant’s lived experience requires an iterative and non-linear style of questioning and thinking, to enable the participant to reflect and interpret their experience (Smith et al., 2009).

IPA is perceived by many researchers to be the most participant focused type of qualitative research (Alase, 2017). IPA allows participants the opportunity to express themselves and their lived experience of the phenomenon being investigated. To facilitate this, a flexible data construction method is required to enable participants the opportunity to talk freely. Semi-structured interviews are considered to be the most effective method of constructing data in IPA research which enables an in-depth understanding of a participant’s experiences to be elicited (Reid et al., 2005; Smith & Osborn, 2003) and also facilitates the idiographic element of IPA. As a novice researcher, semi-structured interviews would also provide some flexible guidance ensuring that the key information was obtained (Smith et al., 2009). In IPA research the participants are active participants in the research and are encouraged to talk freely about their experiences, reflecting the idiographic nature of the approach. So, although questions are developed to guide the process, a flexible approach is adopted which allows the researcher to probe and digress away from the interview questions if the participant’s narrative is relevant to the research question.

Initially the plan had been to pilot the interview questions with a registered nurse from the nursing home sector, to test the appropriateness of the questions. However, due to the difficulty in recruiting participants, a decision was made to pilot the interview questions with a colleague (a registered nurse who had experience of working with the nursing home sector) in a mock interview situation to determine if the questions were suitable and generated responses which would enable the aims and objectives of the study to be explored. Following the pilot interview, minor amendments were made to the questions based on the feedback received.

To reflect the hermeneutic element of IPA, the interview process reflected the hermeneutic cycle described as when the participant is questioned, meaning is uncovered, interpreted, and constructed, which then results in further questioning to obtain a deeper understanding of the phenomenon being studied (Smith et al., 2009). During the interview the participant will be questioned, which may result in a descriptive narrative of the phenomenon in question. However, further questioning may be required to truly elicit the participant's inner most feelings and experiences. This may require self-analysis and interpretation by the participant as they start to construct and apply meaning to their experience of the phenomenon. Smith et al., (2009, pp.64) describe this aspect of the interviewing process as where the researcher steps into the participant's world, with the sole focus being on the participant and their "experiential expertise". Being a nurse-researcher enabled this process to take place, as having an understanding of the role of a registered nurse in the nursing home sector enabled me to question the participants in an empathic manner. Once the participant has developed an understanding of their experience, the data analysis stage takes place where the researcher interprets the narrative offered by the participant; this reflects the double hermeneutic element of IPA research. Through the process of double hermeneutics, the researcher aims to obtain a deep and unique understanding of the phenomenon by drawing on their own experiences and knowledge to support the construction of new knowledge.

Through semi-structured interviews, participants will have the freedom to describe what is important to them (Bryman, 2016). This will facilitate an in-depth insight into the participant's subjective and socially constructed views, supporting the epistemological view that knowledge is socially constructed, subjective and built upon human interactions and experiences. The researcher's role has been described as that of a facilitator to help respondents talk freely. Therefore, the only interview questions should be those that seek clarification, illustration, or further exploration (Parahoo, 2014).

The use of semi-structured interviews requires researchers to have some previous knowledge in the research topic area (Kelly, 2010). The questions were drafted based upon the findings and knowledge acquired from conducting the scoping review along with my own experience of incident reporting from working in the NHS and working with the nursing home sector. The interview guide and questions were reviewed following discussion with the nursing home managers to ensure the questions related

to the local context of incident reporting in the nursing home sector. The interview guide was produced as a flexible tool to aid discussions, additional prompts were also used during the interviews as appropriate to encourage participants to elaborate on key areas. The interview guide can be found in appendix 5.

Due to the Covid-19 pandemic and to ensure national guidance was followed in relation to minimising contact to prevent the spread of the virus, interviews, although initially planned to be face to face, were changed to take place via Microsoft Teams to maintain the health and wellbeing of the nursing home residents, the participants (and other staff within the home) and also the researcher. Permission was sought from the nursing home managers to interview the registered nurses during working hours, to try and facilitate engagement with the study. Participants were also offered the option of being interviewed in non-working hours, to maintain confidentiality, in case participants did not want their manager to know that they were taking part in the study (Braun & Clarke, 2013). However, participants were reluctant to be interviewed via Microsoft Teams, some claiming not to have the technical ability to use Microsoft Teams, some stating that they didn't want to be on camera. However, all four participants agreed to be interviewed over the phone and for the interview to be audio recorded. It is acknowledged that being unable to meet with the participants face to face or conduct the interview via Microsoft Teams prevented observation of the participants' body language which may have added an additional dimension to the data construction, however the restrictions imposed by the national pandemic had to be adhered to, to maintain the safety of all involved and the research plan had to be modified to accommodate the requests of the participants.

In IPA research, face to face interviews are recommended as qualitative researchers are not only concerned with what is verbalised, but also the participant's body language (Bryman, 2016). However, due to the reluctance of participants to take part in a Microsoft Teams meeting, telephone interviews were conducted. With permission from the participants, the telephone calls were audio recorded to enable accurate data transcription and construction and field notes were taken throughout the interview to capture any significant thoughts (Ritchie & Lewis, 2003). Unfortunately, as the interviews took place via telephone, non-verbal cues such as the participants body language and facial expressions were not able to be captured. However, Smith et al., (2009) suggest that the focus of IPA is on the actual content of the language and that prosodic aspects of the conversation do not need to be captured. However, when

transcribing I did make note of any prolonged silences and any non-verbal cues such as laughing, to assist with the interpretation.

Initial interviews took place, on a one-to-one basis, over a three-week period, with participants being advised that a follow up interview may be required after the data had been transcribed in case any clarification was required. At the start of the interviews, I tried to help the participants feel at ease by explaining that there were no right or wrong answers. The interviews lasted between 52 and 61 minutes. Two participants agreed to being interviewed in work time, with permission from their managers and two participants were interviewed in their own time at their request, although both stated that their manager knew they were taking part in the study.

Reflections 3

The interview guide was developed based on my existing knowledge of the sector and further refined after conducting the scoping review. The guide was also reviewed after discussion and reflection with my supervisors. Although a pilot study wasn't conducted, I did test the questions out on colleagues who had some experiences of working with the nursing home sector to check for understanding, resulting in further minor amendments to the questions.

During the interviews I had to be cognisant of my prior knowledge and not allow this to direct the interviews. I was mindful to progress the participants' line of discussion and used comments that they had made to probe further into their line of discussion. It was difficult as I can recall when a participant discussed an issue, for example – lack of knowledge, that I could relate to due to my previous experiences and from the scoping review, I was conscious that I could relate to their experiences but remained neutral with my line of questioning so as not to steer the discussion, allowing the conversation to be directed by the participant.

The interview guide was used to "guide" the interviews but was not followed rigidly. Participants were allowed the freedom to speak and to influence the direction of the conversation, by sharing their unique experiences and beliefs, with prompts or probing questions being asked, based upon their responses, to gain more information.

At the end of each interview, participants were asked if they wanted to review the transcription, but none felt that this was necessary given the interview was being audio recorded, however all agreed to being contacted again should any clarification be required to ensure I had accurately captured their thoughts and interpretations to add credibility and validity to the study (Jootun, McGhee & Marland, 2009). Once the interviews had taken place, the process of data analysis commenced.

Data Analysis

Polit & Hungler (1995) describe data analysis as a process to bring about order, interpretation and meaning to data, and in relation to IPA data analysis serves to interpret participants' experiences to understand their lived experience (Reid et al., 2005). However, data analysis is not an isolated process and needs to be considered alongside the data construction process. Before data analysis can begin the data has to be transcribed. Transcription is a key part of data analysis, but one which is often overlooked in the literature (Braun & Clarke, 2013). In fact, the transcription of interviews is considered by some to be the first stage of the data analysis process (Braun & Clarke, 2013; Clancy, 2013) and is a stage that is often missing from data analysis frameworks. In addition, field notes taken during the interviews, which may reflect feelings or emotions of the researcher, form the first stages of data analysis.

Therefore, for the purpose of this research the data analysis began with the transcription of the interviews along with a simultaneous review of the field notes, taken during the interview. Whilst it is acknowledged that data transcribing is time consuming, I carried out my own data transcription, to enable me to start to develop familiarity with the data and assist in developing a deeper understanding of the data (Sutton & Austin, 2015).

Computer software packages are available to support the data analysis of qualitative data, such as NVivo. However, it must be noted that whilst the packages can assist in coding the data, it is the researcher who conducts the actual analysis, interpretation and identifies the themes (Denzin & Lincoln, 2018). This is because the actual analysis requires an understanding of the data being explored to ensure that each theme identified will represent an important and interesting account of the essence being explored enabling the research objectives to be achieved (Joffe, 2011). As this study only involved relatively small numbers of participants, and to ensure the true essence of the phenomenon was elicited, the data analysis was conducted manually, without the aid of a software package.

In IPA research, Smith et al. (2009) acknowledge that whilst there are many approaches to data analysis, there is no right or wrong way to conduct the data analysis and furthermore that the literature does not recommend a specific approach for analysing the data. Acknowledging the complexity of data analysis in IPA research, Smith et al. (2009) proposes a step-by-step framework to carrying out data analysis. Their framework is based upon the basic principles and strategies typically used by

IPA researchers when conducting data analysis to support novice researchers and can be seen in table 8. It adopts a thematic approach to data analysis and has a specific focus on the idiographic nature of the data along with the hermeneutic element of the interpretation. The hermeneutic element, whereby the researcher uses their own knowledge and experiences to interpret the participants' narrative, is pivotal to the process and IPA research (Smith et al., 2009).

Thematic analysis is an approach often used to order data in qualitative research (Smith & Firth, 2011), and is a method which is used to identify, analyse, and report themes that emerge from the data (Braun & Clarke, 2006). Braun & Clarke (2006) also devised a thematic analysis framework to guide qualitative researchers in data analysis. However, Braun & Clarke's (2006) framework does not include the hermeneutic element, essential to IPA research. Whilst there are a number of similarities in the frameworks proposed by Smith et al., (2009) and Braun & Clarke (2006), the absence of the hermeneutic element in Braun & Clarke's (2006) framework renders their framework unsuitable for IPA research as the risk is that a descriptive analysis of the data will be presented instead of an interpretative analysis. Therefore, as Smith et al.'s (2009) framework was designed specifically for IPA research I have opted to use their framework to guide the data analysis process, to enable the progression from a descriptive level to an interpretative one (Smith et al., 2009).

Table 8 - Step by step guide to conducting IPA analysis (Smith et al., 2009)

Step 1 - Reading and re-reading	This stage involved the reading and re-reading of the transcript whilst also listening to the recording to develop familiarity with the content. My initial observations were noted in an attempt to set them aside to enable me to focus purely on the data contained within the transcript at this stage.
Step 2 - Initial noting	This stage involved the initial noting, picking out areas of the text that were of interest in relation to the phenomenon, trying to understand the given meaning, they were divided into three areas as suggested by Smith et al., (2009): • Descriptive comments- focusing on content and describing the objects of concern • Linguistic comments- reflecting on the specific use of language

	• Conceptual comments- asking questions of the data and moving towards a more conceptual understanding of what it means to have these concerns in this context.
Step 3 - Developing emergent themes	The next stage is "developing emergent themes". Here the focus is on discrete chunks of the data to turn the notes made previously into statements which reflect important aspects of the data. The analysis of the notes in the previous stage leads to the identification of emergent themes, or the construction of themes, and represents another stage of the hermeneutic cycle, as the researcher is now beginning to analyse the participants experiences resulting in a collaborative interpretation of the data, between the participants raw data and the researcher's interpretation.
Step 4 - Searching for connections across emergent themes	This stage provides an element of structure to the process for searching for the connections across the themes. Abstraction is a process of identifying patterns between emerging themes, these emerging themes may be classed as subordinate themes. Following which, a number of subordinate themes may be identified which can be grouped together to form superordinate themes.
Step 5 - Moving to the next case	The remaining transcripts need to be analysed using stages 1-4 as described above. Each case needs to be reviewed in its own right to reflect the idiographic nature of IPA and to allow any new themes to be developed.
Step 6 - Looking for patterns across cases	This stage involves looking at connections across the different transcripts, exploring which themes exist in different transcripts, which are more potent. Despite the idiographic nature of IPA, it is possible that some of the superordinate themes are reflected across multiple transcripts reflecting convergence of the data.

Step 1 – Reading and re-reading

Smith et al. (2009, pp.82) describe the first stage as "immersing oneself" in the data, which is achieved by reading and re-reading the transcripts to become familiar with the data. Once all interviews had been conducted, I listened to them all again. Smith et al. (2009) suggests choosing an interview to transcribe first which is detailed; therefore, I chose an interview which I felt contained rich information and decided to transcribe this interview first. To reflect the idiographic nature of IPA, one interview was transcribed and analysed before moving onto the next interview. Before transcribing, I listened to the recording again to start to develop familiarity with how the participant spoke. The data was transcribed verbatim, whereby the spoken words were transcribed from the

recorded data (Braun & Clarke, 2013) capturing the participants' spoken language. The first transcription was purely to capture the spoken words, which was checked for accuracy by listening to the recording again whilst simultaneously reading the transcript with corrections being made throughout to ensure data accuracy. Finally, the recording was listened to again to capture all the pauses and other non-linguistic elements of the conversation to ensure a complete and accurate transcription of the conversation. Listening to the recording of the interview can help in imagining the voice of the participant whilst reading the transcript which can help with analysing the data (Smith et al., 2009).

Throughout the interviews, field notes were taken. Field notes are considered to be an essential aspect of qualitative research and are used to support rigour in research (Phillippi & Lauderdale, 2018). Field notes consist of the researcher's ideas, thoughts and initial interpretations that occurred during the interview and are used to aid data analysis (Simony et al., 2018). Field notes signify the start of the double hermeneutics in the hermeneutic cycle, as this is where the researcher starts to interpret the participant's narrative. Field notes were reviewed simultaneously whilst transcribing the data to also capture any non-linguistic features noted during the interview which may affect the interpretation and analysis of the data (Sandelowski, 1998).

Once the first transcription was complete, the same process was followed for all interviews. To ensure I was able to consider each case individually, without being influenced by the previously analysed transcripts, time was left between the transcription and analysis of each interview. The first transcription took approximately 14 hours to complete, with subsequent transcriptions taking a similar amount of time.

Transcribing the data, is a stage omitted from the guide proposed by Smith et al. (2009) but a key stage in the data construction process. Data transcription enables the researcher to start to immerse themselves in the data and assists in developing a deeper understanding.

Step 2 – Initial noting

This is where the researcher starts to annotate the transcript, by noting anything of interest. This may include comments in relation to the phenomenological focus of the study, key areas of concern for the participant and the meaning behind those concerns. The topics of interest were divided into three key areas as suggested by Smith et al.,

(2009, p. 84): descriptive comments, linguistic comments and conceptual comments which will be explored below.

Descriptive comments

Descriptive comments focus on elements within the transcript that are of concern to the participant. They may consist of key elements or experiences and be described by the participant as they were experienced. Smith et al. (2009) state that at the descriptive stage the researcher takes things at face value, identifying aspects which structure the participant's thoughts and experiences to encourage the researcher to start thinking about the participant's experiences in relation to the factors which influence their world. As an example of a descriptive comment, participant 4 described their experience as to how they were discouraged from logging incidents about low staffing levels in the nursing home *"sometimes management don't want you to add that as it comes back on them as to why they have not helped with that."* They further shared their experiences of working in the NHS where *"in the hospitals they push you to report when you've got no staff, to flag it to higher management."*

Reflecting the epistemological approach of social constructionism, which underpins this study, the focus is on achieving an "empathic understanding of the social phenomena from the participants' point of view (Rodwell, 1998, p. 33) thus highlighting the need to remain close to the participant's voice. Social constructionism identifies the importance of language to formulate constructions about a problem that exists within a participant's social environment (Franklin, 1995) which is achieved by focusing on the participants' stories.

Linguistic comments

Linguistics relates to the specific use of language and how this is used to interpret and construct the participants' experiences. Rodwell (1998) suggests that in social constructionism, knowledge is generated through linguistic negotiation (conversation) and that social constructionism seeks to understand what events mean to individuals, and how individuals construct meaning of a phenomenon (Creswell & Plano Clark, 2007). The importance of language is highlighted in social constructionism as the language used by the participants helps to formulate constructions of their experiences (Franklin, 1995). The language and linguistic features of the participants' narratives were important aspects which informed the data analysis, as the transcripts reflects the way in which the participants' experiences were presented.

The interviews conducted were the vehicle to facilitate the linguistic negotiation, to allow the participants to reflect on and share their lived experiences. During the initial noting, attention was paid to the linguistic aspects of the conversation, such as any pauses in the conversation which could evidence the participant reflecting and internally renegotiating their experience of the phenomenon based on the interaction with the researcher. In addition, the use of metaphors was analysed and interpreted. Metaphors are a powerful aspect of the analysis as metaphors can be used to connect the descriptive notes to the conceptual notes (Smith et al., 2009). An example is with participant 3, they frequently used the metaphor *"off you trot"* throughout their interview, on one occasion it was used to connect the descriptive note in relation to incident reports being *"filed away"* and not acted upon, with the conceptual note of being dismissed.

Conceptual comments

This stage requires an interrogation of the data and an element of self-reflection and interpretation, once again reflecting the double hermeneutics of IPA. This is where the researcher uses their own experience, knowledge, and interpretation to support the progression towards a more conceptual understanding of the data (Smith et al., 2009). Rapport (2005, p.135) describes this as a process whereby the researcher has a "hermeneutic conversation" with the narrative to blend their personal knowledge to support the construction of new knowledge.

Smith et al. (2009) highlight that the process of conceptual development requires a move away from the specific narrative proposed by the participant to a broader explanation of the narrative, constructed by the researcher drawing on their own knowledge and experience to facilitate the interpretation. Whilst it is accepted that conceptual comments may digress from the original text of the participant, what is

Reflections 4

Although there was limited research, particularly in the UK exploring registered nurses' experiences of incident reporting in the nursing home sector, the findings from the scoping review did enhance my knowledge in the area. During the initial noting stage, I had to really try and block out the findings from the scoping review to prevent them from influencing my interpretation of the data, this was much harder than I had anticipated. This stage really reflected the iterative stage of data analysis as I found repeated listening to the audio recording whilst also reading the transcript helped me to connect with the data and to retain focus on each participant's unique and specific narrative and linguistic language. I was completely unprepared for how time consuming and demanding this stage would be.

important is that the researcher's interpretation stems from the participants words (Smith et al., 2009), this is supported by Rodwell (1998) who suggests that in IPA, data analysis is inductive, whereby new theories are generated from the data and any constructs are grounded within the content of the inquiry.

In their interview, participant 3 commented *"I don't feel in a nursing home you get as much backup as you do in the hospital.*" Drawing on my own experiences of working with the nursing homes, reflecting, and interpreting the participants' narrative, led me to construct the conceptual comments "What do they mean by backup? Do they feel supported within the nursing home, or does this reflect a lack of support?" I feel that applying my knowledge and experience enabled me to interpret the participants' experiences which led me to conclude that nurses in the nursing homes often feel isolated and don't always receive the support from the managers or the wider health and social care system when it comes to reporting incidents.

The initial noting stage was again a very lengthy and iterative process, with the transcripts being reviewed line by line to try and pull out the descriptive, linguistic, and conceptual comments. In the initial noting stage, the participants' vocabulary was used to ensure that as concepts were constructed, they remained close to the participants' spoken words to reflect the unique social experiences of the participants (Franklin, 1995) and the idiographic element of IPA.

During this stage I completed numerous analytical memos for each transcript, described as where the researcher documents their thoughts about the content of the interview and the phenomenon under investigation (Saldana, 2016.) Writing analytical memos are an essential part of the data analysis stage, help to support the hermeneutic element, and is a process which takes place simultaneously with the initial noting stage (Saldana, 2016.) The analytical memos were used to help to understand and interpret the data, and along with the initial noting they were used to support the construction of themes.

Reflections 5

After I had completed the initial noting, I found that I was jumping to themes, similar to the themes identified through the scoping review. I do not think that I was doing this consciously but on reflection, after being highlighted by my supervisors the themes were very similar. I therefore deleted all the themes and reflecting the iterative nature of IPA research and data analysis I started again to review the transcript to explore the initial noting and concepts in more detail before starting to consider the emerging themes.

Step 3 – Developing emergent themes

Once the initial noting has been completed, the next stage is "developing emergent themes" which reflect the lived experience of the participant as captured from within the original transcript. Morse (2008) describes a theme as reflecting a meaningful essence within the data. During this stage, multiple constructions may be proposed in relation to the phenomenon, which enable the essential elements of the phenomenon to be understood (Rapport, 2005) and the research question to be answered.

In IPA, the aim is to start to examine the underlying ideas, thoughts, and experience of the participant, and through interpretation, elicit the latent content (Braun & Clarke, 2008). Experiences can be presented as either manifest or latent. Manifest refers to content which is visible and obvious and is directly seen, such as the words spoken during an interview (Graneheim & Lundman, 2004). Latent content is described as being hidden deep within the narrative (Kleinheskel, Rockich-Winston, Tawfik, & Wyatt, 2020), to access the latent, the researcher needs to interpret the implied meaning of the participant's experiences. The analysis and interpretation of the notes in the previous stage leads to the identification of emergent themes, or the construction of themes, and represents another element of the hermeneutic cycle. The first stage of the hermeneutic cycle took place during the interview when the participants were reflecting and interpreting their experiences. The next stage of the hermeneutic cycle is where the researcher uses their own knowledge and experiences to support the interpretation of the narrative offered by the participant. So, by using my prior knowledge and experiences I started to reflect and interpret, to make sense of the participants' lived experiences and to elicit the participants' implied meaning or the latent content of their narrative to develop themes. For example, an initial subordinate theme that was constructed, following analysis of the first interview (participant 3) was "lack of interest". Participant 3 shared an experience whereby they had reported an incident and felt that they were being dismissed by management, which was reflected in their narrative:

> *you've phoned next line manager and then that's it . . it just kinda stops . . . it's like why it's kinda like oh right I've read it on (computer system) blah de blah I might put an action plan in place I might not, I might do an audit on it I might not and that's where it slips down to me in a nursing home*

Drawing on my own experiences, and the narrative of the participant, my initial interpretation was that this reflected a lack of interest in incidents. This was not

manifest content, explicit in the participants narrative but instead latent, hidden within their narrative that was constructed following reflection upon my own experiences of working with the nursing home sector.

Reflecting the epistemological underpinnings of the study, analysis that focuses on the latent content, resulting in multiple constructions, is aligned to the constructionist epistemology (Braun & Clarke, 2008). In social constructionism reality is constructed and evolves based upon individual experiences and social interactions (Crotty, 2003). This demonstrates how through interaction between the participants and researcher, and with interpretation, the latent content of the participants' narrative is elicited and constructed into multiple themes further highlighting how, in social constructionism, multiple realities of the same experiences may be constructed pertaining to the same phenomenon (Burr, 2015).

Reflecting the interpretative element of IPA, the initial themes – the subordinate themes, were constructed based upon the participant's interpretation of the phenomenon, along with my own interpretation of the participant's narrative. The interpretative element of the data analysis was supported by my previous knowledge of working with the nursing home sector and my experience of incident reporting both in the NHS and the nursing home sector. This resulted in the construction of several themes which illustrated the key experiences of the participants.

Reflections 6

During the data analysis stages, it was noted that all participants highlighted situations which colleagues had been involved in, along with their own experiences. This made me question whether this was a triple hermeneutic rather than just a double hermeneutic in that the participants were recalling and interpreting the lived experiences of their colleagues, which had already been interpreted by their colleagues during discussions with the participants, following which I as the researcher was also then interpreting the participant's narrative. As I had only ever heard of double hermeneutics, this led me to review the literature to explore if there was any literature in relation to a triple hermeneutic.

From reviewing the literature, it was identified that there is little written about triple hermeneutics. Mare (2011) refers to a potential triple hermeneutic, where the third element is made up of the reader, who is trying to interpret the researcher, who is trying to make sense of the participant who is trying to make sense of their lived experience, as opposed to the participant trying to make sense of another person's lived experience

in relation to the content of the research. Montague, Phillips, Holland & Archer (2020) also discuss the challenges and complexities of hermeneutics when multiple researchers are involved, describing this as a triple hermeneutic. However, I was unable to identify any literature referencing the triple hermeneutics as I experienced them within my study. This could be an area requiring further exploration to provide guidance, structure, and to ensure a more consistent approach to the use of triple hermeneutics.

Step 4 - Searching for connections across emergent themes

The fourth stage is "searching for connections across emergent themes." Initially, the subordinate themes were presented chronologically in the transcript, in the order they were discussed during the interview and were then reordered to represent the connections between the subordinate themes. The subordinate themes were continually reviewed, regrouped, and renamed to ensure the most appropriate connections to construct the superordinate themes, whilst ensuring that the themes continued to closely reflect the participants' conversation. Adopting the hermeneutic approach of IPA research, again the superordinate themes were constructed by reviewing, analysing, and interpreting the participants' narrative. Drawing upon my own knowledge, and experience, along with information obtained from the scoping review, the participants' narrative was interpreted to construct themes based upon the research question and the aims and objectives of the research study. Reflecting the social constructionist approach, this enabled themes to be constructed which not only reflected the scope of the study, but also the participant's lived experience.

IPA is an iterative process, which resulted in the continual review of the themes. Some of the subordinate themes appeared quite fluid, in that they could fit into several the superordinate themes. Refining the subordinate and superordinate themes was an in-depth and assiduous process, to ensure the subordinate themes were appropriately aligned to the superordinate themes.

Step 5 - Moving to the next case

Once the first transcript had been analysed using the stages described above, the remaining three interviews were then transcribed and analysed using the same approach described above in stages 1-4. Reflecting the idiographic nature of IPA, the

contributions of each participant were reviewed to construct themes which reflected their own unique lived experience. Smith et al. (2009, p.100) suggest that to achieve this, “bracketing the analysis of the first case” is required to ensure each case is viewed in its own terms, to ensure the focus was specific to the participant’s experiences so that individual experiences were captured. Bracketing continued with each subsequent case to ensure the focus remained true to each participant’s unique experiences. This resulted in several subordinate themes being constructed for each participant.

Step 6 - Looking for patterns across cases

Once all interviews had been analysed as above, the final stage of the data analysis process took place. It is only once all transcripts have been analysed, and subordinate themes for each participant have been constructed that the cross-case analysis can begin. Although reflecting social constructionism and the belief that multiple realities exist, it was acknowledged that the data may reflect “multiple less aggregable realities” (Rodwell, 1998, p. 70) and data divergence. This was evidenced by some subordinate themes being developed which were only identified by one participant. For example, level of risk in the superordinate theme incident severity was only identified by participant 3, however as this reflected their lived experience, whilst also being considered relevant to the aims of objectives of the study, a decision was made to include this as a theme. An idiographic representation of the participant’s themes has been illustrated in appendix 6.

This stage involved looking for patterns across the different transcripts. The subordinate themes from each transcript were reviewed alongside the subordinate themes from the other transcripts. This process enabled the uniqueness of some themes to be identified along with the recurrence of some themes. This resulted in some themes being abandoned, and some themes being reconfigured and relabelled.

An example is in relation to the subordinate theme “lack of interest.” Following analysis of the first transcript, this was initially constructed as a subordinate theme, but as more transcripts were analysed and interpreted, other themes were constructed, which were connected to this theme. For example, “limited understanding/lack of knowledge” was considered to be as a result of a “lack of interest” in the area of incident reporting but was also significant enough to justify being a specific subordinate theme. “Lack of interest” as a subordinate theme then evolved into a superordinate theme and was

renamed “incident apathy”. Apathy reflects a lack of interest, and it was considered that this would be an appropriate overarching theme to aggregate a number of the subordinate themes which could be considered to reflect a general lack of interest.

Despite the idiographic nature of IPA, some of the subordinate themes are reflected across multiple transcripts reflecting convergence of the data. Smith et al. (2009) refer to this as recurrence. Smith et al. (2009, p.107) suggest that ‘no specific rule is used to determine what constitutes a recurrence’ but suggests that for an emergent or superordinate theme to be classified as recurrent it must be present in at least a third, or half of all participant interviews. This was the case in this study as five of the six superordinate themes constructed were reflected by the subordinate themes of all four participants. For example, the subordinate theme limited understanding/lack of knowledge, was identified by all four participants reflecting real data convergence. In contrast, there were some areas that were only identified by one participant, reflecting the idiographic nature of IPA and data divergence. However, these areas were still captured as a subordinate theme as they were considered relevant to the scope of the research study and in line with the research aims.

The analysis was dependent upon my interpretations, informed by my own knowledge and experiences and supported by reflections upon my own experiences. This helped to ensure that the connections between the emerging themes were relevant, and that the clustering of the subordinate themes demonstrated an interrelationship to construct the final superordinate themes (Smith et al., 2009).

Once the subordinate themes were determined, they were grouped to reflect the relationships between them to construct the superordinate themes. Graneheim & Lundman (2004) describe a theme as an expression of the latent content of the text and further suggest that a theme can be constructed of sub-themes (subordinate). A total of six superordinate themes were developed which will be presented and explored in detail in the following chapter.

Reflexivity

Professional Doctorates combine clinical practice along with a research process allowing issues in the real world, relevant to clinical practice, to be explored utilising a research framework (Taylor & Hicks, 2009.) Good research is not simply a matter of following rules and developing competencies. Researchers must be able to

demonstrate how and why decisions are made, rather than simply presenting the data; to achieve this the researcher needs to be reflexive. Reflexivity is described by Underwood, Satterthwait & Bartlett (2011, p.1585) as “the acknowledgment and identification of one’s place and presence in the research . . . and the process of using these insights to critically analyse the research process.” Reflexivity is concerned with how the researcher can influence the findings of a research study, either intentionally or unintentionally. Historically, researchers have rejected the notion of reflexivity, believing that it could hinder the research process (Etherington, 2004). However, some believe that reflexivity cannot be avoided in research (Smith, 1994) and that most researchers will acknowledge their role in the research.

Reflexivity is required to ensure the quality and credibility of the research (Barratt et al., 2020; Barry, Britten, Barber, Bradley, & Stevenson, 1999; Clancy, 2013; Finlay, 2003). Reflexivity does not eliminate bias but does assist to minimise it (Lincoln & Guba, 1985) by bringing any biases to the fore rather than attempting to deny them. The analysis of qualitative data can be a subjective process (Boyatzis, 1998) and as such data could be interpreted differently by other researchers (Noble & Smith, 2014). This is even more pertinent when using IPA as a research methodology, as the researcher is required to use their knowledge and experience to interpret the data. This is further acknowledged by Underwood et al. (2011) who suggest that researchers may not always want to minimise their impact on the research outcomes, for example in IPA research.

In IPA research the data analysis will always be a subjective process, as the analysis is dependent upon the double hermeneutics of the researcher trying to make sense and interpret the participant, who is interpreting and making sense of their experiences. IPA research will therefore always be influenced and dependent upon the researcher’s own interpretation. However, any fore conceptions as described by Heidegger (Smith et al., 2009), which involves a prior experience of working with the nursing homes, will need to be considered as these could pose a barrier to the data analysis. Fore conceptions, described as a “practical preunderstanding” (Warnke, 2011, p.91) could result in the researcher assuming a prior level of knowledge and being subconsciously resistant to new knowledge being offered. Conversely, fore conceptions could assist the researcher in understanding the complexities of the phenomenon being shared and influence the interpretation of the data and the generation of new knowledge. It is acknowledged that these factors could affect the trustworthiness of the study; however,

the subjective nature of the interpretation is a pre-requisite of IPA research, and the analysis of the data reflects the ontological and epistemological underpinnings of the study that reality is subjective and socially constructed. Therefore, it is essential that I acknowledge my experience and knowledge in relation to the research area and consider how this may influence my decision making.

Researchers should start by positioning themselves in relation to the research, to enable them to consider how their role can influence the research (Clancy, 2013). Therefore, I first needed to consider my role as a registered nurse, my role as Head of Quality in a CCG (at the time the research was conducted) and also as a practitioner-researcher and the possible conflict that this may cause, Clancy (2013) refers to this as the nurse/researcher divide. Ultimately the aim is for the research participants to open up and share their experiences. Being a nurse may help in developing a rapport with the participants due to sharing a common professional background and identity (Asselin, 2003) enabling them to feel more at ease. This is particularly important in IPA research as Alase (2017) claims that a bond is required between the researcher and participant to enable the participants to express themselves without fear of being judged, however, this may also cause conflict. Burns, Fenwick, Schmied and Sheehan (2012) suggests that if a close relationship develops between researcher and participant, the participant may disclose areas of poor practice, leaving the researcher feeling that they have breached a trust by reporting the incident. In acknowledging this, before the interview started participants were advised that any disclosure indicating poor practice would need to be reported to the home manager, in line with regulatory practice.

When the research was conducted, I was employed as Head of Quality in a CCG, where a significant element of my role involved working with the care sector. Although I worked in a different region to where the research was conducted, participants may have felt threatened by my role, viewing me as someone in a position of seniority with responsibility for the oversight and quality being delivered in care homes. This could have potentially affected the researcher/participant relationship as there was a risk that participants may have focused more on my clinical role as opposed to my researcher role. To try and minimise the impact of this, my background experience and interest in working to try and support the care sector was shared with the participants, along with information relating to the national context of incident reporting and the differences between the NHS and the care sector. This needed to be balanced with ensuring that

the participants did not assume that I already understood their experiences of incident reporting and omitted important information (Field, 1991; Simmons, 2007).

Having worked closely with nursing homes for several years, I have a good understanding of how they operate and the culture within them. I therefore needed to be cognisant when interviewing the participants that I did not assume that I already knew what was being shared by the participant and continued to probe to understand the participant's experience along with their own interpretation.

Etherington (2004) suggests that being reflexive is not easy. It requires the researcher to acknowledge their own experiences and how these may influence the research. Furthermore, the researcher needs to engage in a process of self-analysis and self-disclosure, whilst being able to strike a balance between self-disclosure and self-indulgence to ensure the focus remains primarily on the participants (Finlay, 2003). The researcher also needs to ensure that the participants' perspectives are emphasised over those of the researcher (Underwood et al., 2011).

Reflexivity is an iterative process, which has been undertaken throughout the duration of the study to provide good quality research. A research journal has been kept throughout the process to capture any thoughts and ideas along the journey, which are explored alongside the data (Clancy, 2013.) Jootun et al. (2009) further suggests that supervisors who are willing to challenge beliefs can assist a researcher in being reflexive. Therefore, relevant issues captured in my journal have been discussed with my supervisors, to seek challenge and an objective viewpoint.

Furthermore, reflecting on my own professional practice throughout this academic journey, I can see how my ability to reflect, apply critical thinking and analysis have been enhanced through undertaking a Professional Doctorate. These skills have been integrated into my professional practice to support with decision making, and in applying a more critical approach in my clinical and professional field.

Ethical considerations

Research ethics are a set of principles which guide research practice, the researcher's conduct and the management of any data collected (University of Salford, 2021). When undertaking any research, the ethical implications of the study needed to be considered to prevent any harm to either the researcher or the participants. Prior to commencing the research study, ethical approval was obtained from The University of Salford's Ethics Committee in February 2021 (see appendix 7), which required a

comprehensive application to be submitted detailing the ethical implications of the study. The ethical issues relating to this study will be discussed below.

Consent

Williamson (2007) suggests that to enable potential participants to be able to provide informed consent, all participants need to be fully informed about the planned research. Prior to recruitment, the nursing home managers were asked to distribute written information describing the research study and required involvement, to all registered nurses in their home who met the inclusion criteria (appendix 2 and appendix 3).

After initially speaking to all potential participants, I forwarded the participant information letter and sheet (appendix 2 and appendix 3) and consent form (appendix 4) and asked them to read the information ahead of the agreed interview date. Participants were advised that they could contact me directly either by phone or email to seek further clarification or ask any additional questions before the agreed interview date. Due to Covid-19 restrictions and the interviews having to take place over the telephone, I was unable to obtain a signed written consent form for participants. As an alternative, approved by the ethics committee, verbal consent was obtained. At the start of the interview, participants were asked if they had read the consent form, to confirm that they understood their involvement in the study and that they agreed to participate. Participants were also informed of their right to withdraw from the study, but it was highlighted to participants that any information obtained prior to withdrawal may still be included within the study as per the consent form. Verbal consent was then obtained from participants before taking starting the interview.

Anonymity & confidentiality

The researcher needs to ensure that participants understand the differences between anonymity and confidentiality (Danchev & Ross, 2014; Williamson, 2007). Anonymity is defined as a secure way of protecting data, where even the researcher is unable to easily link the data to the individual participants (Danchev & Ross, 2014; Polit & Beck, 2008).

It was explained to participants that due to the small number of participants involved in the study it may not be possible to assure anonymity, as the researcher and even the

participants themselves may be able to identify extracts within the study. However, anonymity to external readers was assured as no identifiable characteristics of the participants, such as job title or place of work, would be included within the report.

Confidentiality, defined as when data is reported in a way that will not publicly identify a participant (Polit & Beck, 2008), was assured for all participants. Participants were allocated an identification number and throughout the research study, all data obtained was stored securely ensuring that the participant cannot be associated to their identification number. Anonymity and confidentiality were discussed with all participants at the start of the interview before obtaining consent.

Organisational Reputation

Due to the sensitive nature of the research, it may be perceived that there is a risk of reputational damage to the nursing homes. As such, nursing homes may be reluctant to take part as it could be interpreted that the findings will suggest poor practice (Wagner et al., 2013) which may adversely affect the nursing home's reputation. To counter this, nursing home managers and research participants were provided with background information to the study to inform them that although incident reporting is well established within the NHS, that it is not yet been embedded within the nursing home sector, either nationally or internationally, as evidenced by the scoping review. They were informed that the aim of the research is to understand more about incident reporting in nursing homes and to look at how the findings could be used to support improvements in practice. The intention is to present the findings, along with reference to the national context of incident reporting in the care sector, to minimise the risk of harm and reputational damage to the nursing home sector as a whole.

All NHS providers and nursing homes have a regulatory requirement to report harms of moderate or severe harm (Ashurst, 2007), ensuring an investigation takes place to identify learning to prevent similar incidents from occurring. However, the scoping review identified that often participants are unclear as to what constitutes an incident which requires reporting (Hammoudi et al., 2018; Haw et al., 2014; Mostafaei et al., 2014; Rutledge et al., 2018; Yung et al., 2016). Therefore, it was possible that participants may disclose details of an incident that had not been reported at the time. As the researcher and participants were registered nurses, they were bound by the Nursing & Midwifery Council's [NMC] Code (2018) which incorporates areas such as

informed consent, confidentiality, and data protection (NMC, 2018). Clause 17.2 of the NMC Code "share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information" (NMC, 2018 p. 15) was highlighted to all participants.

Participants were informed at the start of the interview that if any information was shared during the interview which suggested that someone may have been harmed and that this incident not been reported appropriately that the researcher would be required to adhere to the NMC Code (2018) and ensure the incident was reported to the nursing home manager to enable an investigation to take place.

Whilst nursing homes are required to report incidents which result in moderate or serious harm there are no regulatory requirements to report incidents relating to no or low harm. Whilst these incidents may not have caused harm, they still meet the definition of an incident as defined by the NRLS (n.d.) as "any unintended or unexpected incident which could have or did lead to harm for one of more patients receiving NHS care". In NHS organisations incident reporting systems are widely used as a mechanism to identify and investigate risks so that practice can be changed (Pham et al., 2013), including the reporting of incidents of no or low harm. However, the adoption of incident reporting systems has been much slower across the care sector (Lafton & Fagerstrom, 2011) possibly indicating that the reporting of lower-level incidents has not been adopted. The scoping review highlighted that many participants do not feel it necessary to report an incident if no or low harm was sustained by the patient (Boyazidi et al., 2012; Dyab et al., 2018; Hammoudi et al., 2018; Haw et al., 2014; Lee, 2017; Mostafaei et al., 2014; Rutledge et al., 2018; Yung et al., 2016). Therefore, it was possible that during the interview incidents of no or low harm may be disclosed. However, during the interviews, whilst a number of incidents were discussed, ranging from near misses to serious harm, all appeared to have been reported appropriately.

Data Protection

The Caldicott Principles developed in 2013 and the General Data Protection Act (2018) were followed to ensure the correct use and storage of data. Data collected from the interviews is stored securely on the University of Salford's protected drive. Interview transcriptions have been coded to ensure anonymity of the participants. The

recordings of the interviews were deleted once transcribed and the files relating to the study will be deleted three years after completion of the study.

As the study does not involve researching patients and is not being conducted within an NHS organisation, ethical approval was only required from the University of Salford's Ethics Committee as opposed to the NHS Research Ethics Committee.

Chapter Summary

This chapter has identified the methods chosen to undertake the study along with a rationale for their choice and a reflection of their alignment to the chosen methodology of IPA. Data construction processes have been explored along with the supporting framework to aid the data analysis. Reflexivity has been introduced to identify how I have positioned myself in relation to the research and finally, the ethical considerations of the study have been presented along with confirmation that ethics approval had been granted prior to commencing the study. The following chapter will present the findings of the research which have been transcribed, analysed, and presented thematically.

Chapter 5

Findings

Introduction

This chapter will present the research findings along with a discussion reflecting the phenomenological, idiographic, and interpretative nature of the research. The unique nature of the research findings will be explored along with a consideration of the implications of practice.

Four participants were interviewed, all participants were female and a summary of their clinical background and experience is detailed in table 9. A more detailed synopsis of each participant's lived experience can be found in appendix 7. An extract from one of the interviews is also included as appendix 8.

Table 9 – Brief overview of participant's backgrounds

Participant 1	Participant 1 has been qualified for over 30 years and has spent the vast majority working in the care sector, only working in the NHS for a short period of time when first qualified.
Participant 2	Participant 2 has been qualified for over 30 years and has spent most of their career in the NHS, moving to the care sector approximately 5 years ago. They were employed in ward manager roles for the latter part of their NHS career prior to moving to the care sector
Participant 3	Participant 3 has been qualified for over 30 years and has spent most of their career working in the NHS. They were employed in senior nursing roles, similar to ward manager level and self-report a good understanding of incident reporting due to their experiences within the NHS They moved to the nursing home sector approximately three years ago.
Participant 4	Participant 4 has been qualified for almost 3 years. They started working in the NHS but left to move to the nursing home sector as they felt that they were not allowed sufficient patient focused time in their role in the NHS. They have worked in the nursing home sector for approximately 2 and a half years

Findings

A total of six superordinate themes were constructed, most with several subordinate themes: incident apathy, incident angst, incident severity, systems, inequity to the NHS, and benefits which can be seen in table 10. The final column of the table identifies which participants contributed to each subordinate theme.

Table 10 –Superordinate themes and related subordinate themes

Superordinate themes	Subordinate themes	Participants
Incident apathy	Limited understanding/lack of knowledge	P1, P2, P3, P4
	Limited education/training	P2, P3
	Limited management support	P2, P3, P4
	Lack of feedback	P3, P4
	Lack of carer involvement	P1, P2, P3, P4
	Organisational priority	P2, P3, P4
Incident angst	Fear	P1, P2, P3, P4
	Blame/Self-blame	P1, P3, P4
Incident severity	Level of harm	P2, P3, P4
	Level of risk	P3
Systems	Time	P1, P4
	Paper versus computer	P2, P4
	Access to IT systems	P2, P3, P4
Inequity to the NHS	Incident escalation	P2, P3
	Positive learning culture	P2, P4
Benefits – shared learning	No subordinate themes	P1, P2, P3, P4

The superordinate themes and related subordinate themes will be presented and discussed individually. Although the subordinate themes have been assigned to a superordinate theme, there is some overlap as some of the subordinate themes overlap with other superordinate themes, for example the subordinate theme - level of harm has been placed in the superordinate theme Incident Severity but it also closely related to the subordinate theme – Limited understanding/lack of knowledge in the

Incident Apathy superordinate theme. Connections between the themes will be discussed further within the narrative analysis below.

Extracts from the transcripts will be used to highlight the phenomenological and idiographic elements of the discussion and to highlight from where the interpretations developed. Throughout the narrative I have attempted to use quotes proportionally between the four participants, acknowledging that there were some themes where all participants shared similar experiences suggesting a degree of data convergence. There are also some themes only identified by one participant which serves to reflect the idiographic nature and also data divergence of IPA research.

Where ". . ." appears in the quotations, this is to reflect a pause in the participants' conversation. In social constructionism reality is considered to be the product of individual experiences that are constructed by each individual interpreting their own experiences (Rodwell, 1998); therefore, it is essential to reflect these pauses in the conversation as these linguistic elements of the narrative could be attributed to the participant reflecting on and interpreting their experiences.

Also, the name of the computer systems used within the nursing homes has been withheld so as not to identify the nursing homes.

Incident Apathy

Graneheim & Lundman (2004) describe a theme as an expression of the latent content of the text and further suggest that a theme can be constructed of sub-themes (subordinate). Therefore, through the process of data analysis and interpretation the researcher is illuminating the latent elements of the data. Following the interviews with the participants, and from analysing and interpreting the data, my interpretations identified "apathy" as a latent finding within the data. Apathy means a general lack of interest or enthusiasm, and from the interviews with the participants, and reflecting on my own experiences, my interpretation was that this collectively describes the participants' experiences in relation to incident reporting within the nursing homes. From analysing and interpreting the participants' experiences, and reflecting upon my own experiences, this led me to consider that the apathy towards incident reporting may also be a contributory factor of a number of the subordinate themes which were constructed. For example, apathy towards incident reporting could be a contributory factor for the limited training which is provided; if there is no interest in incident

reporting within the home then they are unlikely to invest in training. Similarly, if there is apathy towards incident reporting, this could be why there is a lack of feedback when incidents are reported. This superordinate theme starts to provide some insight as to why incidents may not be reported within the nursing home sector. All participants contributed to this superordinate theme and a number of the subordinate themes are interrelated, which will be discussed in the narrative below. Table 11 shows the subordinate themes constructed and which participants experienced each theme.

Table 11 – Superordinate theme – Incident apathy and related subordinate themes

Superordinate theme - Incident apathy				
Subordinate theme	P1	P2	P3	P4
Limited understanding/lack of knowledge	✓	✓	✓	✓
Limited education/training		✓	✓	
Limited management support		✓	✓	✓
Lack of feedback			✓	✓
Lack of carer involvement	✓	✓	✓	✓
Organisational priority		✓	✓	✓

<u>Limited understanding/lack of knowledge</u>

This theme reflects a limited understanding/lack of knowledge in relation to the identification of incidents, the importance of incident reporting and the related processes.

All four participants (P) indicated that there is a limited understanding/lack of knowledge in relation to incident reporting in the nursing home where they worked. The participants' experiences reflect a limited understanding of incident reporting by both the participants and also other staff within the homes, including the management teams.

> *we got told that we had to report ten incidents per month but sometimes there's not that in four weeks (P1)*

An incident can involve harm or no harm, and even near misses. Given the vast array of situations that could be reported as an incident, there appears to be a limited understanding about incident reporting, as even in a small nursing home it is highly probable that significantly more than ten incidents would occur per month.

> *sometimes, they might say aww you don't need to report that it's only a couple of missing tablets it's too much paperwork (P2)*

An incident such as this could result in significant harm, and if reported and investigated could lead to the identification of learning to improve practice. Failure to appreciate this and dismiss the incident again reflects a limited understanding of the incident reporting process.

Whist some participants (P2, P3) were able to demonstrate a good understanding of incident reporting due to their experiences working within the NHS, their interpretation was that the same level of knowledge was not shared by other staff within their nursing home.

> *it's about reporting on any incidents, if its clinical or non-clinical incident, it's about improving practice and being open and honest and transparent. (P2)*

P3 throughout their interview, reflected on a number of occasions, how their peers and the management team would often fail to see the bigger picture. In particular they discussed a limited understanding particularly in relation to near miss incidents in the nursing home sector, and described how they were viewed by staff for reporting near misses:

> *in a hospital you kinda pick up on the near misses, whereas in a nursing home I've just personally noticed it kinda waits until it happens (P3)*

> *they're not looking at the bigger picture, that's how I've seen it cause I do write a lot of near misses which they all think I'm crazy (P3)*

P3 further describes her frustrations when incidents that occur within the home are dismissed:

> *when you kinda do an incident form and you know it's going to build up you know it's going to get worse it kinda gets dismissed it's all kinda been written down before and right that's fine and stash it away (P3)*

P3 elaborates and highlights how she has tried to report incidents, near miss incidents, but explains the lack of acknowledgement in relation to the incident report:

> *well, this is what I was trying to tell you two weeks ago this is what I did an incident form for and you kind of get pushed back away it's kind of like it's not really happened so it's not really an incident but it is it's an incident waiting to happen (P3)*

This suggests that the nursing homes are not looking at the bigger picture, as described by P3, in that they appear to only focus on the specific incident and not the wider contributory factors which could have preceded the incident. This again reflects a lack of understanding.

Reflections 7

I can truly relate to P3's frustrations in relation to the identification and reporting of near misses. I can recall from my time working with various nursing homes, past and present, that there appears to be a lack of understanding as to what actually constitutes a near miss and also the connections between how a near miss incident can lead to a much bigger incident which causes significant harm. I appreciate the concerns expressed by P3 in that near misses can lead to a bigger incident as I have witnessed both in the NHS and also the nursing home sector: when reviewing an incident – there are often multiple smaller incidents which have occurred but have not been addressed, which could have prevented the bigger incident from occurring. I can also personally relate to P3's comment about people thinking that she is crazy for continuing to report multiple near misses – she is doing the right thing and I personally feel that it is a lack of knowledge and understanding on the part of others in relation to the process that make them view her in this way.

Limited education/training

A lack of education or training in relation to incident reporting could account for the limited knowledge and understanding discussed in the previous theme. During the interviews, the participants highlighted that there was a lack of training in relation to incident reporting. So, whilst it was evident from the interviews with participants that there was a lack of training, the rationale for the lack of training was latent. Interpreting the participant's experiences and drawing upon my own knowledge and experiences led me to the interpretation that this could be as a direct result of the general apathy towards incident reporting, by both participants for not seeking out training and also the nursing home managers for not providing training. Participants' shared their frustrations when they were dismissed by the managers when trying to report incidents,

which led me to reflect on my own experiences where my concerns about incident reporting had also been disregarded. Participants interpretations suggest that there is a general lack of understanding in relation to incident reporting, by both registered nurses in the home and also the nursing home managers, this could reflect the general apathy towards incident reporting and be why incident reporting does not appear to be considered a priority within the nursing home by either the registered nurses or home managers. Furthermore, if staff have a limited understanding of incident reporting, then they are unlikely to understand the requirements and rationale for reporting incidents.

As well as a limited understanding of incidents in general in the nursing home sector, P3 also highlighted that the registered nurses within the nursing homes struggle to complete an incident report:

> *they just don't know how to write so I think a lot of it is learning how to write an incident form errm . . . without either waffling or just not putting enough on (P3)*

This further supports the lack of training within the nursing home in relation to incident reporting and how to complete an incident form, accessing training may support the nurses in how to complete an incident form but also serve to raise awareness of incidents and the importance of reporting.

> *there's no education, you know about all the different kinds of harms that someone can have (P2)*

> *I don't think there's a lot of training out there whether its incidents, accidents, near misses anything like that (P3)*

Education and training in relation to incident reporting are necessary to support staff in developing knowledge and understanding. Whilst training in relation to incident reporting is common practice in many NHS organisations, it does not appear to be so in nursing homes. It is not clear why training in relation to incidents is not provided in the nursing home, further exploration, reflection, and interpretation of this latent content has identified two possible explanations. Primarily, participants expressed a lack of understanding generally about incidents. When asked if other nurses in the home and the management team understand what incidents are, participant 3 responded:

> *I think a lot of them. . . and this sounds awful . . .I don't think a lot of them do (P3)*

If the nurses and carers who work in the nursing homes do not have a good understanding of incidents, then they are unlikely to understand the need for training to develop their knowledge in the area. Reflecting on my own experiences I also consider this to be an accurate interpretation. Furthermore, from my experience of working with nursing homes, in a commissioning capacity and also supporting clinically, incident reporting as a process did not appear to be a priority within the homes and there did not appear to be any incident reporting training provided in the homes. Participant 2 reflected on a situation where they were advised by management not to bother reporting an incident when a medication error occurred:

> *Sometimes, they might say aww you don't need to report that it's only a couple of missing tablets it's too much paperwork (P2)*

Suggesting that reporting an incident is too much paperwork, not only suggests a lack of understanding about incidents, but also that completing the paperwork is not a priority. The managers' response to incidents could also be interpreted as a lack of knowledge in relation to incident reporting, although the managers' experience of incident reporting was not part of the remit of this study. Organisational priority is a subordinate theme which sits under the incident apathy superordinate theme which is explored below.

<u>Limited management support.</u>

Limited management support was identified by three participants with participants describing how they were often excluded from the incident reporting process and experienced criticism from management:

> *It's [the incident] managed you know from the managers perspective whereas I think when I worked in the hospital it was much more open, a team approach (P2)*

> *Staff are not involved in the investigations in this nursing home, no no, never (P2)*

> *you just kinda get pushed out once you've done the incident form (P3)*

P3 also described how they often felt dismissed when reporting an incident. They used the metaphor *"off you trot"* on a number of occasions to illuminate their experiences

and how that, often when reporting incidents, she felt that she was being dismissed by the management team:

> *it's kinda dismissed so you're like oh right ok and it's kinda filed away and off you trot carry on (P3)*

If the nursing staff feel like they are being dismissed when they report an incident, this may prevent further incidents from being reported, by feeling like they are wasting their time.

P4 also described the criticism received from the management team in relation to the completion of incident reports; management support and training would help to improve knowledge of incident reporting and also the quality and content of the reports:

> *if they've not done it fully correct in terms of not putting it on [the computer] then they get negative feedback from the management team (P4)*

Managers were also identified as a barrier to reporting. P4 explained that in the incident reporting system there is a section that asks about staffing levels. This is also asked in NHS incidents as it is widely acknowledged that low staffing levels can be a contributory factor to incidents occurring, but P4 describes how they are told not to highlight staffing issues in incident reports:

> *there's a section on there [the computer system] where you've got low staffing to report staffing issues . . . but sometimes management don't want you to add that as it comes back on them as to why they have not helped with that whereas in the hospital if you've not got the staff, they encourage you to put it on there to flag it to higher management but it seems the opposite in the care homes (P4)*

This not only reflects a lack of management support but also limited understanding about the purpose of incident reporting being to learn to improve practice. If low staffing levels have contributed to an incident, then it needs identifying and addressing, to prevent similar incidents from occurring.

<u>Lack of feedback</u>

This theme was identified by a couple of participants and described their frustrations about a lack of follow up once they had reported an incident and how not receiving any feedback made them feel like reporting incidents was a waste of time:

I suppose it's like a negative feeling because you don't really get anything back its just like oh right, I've read that report, and you know you're waiting for a bit more but you don't get it (P3)

you don't always get feedback so do you wonder about the value of completing an incident report? (P4)

P4 also reports how often the only feedback they receive is in relation to negative situations, so this serves to further discourage staff from reporting

there's a lot more feedback if it's something negative that's gone on rather than being a positive thing (P4)

Lack of carer involvement

Three of the four participants identified that although carers (may also be referred to as support workers) often identify incidents they were unable to report an incident into the system and that they had to verbally report to the registered nurse who would then input into the system:

so, it might be the carer that discovers but it won't be the carer in the care home who reports it (P2)

carers identify incidents but can't access system (P3)

it wouldn't be the carer (that would report) they would go to the nurse on duty (P1)

the carers don't report incidents no (P2)

carers don't write incident forms (P3)

P4 explained that carer's understanding of the incident reporting system is limited as they are not actively involved. This also links to the subordinate theme of limited understanding and extends to include all staff working within the nursing home, not just the registered nurses.

carers don't have much of an understanding of the system cause they're not involved (P4)

Improving carers knowledge and allowing them to report incidents may serve to increase incident reporting in the nursing home sector.

Organisational priority

Closely related to the other subordinate themes and possibly a causative factor of some of the other subordinate themes is incident reporting as an organisational priority. If incident reporting was considered to be an organisational priority within the nursing homes, like it is in the NHS, then it is probable that there would be more education and training which would help to develop knowledge and awareness. This in turn may result in a more open and supportive approach being adopted by management with more feedback being provided which is an essential element of the incident reporting process. In exploring options to encourage and facilitate increased incident reporting, it is also possible that the incident reporting process would be opened up to all staff within the home such as carers instead of excluding their largest workforce from a key patient safety process.

> *in some nursing homes it's like it's too much paperwork so we don't bother (P2)*

P4 describes how there are no positive outcomes from incident reporting and how management often discourage reporting:

> *more like a pen and paper exercise and we don't actually achieve anything from it (P4)*
>
> *I remember mentioning to one manager about unsafe staffing as there was not enough staff to do the job and it was like no no you don't need to do that kinda response (p4)*

Incident apathy as a superordinate theme collates a number of experiences discussed by the participants to reflect an overall lack of interest in relation to incident reporting. Reflecting on and interpreting the experiences shared by the participants led me to the conclusion that incident reporting is not an organisational priority in nursing homes, as it is in the NHS, and this may be a key contributory factor to the other subordinate themes.

Incident Angst

This theme relates to the numerous fears and anxieties experienced by participants in relation to incident reporting, see table 12 for related subordinate themes which will be discussed below.

Table 12 – Superordinate theme – Incident angst and related subordinate themes

Superordinate theme - Incident angst				
Subordinate theme	P1	P2	P3	P4
Fear	✓	✓	✓	✓
Blame/self-blame	✓		✓	✓

Fear

Fear was identified by all participants as an experience in relation to incident reporting. Fear could also pose a barrier to incident reporting by preventing the reporting of incidents. P1 describes an experience of taking part in an incident investigation and how they felt:

> *just sitting there, you just felt like you were on trial (P1)*

P2 highlighted how staff are concerned about the consequences of reporting an incident:

> *staff are frightened to report errors, yes . . . people are frightened of the consequences of losing their job (P2)*

P3 described how one situation relating to an incident escalated into *"all hell breaking loose"* to reflect the fear staff involved in an incident experienced and went on to further explain how they felt when an incident occurred:

> *it's like that scared cat moment, you're in the headlight (P3)*

P4 recalled an experience whereby the way the incident was handled by the management team resulted in the member of staff involved being too scared to admit their involvement:

> *it was made out to be such a big thing and they probably thought that they were going to lose their job (P4)*

P3 further highlights that management could help to allay fears and improve the situation by talking to the nursing staff and explaining that whilst an incident may have to be investigated, it doesn't mean that they will get in trouble:

> *if you write an incident, we're gonna act on it but it doesn't mean that we're gonna come down and scream down your neck (P3)*

Blame

Blame was identified by three participants as a reason why some nursing staff are reluctant to report incidents. P1 explained how nursing staff feel that the incident reporting process is more concerned with blaming staff rather than looking how to learn and improve practice:

> *I think it's that they (nurses) feel that it's about blame instead of learning (P1)*

P1 also described concerns about the consequences for colleagues when reporting an incident:

> *It's like a . . . you don't want to get your work colleague into trouble (P1)*

Whilst P3 did not personally feel as though they were being blamed if they reported an incident, they did identify that some of their colleagues do feel as though they are being blamed when an incident occurs:

> *I do feel that a lot of them feel like they're getting blamed if they put an incident report in (P3)*

However, P1 also explains that they have personally apportioned self-blame when an incident has occurred or when having to report an incident:

> *I think I just blamed myself . . . for not doing the job properly (P1)*

P4 describes the culture within their organisation as being more focused on blame than learning, and highlights how during one incident investigation, management seemed to be actively trying to identify the person involved in the incident to apportion blame:

> *I would say the actual system and processes leans more towards blame (P4)*

> *management were looking for who was to blame errm . . . they even went as far as looking at the food diaries for that date to see who had given her the food (P4)*

The way this was pursued by management resulted in the member of staff never coming forward to acknowledge their involvement in the incident.

Fear and blame are significant factors experienced by most of the participants. The participants have reflected on how these experiences have made them feel in relation to incident reporting, and it is clear from their narrative that these feelings could pose as a barrier to incident reporting.

Incident Severity

The subordinate themes of level of harm and level of risk were grouped together under the superordinate theme of Incident Severity – see table 13, to indicate how risks appear to be managed depending upon the level of harm or level of the risk within the nursing home.

Table 13– Superordinate theme – Incident severity and related subordinate themes

Superordinate theme - Incident severity				
Subordinate theme	P1	P2	P3	P4
Level of harm		✓	✓	✓
Level of risk			✓	

<u>Level of harm</u>

In attempting to elicit what determines whether to report an incident, the level of harm a patient sustained because of the incident was explored. Three of the participants identified level of harm as a factor in determining whether to report an incident, but also as to how the incident was received by management:

> *sometimes they'll (management) look at what the tablet is, so say its docusate or something like that it's like, . . . it's only a docusate they're not going to come to any harm by not having a docusate so that wouldn't be reported (P2)*

P3 highlights that whilst harms of both low harm and severe harm may be reported, incidents resulting in low harm may not be investigated:

> *whereas if they've (resident) fallen and no injuries it's like oh right they've fallen thanks for your incident report . . . do you know what I mean, it's kind of I think acted on* ***more*** *if you know they've needed some kind of intervention (P3)*
>
> *I think it depends on the types of incidents I'd say anything where there is actually harm to a resident is reported (P4)*

This reflects a lack of understanding of incident reporting as the purpose is to learn from errors to prevent similar incidents occurring again, regardless of the degree of harm sustained, if any. Significant learning can often occur from a near miss incident where no harm was sustained.

Level of risk

P3 expanded further on the level of harm to describe the associated level of risk with an incident and described how this would influence how an incident was managed within the home once it had been reported:

> *to me this is where is slips down in a nursing home . . . if its low risk there's not much, whereas if its high risk there's a lot more investigation. The CCG are informed everything, everybody gets informed but if its low risk it's kinda . . . like right there we go nothing doesn't really get far, no [laughs] (P3)*

If there is a risk to organisational reputation, or an external investigation, P3 suggests that there is more likely to be a comprehensive investigation, and conversely identifies that with lower-risk incidents, which presumably do not require external involvement, will not be investigated in the same way. P3 laughed after making this comment, my interpretation was that this was possibly as a reflection of embarrassment in the way in which the incidents are not managed equitably to the NHS.

Whilst the level of harm and risk may affect how an incident is managed in the nursing home, this also relates to the subordinate theme *limited understanding/lack of knowledge.* All incidents have the potential to highlight learning and should therefore all be subject to a comprehensive review in an attempt to prevent similar incidents from occurring, regardless of external scrutiny within or external to the home.

Systems

Systems was constructed as a superordinate theme to reflect the operational systems within the nursing homes and integrates the subordinate themes of time, reporting systems, and access to information technology (IT) – see table 14.

Table 14 – Superordinate theme – Systems and related subordinate themes

Superordinate theme - Systems				
Subordinate theme	P1	P2	P3	P4
Time	✓			✓
Paper versus computer		✓		✓
Access to IT systems		✓	✓	✓

Time

Time was identified as a subordinate theme by two participants, both of whom had spent most of their careers in the nursing home sector. When asked if there was enough time to report incidents P1 explained:

> *not at that precise moment . . . no because you're actually dealing with the incident, and then you move onto something else which needs to be done (P1)*
>
> *I know that you should deal with it at the time but when there is only one qualified nurse on there isn't the time (P1)*

P4 also considered lack of time to be a barrier to incident reporting:

> *sometimes there's just not enough time to put things down where it was quite a minor incident or a near miss so things like that are not really reported (P4)*

P4 also considered incident reporting to be a waste of time highlighting that often there was a lack of action following an incident:

> *it takes quite a lot of time and effort to report an incident . . . and if it's nothing major, we don't really see much evidence of anything changing (P4)*

The subordinate theme Time also directly relates to several other themes. If nursing staff had a greater understanding of incident reporting, and the potential benefits, they may not consider time to be a barrier. P1 highlighted that completing an incident report is difficult when they are the only nurse on duty. If carers were involved in the process and able to report, this would alleviate the pressure on the registered nursing staff. Furthermore, P4 shared their frustrations at the lack of change following an incident being reported. With more management support and feedback following an incident, this may help P4 to appreciate the benefits of reporting and not perceive the time taken to complete a report as a barrier.

Reflections 8

*When reviewing and analysing the data I was really surprised that **Time** was not identified by all participants as a theme. When the scoping review was conducted, **Time** featured as a theme in a number of the studies I reviewed, and I know from personal experience of completing incident reports and working with clinical teams that incident reporting is often perceived to be very time consuming. However, it was interesting to note that the two participants who identified **Time** as an issue were both nurses who had spent the majority of their careers in the nursing home sector. It could be that P2 and P3 were more accustomed to completing higher numbers of incident reports due to their NHS background, where incident reporting is well embedded so did not consider time to be a barrier.*

Paper versus computer

Historically, incident reporting systems were generally paper based, handwritten reports collated in a folder in the manager's office. Today a number of electronic incident reporting systems exist to support the process. Whilst electronic systems are common practice in NHS organisations, they are expensive and often unaffordable in smaller private nursing homes, as such many nursing homes still use paper-based systems to report incidents. However, the participants reflected different opinions as to which is considered to be the better approach.

P2 has a background experience of working in the NHS so is used to working with an electronic system and also uses an electronic system to incident report in their current nursing home. However, from experience of working in other nursing homes they acknowledge the difficulties of using a paper-based system:

I also think that paperwork is a barrier, it's much easier now to do it online (P2)

P4 has limited experience of working in the NHS but works in a larger nursing home which has an electronic system to report incidents. However, in contrast to P2, they feel that the electronic system is an actual barrier to reporting incidents:

> *the technology that is used is a bit of a barrier for some of the nurses, some of the older nurses do struggle with computer technology (P4)*
>
> *I think a lot of staff preferred when it was pen and paper version as it was a lot quicker for them (P4)*

The electronic incident reporting system used in the home where P4 worked was relatively new and there had been limited training to support the implementation. This could link in with the subordinate theme of limited training as if the nursing staff received adequate training and support in using the new IT system, there may not be the same barriers.

Access to IT systems

Access to IT systems, including training to use the systems, was highlighted by three participants. P2 highlighted the differences between technology in the NHS compared to the nursing home sector:

> *but some homes don't have technology, they just don't have the technology like they have in the NHS (P2)*

Although P3 is experienced in using IT systems to report incidents, they do acknowledge that a lot of the staff in the home are not comfortable using the computers, they even describe the system as a "*big computer system"* to emphasise, as though to exaggerate the fear it causes people:

> *it's all on a big computer system and this computer terrifies a lot of nurses in the nursing home as they're just not used to (P3)*

Access to IT is also highlighted as an issue and linked to the subordinate theme of lack of carer involvement. Although it has been highlighted that carers often identify incidents, from the participants interviewed it transpires that carers do not have access to the IT systems in nursing homes, whereas in the NHS all staff have access and are encouraged to directly report into the system:

but none of the carers report no no. . . you can add the carers on errm . . .as a witness errm . . . and then basically write down what they've told me . . .but no, no they don't complete incident forms (P3)

we've got a desk top computer that only a few nurses actually have the log in for, the carers don't have access (P4)

The quality and functionality of the IT equipment was also raised by P4 as a barrier to reporting due to the time taken to navigate through the system to report an incident:

but the tablets are the cheapest ones going; the touch screens are shocking errm . . .I don't think I'd even be able to have the patience to log anything on it errm because of how long it takes to do anything on it and how unresponsive it is so that can be a barrier as well (P4)

Inequity to the NHS

Nursing homes, although private providers, provide NHS funded care. However there appears to be significant inequity between the way incidents are managed in the NHS compared to nursing homes. This superordinate theme has two subordinate themes: incident escalation and positive learning culture – see table 15.

Table 15 – Superordinate theme – Inequity to the NHS and related subordinate themes

Superordinate theme – Inequity to the NHS				
Subordinate theme	P1	P2	P3	P4
Incident escalation		✓	✓	
Positive learning culture		✓		✓

<u>Incident escalation</u>

Participants 2 and 3 who both have extensive backgrounds working in the NHS shared their experiences of how incidents appear to be managed differently in the NHS compared to in the nursing home sector. They believed that a more critical approach is adopted when an incident occurs in the nursing home and staff are treated less favourably.

P2 reflects on their experiences in the NHS and draws a direct comparison to the way in which medication errors are addressed:

I found that there were lots of gaps in the NHS on the drug charts and nothing was ever done even though it was reported but that might have changed now. But when I went started in (nursing home), one gap resulted in an investigation and a potential safeguarding referral (P2)

and if one tablet hasn't been given or signed for its immediately investigated and it's reported as a safeguarding incident. (P2)

P2 also highlighted that whilst greater numbers of incidents were reported in the NHS, they were not always subject to a comprehensive investigation:

I feel that there's more of a raised awareness of harm in care homes, you know, and things are acted on in care homes where maybe they wouldn't have been in the NHS (P2)

so, although the NHS report more incidents, they are not necessarily investigated to the same degree in the care homes (P2)

The fear in relation to the inequitable consequences of incidents in the nursing homes was also shared by P2:

yeah, in the care homes, I wonder sometimes if that makes people frightened in care homes, you know it's so robust I mean I'll check a drug charts 3 times a day in the care home cause I know the consequences of omissions, . . . you know the consequences so I am overly cautious (P2)

P2 further explained how incidents in the nursing home may be referred into safeguarding, whereas similar incidents in the NHS would not be referred and subjected to external investigation. Having experience of working with the nursing home sector I was able to reflect and interpret the participant's experiences in relation to safeguarding. By "safeguarding" the participant was describing a formal process, where an investigation would be conducted and overseen externally by the local authority, thereby introducing external scrutiny:

the consequences are, if you've not given a tablet in care homes it would be investigated and it would be a safeguarding . . . they didn't have that process in the NHS where things would go as far as safeguarding (P2).

P2 has highlighted from their experience of working in both the NHS and the nursing home environment how the management of incidents is inequitable to the NHS. P3 reflects on how, in their experience, the inequity to the NHS is much wider than just incident reporting. In their experience despite all registered nurses holding the same

minimum qualification, nurses who work in nursing homes are not regarded in the same esteem:

> *nurses in care home setting are treated differently than nurses in hospitals . . . well I've noticed that I just feel like people think oh right you work in a nursing home you're not really a nurse then anymore (P3)*

> *like with the incident reporting thinking why this has gone to safeguarding cause if I was on a hospital ward it wouldn't have, so . . . you are treated differently I think you're treated as this lower being that's how I feel sometimes (P3)*

Whilst it is evident from P2's and P3's experience that there appears to be inequity between the NHS and the nursing home sector, it is unclear why this is the case. Further exploration may be required to understand why the differences exist to start to address the issues, although this falls outside the remit of this study.

Positive learning culture

A positive learning culture is well documented as being an essential factor in supporting incident reporting (NHSE & I, 2019). However, experiences shared by a couple of the participants reflects the lack of a positive learning culture within the nursing home sector. P2 discussed a specific incident where a member of staff was dismissed for making an error:

> *I've seen staff be dismissed for making drug errors and not signing for things (P2)*

I personally have been involved in many situations where a medication error has been made in the NHS, and I have never known a member of staff be dismissed. Instead support and training is offered to the individual to try and prevent a similar incident from occurring. This is supported by P2's experiences:

> *I think that the learning in the NHS is different, I think the way they go about it its different it's more positive (P2)*

> *the NHS has moved away from the blame culture, more into supporting people with the learning and development and learning from incidents (P2)*

P2 elaborates by describing their experiences or learning from incidents in the NHS and how this differs in the nursing home sector:

> *they (incidents) just seem to disappear into the ether there doesn't seem to be anything that comes back. In the NHS its built into the system about feeding back to the reporter but we don't have that in the care homes (P2)*

P4 reflected on a situation where an incident occurred, and the approach taken by management was less than supportive and did not reflect a learning culture:

> *I would say the actual system itself actually leans more towards a blame culture as management were looking for who was to blame (P4)*

Developing a positive learning culture is essential to encourage incident reporting. Staff need to feel confident that in reporting errors they will be supported so that learning can be identified to make improvements to patient care.

Benefits – shared learning

The final superordinate theme to be constructed relates to the Benefits of incident reporting, with all participants contributing suggesting convergence of the findings. The findings all reflected the shared learning that occurs as a result of incident reporting – see table 16.

Table 16 – Superordinate theme – Benefits of incident reporting

Superordinate theme – Benefits				
	P1	P2	P3	P4
Shared learning	✓	✓	✓	✓

P1 reflected on how, as a team, they learned from an incident where a resident had sustained a fall and how this had changed their practice:

> *we did learn a lot from that and that has changed the way we deal with falls (P1)*

However, they also highlighted that whilst incidents are discussed with all qualified nurses within the nursing home, there is no mention of whether the same is communicated to the other staff within the home:

> *incidents are discussed with all qualified nurses to make sure it doesn't happen again (P1)*

It was also identified how the learning can be translated into improving patient care and how positives can be realised from a negative situation:

> *the benefits are to . . . . provide you with errm . . . the audit trail and the evidence, benefits of reporting incidents is to learn from what we do and to gather data that can be used in other sources regarding incidents and to make things better for patients or residents, how we can do things better (P2)*
>
> *and I think that if they understand with the shared learning that it's about making things better and that we're doing something with something that might not have gone well but we're turning it round and turning it into something positive (P2)*
>
> *I think it's important for the safety aspects as well as anything else you know that's what you're there for patients' wellbeing and safety (P3)*

P4 described how the incident reporting process creates wider opportunities for learning and highlights how trends can be captured to support learning:

> *it can help look at factors that you not particularly thought to look at before (P4)*
>
> *the main benefit is that you do get to look at the bigger picture and if there are trends in things occurring on the unit you can pick them up a bit more with them all being collated into one system (P4)*

All participants shared their understanding and experiences of the benefits of learning from incidents. There are many benefits to reporting patient safety incidents, not just to improve the safety of care and patient experience, but also for the individual staff involved as well as the organisation. This needs to be acknowledged and embraced by all care providers to support engagement with the incident reporting process.

Higher level interpretation

The aim of the study was to develop an understanding of the registered nurses' lived experience of incident reporting in the nursing home sector. The data demonstrates

both data convergence, whereby all participants reflect similar experiences and data divergence, with two subordinate themes only being experienced by one participant.

Six superordinate themes were identified along with 15 subordinate themes. The superordinate themes are broad, overarching themes, containing inter-related subordinate themes. Whereas the subordinate themes relate to specific areas which influenced the registered nurses' lived experience of incident reporting. These themes could be both internal or external to their sphere of control, and can be classified as either micro, meso or macro. The micro level includes day to day and individual factors and will be described in relation to individual accountability. Meso level relates to organisational and institutional factors and will be discussed in relation to local engagement, and finally macro level factors are legal, regulatory, or economic and will be explored in relation to system level facilitation (Smith et al., 2019).

Higher level interpretation relates specifically to IPA as a research methodology, where the hermeneutic cycle requires a deeper interpretation of the findings to elicit the essence of the participant's lived experience.

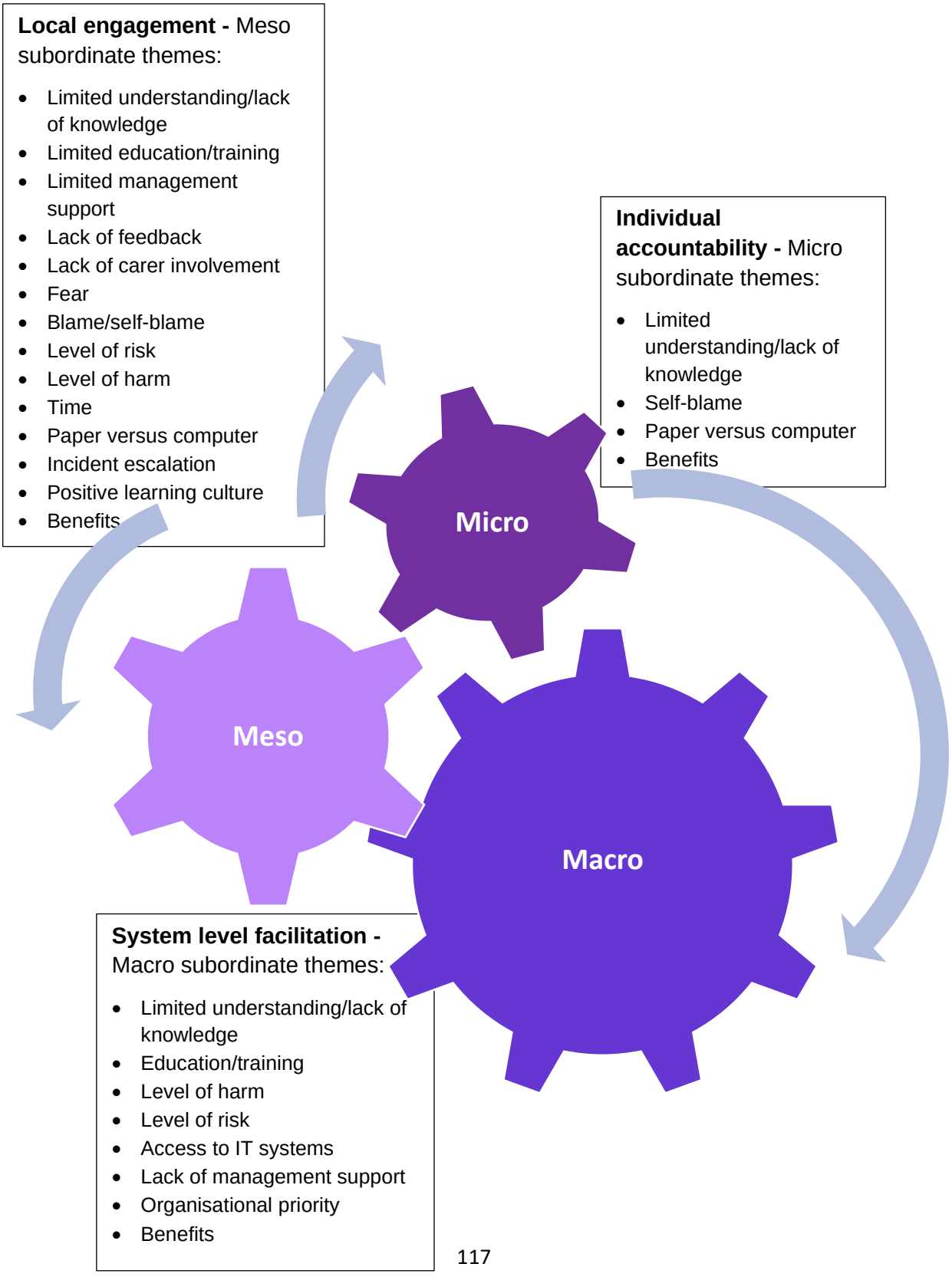
Dynamic Gears Model

In 2016, Mulvale, Embrett and Razzavi (2016) developed a dynamic gears model to present their study findings. The dynamic gears model indicates that the relationship between the internal and external factors is dynamic, due to changes in policy, contexts, and experiences (Mulvale et al., 2016) and this in turn integrates the input with the output. These factors co-exist as "gears" that function together to determine the collaborative output. Therefore, a change in one element of the input (macro, meso or micro) will result in a gear change which will directly influence the output (the nurses' lived experience).

This model is being used to present the findings from this study – see figure 3. In relation to this study, the input reflects the contextual factors (themes), divided into micro, meso and macro levels, whilst the output reflects the nurses lived experience, and my interpretations as the researcher. Due to the breadth of the superordinate themes, they are represented within all three levels – micro, meso and macro, therefore it is the subordinate themes which will be explored in more detail. The levels have been described in relation to their context in this study and the registered nurses' lived experience.

It is noted in the following that some of the subordinate themes sit in more than one of the levels – micro, meso and macro, which reflects the fluidity and the multidimensional elements of the factors, for example limited understanding/lack of knowledge sits in both the micro and meso domains.

Figure 3 - Dynamic gears model by (Mulvale et al., 2016)



Individual accountability (micro)

In keeping with the hermeneutic cycle of IPA, the following section will present further interpretations of the findings that relate to individual accountability (micro level). Micro level themes relate to day-to-day practice and individual factors (Smith et al., 2019) reflecting the individual accountability that all registered nurses have in relation to their practice. These factors will have a direct impact on the registered nurses' lived experience of incident reporting and includes the following subordinate themes:

- limited understanding/lack of knowledge
- paper versus computer
- self-blame
- benefits

Micro level factors are ones which have the potential to be influenced in part, and changed by the individuals involved, such as the registered nurses, rather than requiring higher authority or external input to influence.

One of the objectives of the study was 'to determine what registered nurses in nursing homes, understand by the term "incident" in relation to incident reporting.' My interpretation of the findings is that there is significant variation as to what the registered nurses in nursing homes understand by the term incident dependent upon their previous experiences. Furthermore, it appears that failure to identify incidents and acknowledge near misses, could indicate a *limited understanding/lack of knowledge* in relation to incidents and reporting. Limited understanding could also be a barrier to incident reporting, with the identification of barriers also highlighted as an objective of the research.

The level of understanding in relation to incident reporting was variable between the four participants. Two of the participants (P2 & P3), who had worked extensively in the NHS, demonstrated a good understanding of incident reporting, whilst acknowledging that the same level of knowledge was not shared by their peers in the nursing home sector.

My interpretations led me to conclude that enhancing knowledge and understanding of incident reporting, would enable registered nurses to understand their responsibilities in relation to incidents, together with an understanding of the wider system issues that contribute to incidents occurring. This in turn may help to reduce the element of self-

blame experienced by one participant in the study. Although *self-blame* was only reflected by one participant (P1), this was still considered relevant to the study and included, reflecting the idiographic nature of IPA. Whilst fear and blame were identified in the scoping review, self-blame was not, indicating that this is a new finding.

Another micro level factor to consider is in relation to the participants' experiences of reporting systems. Experiences were mixed in relation to the use of either *paper or computer-based* systems to report incidents. One participant (P2) reflected that it was easier to report incidents via an online system, whereas another (P4) felt that it was much easier to use a paper-based system. The rationales were multifactorial and considered factors such as the age of staff, familiarity, and capability in using computer systems and the number of physical computers available.

One participant (P3) reported that staff were terrified of the *"big computer system"* within the home. This provides a new insight into the use of technology within the nursing homes as whilst electronic systems were identified in the scoping review as a potential barrier to incident reporting, this was in relation to making the reporting process more difficult than previous paper-based systems, rather than fear. However, staff being terrified to use the *"big computer system"* could reflect a latent element of their experience. Rather than being terrified to report an incident due to having to use the computer system, it could be that the computer was used to disguise other fears associated with reporting an incident, such as the fear of being blamed for an incident occurring.

However, my interpretations are that incident reporting systems, whether paper based or computer, are only a vehicle to report. Unless staff are supported to develop the knowledge and understanding so that they can identify incidents and understand the importance of incident reporting, it is probable that incidents will remain unreported.

Furthermore, regardless of the incident reporting system in use, registered nurses need to take accountability by familiarising themselves and actively engaging with the process so that the *benefits* of incident reporting are realised. Although one of themes was limited knowledge and understanding of incident reporting, it was positive that all participants were able to describe the *benefits* of incident reporting and the shared learning that can occur following an incident. However, the fact that it was reported by all participants that incidents often go unreported, challenges the depth of knowledge and understanding in relation to the benefits of incident reporting.

Understanding the *benefits* of incident reporting is directly related to the theme limited understanding/lack of knowledge, as it is my interpretation that if knowledge and understanding of incident reporting was strengthened in the nursing home workforce, then it is likely that more incidents would be reported, and more staff would realise the benefits.

The *benefits* of incident reporting were not identified as a theme from the scoping review, therefore the findings from this study further contribute to and enhance the body of knowledge in relation to registered nurses' understanding the benefits of incident reporting. However, the limited knowledge in relation to incident reporting has further highlighted that nurses may not fully appreciate the benefits of incident reporting.

Individual accountability summary

My interpretations of the findings relating to individual accountability in this study are that registered nurses need to be accountable for their practice, which is a requirement of the NMC Code (2018). Whilst it could be argued that the nursing homes (as employers) have a responsibility to provide relevant training to their staff, registered nurses as accountable practitioners within their own right, have a responsibility to keep their own knowledge up to date. Developing knowledge in relation to incident reporting would in turn help them to understand the processes, reducing the associated fear, and developing an enhanced understanding of the benefits to be gained. Registered nurses within the nursing home sector should seek to influence the training agenda provided to them, particularly when it relates to national guidance and promoting patient safety.

The unique findings identified in relation to individual accountability are self-blame and fear of the computer systems.

Local engagement (meso)

Maintaining engagement with the hermeneutic element of IPA, the meso level factors relating to the local organisational and community issues (Smith et al., 2019) will be presented. Meso level factors are factors that impact upon the registered nurses' lived experience of working in the nursing homes, and highlight the local engagement

required to support incident reporting within the nursing homes. The following subordinate themes were identified that relate to the registered nurses' experience of local engagement, and the discussion below reflects my interpretations of the findings:

- limited understanding/lack of knowledge
- limited education/training
- limited management support
- lack of feedback
- lack of carer involvement
- fear
- blame/self-blame
- time
- paper versus computer
- level of risk
- level of harm
- incident escalation
- positive learning culture
- benefits

Meso level factors identified in this study require addressing at an organisational level to support and enhance the registered nurses' experience of incident reporting within the nursing home.

Limited understanding/lack of knowledge has also been considered as a micro subordinate theme, but my interpretations constructed from the interviews with the research participants also identified that there appeared to be a *limited understanding/lack of knowledge* in relation to incident reporting at a higher level, for example by the managers in the nursing homes and even at a corporate level in the larger homes. P3 demonstrated a good understanding of incident reporting, however from their experiences of reporting incidents, they seemed to be faced with a degree of apathy from both their peers and the management team in the nursing home. P3 regularly used the metaphors *"off you trot"* and "*stashed away*" to describe their experiences when reporting a near miss or an incident of low harm. It is difficult to determine the exact cause of the lack of interest and apathy without talking directly to the nursing home managers. One interpretation of the lack of interest could be that this was symptomatic of the Covid -19 pandemic, being two years into a pandemic will have

placed additional pressures on the nursing home sector in terms of excess resident deaths and staffing issues. However, reflecting on my own experiences of working with nursing homes I feel that this culture was in place pre-pandemic and suspect it may be due to a couple of subordinate themes *limited understanding/lack of knowledge* (micro and meso) and *organisational priority* (macro).

Directly related to understanding/lack of knowledge is *education/training*. Education and training would help to develop knowledge and understanding so, in the absence of training, it is understandable that knowledge in relation to incident reporting within the nursing home sector is limited.

During the interviews, participants identified how they were often excluded from the incident investigation, dismissed when attempting to report and subject to criticism post incident, reflecting *limited management support*. It's understandable that nurses may be scared when an incident occurs, but mistakes do happen, and managers have a key role in supporting staff so that staff feel that they will be treated fairly and supported to learn when an incident happens. This links to the theme *positive learning culture*. A *positive learning culture* is well documented as being an essential factor in supporting incident reporting (NHS, 2014) and is actively promoted within NHS organisations. Whilst individual nurses within the nursing home can contribute to creating a *positive learning culture*, the role of the nursing home manager is essential in creating the culture within the home.

In creating a *positive learning culture*, nursing home managers need to also consider the tools they use to facilitate incident reporting. Whilst all staff have a responsibility to engage with the local processes adopted, nursing home managers need to consider which processes are the most appropriate and would support the process. Participants' views were mixed as to whether *paper or computer systems* were better. Whether paper based or computer, nursing homes need to implement systems that make it easy to report incidents, considering accessibility, the quality of the equipment and connectivity, if opting for an electronic system.

Feedback following an incident is a key element of a positive learning culture, as in the absence of feedback, there is no way for the learning to be shared. *Lack of feedback* post incident was identified as a theme by two participants (P3 & P4) and considered to be another barrier to incident reporting. P3 identified that there is often a lack of feedback once an incident had been reported, which often caused anxiety amongst the nursing staff.

Fear identified by all participants as an experience in relation to incident reporting, also relates to a supportive culture, or in the participants' experience, the lack of a supportive culture. P1 likened their involvement in an incident investigation to being *"on trial*," with P3 describing their experience as being like a "*scared cat moment*, *you're in the headlight*." Metaphors were used to highlight the degree of fear, such as "*all hell breaks loose*" and "*complete panics*" and also the *blame/self-blame* they experienced when an incident occurred. Participants reflected on the feelings experienced when an incident occurred and shared experiences about being judged by their peers and feeling blamed or experiencing self-blame post incident.

Associated with fear and blame were the potential consequences of reporting incidents, such as losing their job, which may be a contributory factor to the low level of incident reporting in the nursing home sector, along with the *limited understanding/lack of knowledge.*

Another barrier in relation to reporting incidents that was identified by all four participants was in relation to *carer involvement* in the process. All four participants identified that carers do not have access to the incident reporting system. When carers identify an incident, they are required to report the incident to the registered nurse for them to report in the system. This is a new and unique finding which was not identified in the scoping review and differs significantly from practice within the NHS. Interpreting these findings has led me to believe that providing carers with access to the systems and providing training may help to increase the numbers of incidents reported in the nursing homes.

Level of harm to a resident or *level of risk* (reputation or litigation) to the nursing home appear to be fundamental issues when determining whether to report an incident. Three of the participants reflected on experiences where their concerns had been dismissed by managers when reporting incidents of no or low harm, whereas if a resident had suffered a significant harm, the management team were keen to learn more about the incident. This theme directly relates to *limited understanding/lack of knowledge*, as a greater understanding of incident reporting and the associated *benefits* would encourage incident reporting as an activity to learn, improve practice and reduce harms, regardless of the level of harm or risk to the nursing home.

Whilst *level of harm* was identified in the scoping review, *level of risk* and *incident escalation* were not explored, highlighting the identification of new knowledge. However, it needs to be taken into consideration that as most of the studies included

in the scoping review were international, it is likely that regulatory and safeguarding processes will differ from England, resulting in different findings.

In the absence of local engagement and direction from the nursing home managers in promoting incident reporting, it is understandable how incident reporting may not have been seen as a priority within the homes and therefore viewed as an additional task to be undertaken. *Time* was identified by two of the participants (P1 & P4) in the study as a barrier to reporting; to note, both these participants had spent most of their career in the nursing home sector, with limited NHS experience. Whereas the two participants with extensive NHS experience, did not highlight time as a barrier to incident reporting.

Local engagement summary

My interpretations of the findings in relation to local engagement are that at a local level there are several factors which need consideration to support and influence incident reporting through local engagement. Nursing homes need to develop their knowledge, by providing education and training, in relation to incident reporting as a process. This would help to eradicate factors such as level of harm and risk and ensure a proportionate response to all incidents. Creating a positive learning culture, would enable the benefits to be realised, where feedback is provided and staff feel supported, reducing the fear and blame experienced by the registered nurses.

The unique findings identified in relation to local engagement are carer involvement with the process and level of risk.

System level facilitation (macro)

Themes interpreted at a macro level relate to legal, regulatory, and economic factors (Smith et al., 2019) and consist of the following subordinate themes that need to be addressed via system level facilitation:

- limited understanding/lack of knowledge
- lack of education/training
- level of harm
- level of risk
- access to IT systems
- lack of management support

- organisational priority
- benefits

Throughout the discussion, there have been multiple references to the interconnectivity of the themes identified from the study, and how one theme can directly influence another theme, which have been identified through my interpretations of the findings. Following detailed analysis of the findings, and my interpretations of the participants' experiences, it has been identified that there is one core theme, at system level, and that if this were addressed, it would have a positive and enabling impact on the other themes identified, not only at a macro level but at meso and micro levels. That theme is *organisational priority*.

Findings from the study, constructed from the participants' experiences, indicate what has been described as a general apathy towards incident reporting, where participants describe being dismissed when they try to report incidents, the absence of any training to develop knowledge, limited management support and the absence of a positive learning culture, all of which will have a direct adverse impact on incident reporting. Participants have also shared experiences which have highlighted the inequities between NHS organisations and the nursing home sector, despite both providing NHS care. Reflection and analysis of all these factors led to the interpretation that incident reporting was not considered to be an organisational priority in the nursing home sector and afforded the same significance that it receives in NHS organisations. I believe that this key finding from this study reflects the latent element of the registered nurses' lived experiences.

Chapter Summary

This chapter has presented the findings as they were interpreted and constructed by the participants and the researcher. Unique findings have been identified, in relation to individual accountability and local engagement, as well as the overarching theme sitting within system level facilitation, organisational priority. All themes constructed were considered to answer the research question and will be explored further in the following chapter where a deeper analysis of the findings, in the context of previous literature in this area, will be presented.

Chapter 6

Discussion

Introduction

This chapter will be presented in three parts.

In the first part, the findings of the research study will be discussed and considered in relation to the aims and objectives of the study and in relation to the existing literature. The aim of the research was to explore the lived experiences of registered nurses working in nursing homes in relation to the identification and reporting of incidents. The constructed themes will be discussed to evidence how they build on the existing knowledge base identified from the scoping review, and also provide confirmation in support of some of the findings from the scoping review. New and unique findings will be discussed which enhance the current body of knowledge, whilst also highlighting areas where improvements could be made to support incident reporting in nursing homes.

The second part will explore elements of the methodology adopted to undertake the study, reviewing and critiquing some of the key concepts central to IPA such as idiography, hermeneutics and latent knowledge. The concept of double hermeneutics will be challenged based on my experience of undertaking an IPA research study, and a more suitable concept proposed to replace the double hermeneutics cycle.

The third part will present an overview of the quality within the study.

Part 1 - Findings

The aim of the study was to develop an understanding of the registered nurses' lived experience of incident reporting in the nursing home sector. The subordinate themes, constructed from the study, have been organised under micro, meso and macro levels as described in the 'Dynamic Gears Model' (Mulvale et al., 2016), and were introduced and depicted in figure 3 in chapter 5. The connectivity between the themes has been discussed and it is proposed that all themes flow out of one core theme – organisational priority. My interpretation is that if this theme were addressed, it would have a positive enabling effect on the other themes (inputs), resulting in a more positive experience (outputs) of incident reporting for the registered nurses in the nursing homes. The

themes constructed will be discussed in more detail below and systems thinking will be explored as an option to raise the priority of incident reporting in the nursing home sector so that incident reporting is afforded the same parity as in NHS organisations.

Systems Thinking

Healthcare is delivered through a complex structure of interdependent systems, and nursing homes, as providers of NHS healthcare, constitute a key part of that system. Healthcare is also a system that involves high risks to patients, yet it has been identified that healthcare systems often lack a holistic approach to addressing issues surrounding the delivery of care leading to fragmented solutions (Trbovich, 2014). Incident reporting is an example of such a system. Incident reporting has been recognised to reduce the risk of harm to patients and reduce costs, and whilst incident reporting is well established in NHS organisations, incident reporting is not well established in the nursing home sector. Despite providing more beds than NHS organisations (Handler et al., 2006; Kings Fund, 2021), nursing homes have not been as actively encouraged, or mandated like NHS organisations, to adopt incident reporting, as a system to improve patient safety, despite the widely documented benefits of incident reporting.

The interdependency between the NHS and nursing home sector cannot be underestimated. Arnold & Wade (2015) argue that interdependency requires systems thinking, and that in ‘essence systems thinking consists of looking at the whole system instead of the individual parts’ (Trbovich, 2014, p. 32).

To support a systems approach to health care, the NHS is currently undergoing a re-structure of the provider and commissioning arrangements, and as of 1st July 2022, Integrated Care Systems (ICS) will become statutory bodies across England (NHS, n.d.), and will have delegated responsibility for funding, performance, and population health (NHS Providers, n.d.). An ICS is a partnership of organisations that work collaboratively to plan and deliver integrated health and care services (NHS, n.d.), and is developed around geographical and regional boundaries. An ICS consists of NHS providers, clinical commissioning groups, local authorities, and independent and voluntary sector providers of NHS healthcare, such as nursing homes. The purpose of an ICS is to remove the barriers between organisations to deliver better, more joined up care for local communities. This recent re-structure of the NHS is an ideal

opportunity to engage with the nursing home sector, to break down the barriers and to promote equity between NHS organisations and providers of NHS healthcare. However, although the ICS are still in the developmental phase, there is little specific reference in the national guidance (Department of Health & Social Care, 2022; NHSE & I, 2021) relating to the nursing home sector, further highlighting the inequity between NHS organisations and other providers of NHS healthcare.

The themes of the study will be discussed in more detail below and have been structured within a 'Systems Level Facilitation Model for Incident Reporting'. The model has been designed by the researcher, specifically to present the findings of this study, considering the themes at a micro, meso and macro level, and to demonstrate how all themes flow out of the one core theme – *organisational priority*. The purpose of the model is to demonstrate the need for a systems thinking approach to enable incident reporting to be prioritised within the nursing home sector. In addition, the model demonstrates the interdependency between the themes, and the positive influence organisational priority could have on the constructed themes.

Systems Level Facilitation Model for Incident Reporting

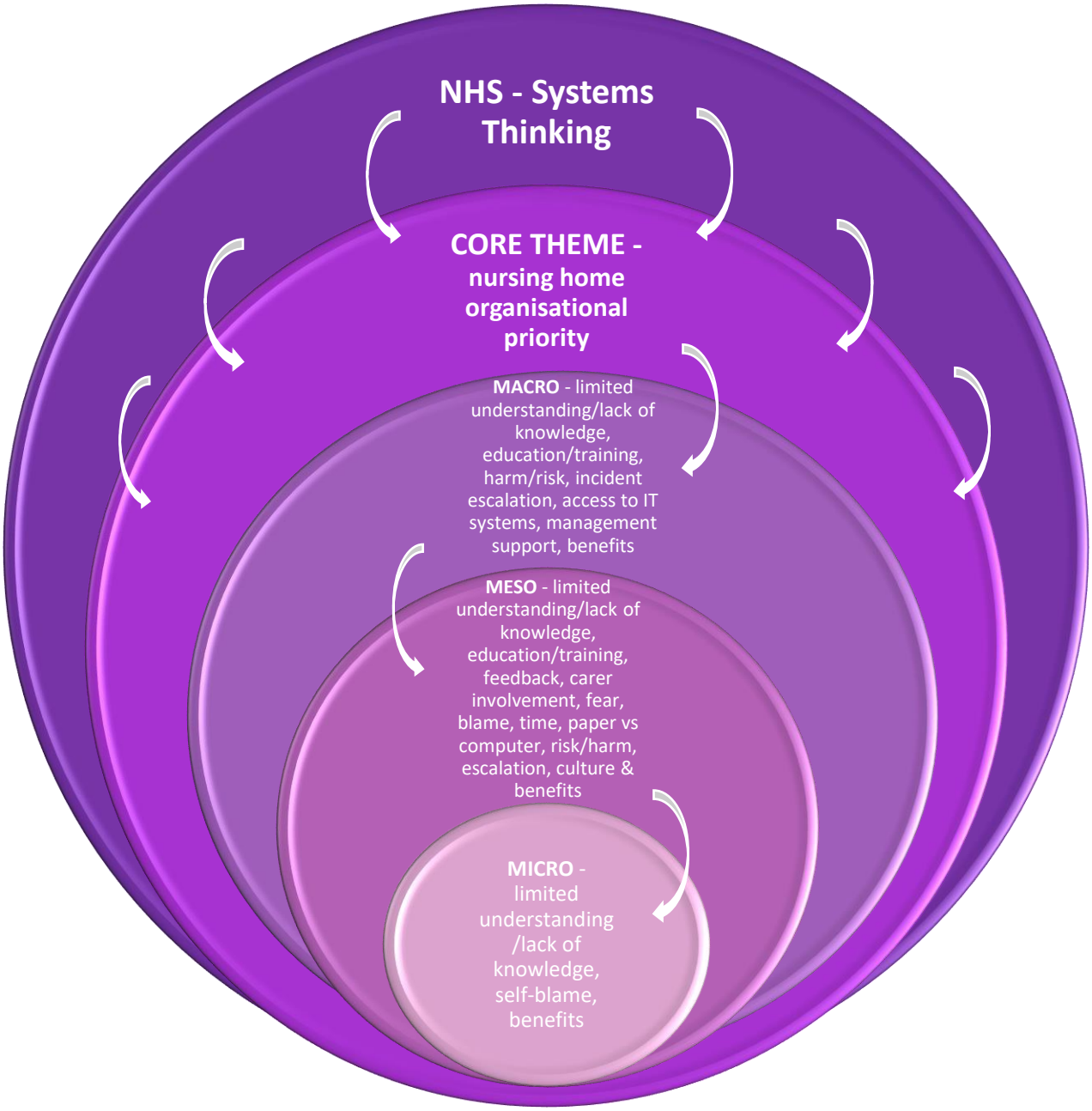
To demonstrate how the key theme identified from this study – organisational priority, sits as a system level, and directly impacts all the other themes identified in this study and ultimately the registered nurses' lived experience of incident reporting, I have developed the Systems Level Facilitation Model for Incident Reporting – see figure 4. Findings from this study indicate that if incident reporting was promoted as an organisational priority at a system level, for all providers of NHS healthcare instead of just NHS organisations, that this would positively influence all the other themes constructed from this study. The Systems Level Facilitation Model for Incident Reporting demonstrates the hierarchy of themes and how all themes flow out of the core theme of organisational priority.

Systems level facilitation

The key theme identified from this study is organisational priority and this sits at a system level. Organisational priority is a key theme as if this were addressed, it would have a positive and enabling effect on all other themes identified. Other themes which also sit at a system level include limited understanding/lack of knowledge, lack of

education/training, level of harm, level of risk, access to IT systems, lack of management support, and benefits.

Figure 4 – Systems Level Facilitation Model for Incident Reporting



In considering the importance of the theme organisational priority, I needed to explore the wider healthcare system to understand more about the position of nursing homes in relation to the wider NHS and healthcare systems.

In England there are more nursing home beds than NHS beds (Care Quality Commission, 2014; Handler et al., 2006; Kings Fund 2021). Nursing homes provide a significant contribution to the health economy by caring for patients with increasingly complex health care needs, yet they remain a sector which is often overlooked (Cousins, Burrows, Cousins, Dunlop & Mitchell, 2016). The interdependency between the NHS and nursing home sector cannot be underestimated. In the absence of nursing homes, it is probable that patients would remain in hospital, occupying beds required for acutely unwell patients. For residents in nursing homes, should they become acutely unwell or have an accident, it is possible that they may require admitting to hospital.

Nursing homes provide care for some of the most vulnerable patients within our society. The vulnerability and dependency of these patients places them at greater risk of harm, and whilst recent studies (Farag et al., 2020; Prang & Jelsness-Jorgensen, 2014; Wagner et al., 2012) have highlighted under- reporting of incidents in the nursing home sector as an area of concern, little has been implemented to address this. The Health Foundation (2019) claim that 4 out of 10 emergency admissions to hospital from the care sector could be avoided by improved care in the community. Incident reporting is a system to support improvements in care and to prevent unnecessary hospital admissions. Hospital beds are limited, and there is a national drive to keep patients in their own homes (which includes residential and nursing home) as far as practicably possible.

Almost 20 years ago, the NRLS was established in England to facilitate the reporting of patient safety incidents in the NHS so that the NHS can gather data in relation to patient safety. NHS providers are monitored monthly by NHS commissioning organisations in relation to the numbers and types of incidents reported and the associated learning, with the aim being to see an increasing number of near misses and low harm incidents reported in relation to a reducing number of incidents resulting in serious harm. The NRLS also produce incident league tables, so that NHS providers can benchmark themselves against other NHS providers. However, incident reporting has never been actively promoted in the nursing home sector and nursing homes are not monitored in the same way by their commissioning organisations (who are the

same organisations that commission and monitor NHS organisations). This reflects a lack of systems thinking by the NHS in relation to incident reporting, and more recently with the launch of the National Patient Safety Strategy (NHSE & I, 2019), where the focus is on NHS organisations rather than engaging all providers of NHS healthcare equitably. Due to the interdependency between health and social care, failing to engage all healthcare providers is short sighted at best, but could result in significant consequences in terms of failings in patient care.

So, despite there being more nursing home beds than NHS beds, care is commissioned differently and the NRLS do not actively support incident reporting in the nursing home sector in the same way as in NHS organisations. Not only does this reflect inequity between the NHS and the nursing home sector, but it may also contribute to why incident reporting is not afforded the same significance and organisational priority within nursing homes as it is within NHS organisations.

Data submitted to the NRLS is analysed for themes and trends and where appropriate National Patient Safety Alerts are produced and forwarded to NHS providers to alert them to issues which may impact on patient safety and provide recommendations for practice (NHSE, 2022a). NHS providers are contractually monitored in relation to the adoption of guidance generated via National Patient Safety Alerts, however nursing homes are generally not. Failing to collate incident data, specifically relating to the nursing home sector, who provide more NHS beds than NHS organisations, poses a significant risk to the residents in the nursing homes and will ultimately have an impact upon the wider healthcare system. Furthermore, the failure to support and govern nursing homes in a similar way to NHS organisations, presents an additional risk for the providers, and the commissioning organisations.

Given the volume of beds in the nursing home sector, and the lack of robust incident reporting systems in the nursing home sector, there will be a wealth of patient safety data which is not being collated nationally and analysed via the NRLS, meaning that opportunities to learn and improve care specific to the nursing home sector are not being captured. The NHS as a national system, which seeks to promote best practice and patient safety, needs to ensure that systems which serve to improve patient care are implemented in all care providers, not just NHS organisations. The benefits of incident reporting need to be realised across all sectors so that the learning from incidents can be shared to improve patient care and safety, and the NHS need to adopt

a systems thinking approach to facilitate incident reporting in the nursing home sector as a national priority to ensure the wealth of data is not lost.

Incident reporting has been actively promoted in the NHS for many years. However, in 2015, a study was conducted, entitled Supporting Nursing Care in Care Homes by Spilsbury, Hanratty & McCaughan, (2015). The report was comprehensive and produced evidence based briefing sheets in areas considered specific to the nursing home environment, such as quality of care and resident safety. Disappointingly, despite the focus in the NHS in relation to the benefits of incident reporting and learning from incidents to improve the quality of care and patient experience, the report failed to recommend incident reporting as a system to support the sector. In 2022 there are plans for the NRLS to be replaced with a new incident management system (NHSE & I, 2019) and within the NHS, organisations are required to demonstrate how they are implementing the National Patient Safety Strategy (NHSE & I, 2019). Requirements include appointing Patient Safety Specialists to drive the strategy forward, reviewing and amending internal incident reporting systems and processes to align with the strategy, and the provision of training for all staff within the organisations. Incident reporting, as a process to learn, was already well established within NHS providers, although there was an acknowledgement that this could be enhanced further. The National Patient Safety Strategy (NHSE & I, 2019) has been developed as a framework to progress this.

However, the offer is not actively promoted or mandated as widely in the independent sector (including nursing homes) as it is within NHS organisations, despite there being significantly more nursing home beds and beds in the independent sector than in NHS organisations. On the NHS England website “Report a patient safety incident” (NHS, 2022a), the NHS invite healthcare staff to report incidents via their new site the ‘Learn From Patient Safety Events’ (LFPSE) acknowledging that “smaller organisations, such as general practice, independent dental surgeries, community pharmacies and opticians, may not have their own local risk management system” however the providers listed could be considered to be NHS organisations and there is limited information to try and engage or encourage the reporting of patient safety incidents in the nursing home sector.

Factors relating to the strategic direction of healthcare in England, developed by governmental bodies, such as the NHS, should also apply to independent organisations who provide NHS care, such as nursing homes. In the absence of

national policy in relation to incident reporting in the nursing home sector, like the approach within the NHS, it is clear to see why incident reporting is not afforded the same organisational priority as it is within NHS organisations. Furthermore, it is understandable that due to the volume of competing priorities within all healthcare providers, that incident reporting, as an additional process has not been embraced. As such, incident reporting does not appear to be an organisational priority in the nursing home sector, which could be perceived as a barrier to incident reporting and directly related to several themes identified in this study. It is also noted that organisational priority was not identified as a theme from the scoping review, indicating that this reflects new and unique findings in the field.

Incident reporting needs to be viewed as an organisational priority in the nursing home sector, like the approach adopted in NHS organisations and there needs to be further consideration as to how this can be addressed, with system level facilitation from the NHS, to influence incident reporting within the nursing home sector to implement the changes in practice.

If incident reporting was deemed an organisational priority, like in NHS organisations, this would support the other themes identified as a macro level. For example, training programmes would be implemented to develop knowledge and understanding, and nursing homes would also be actively encouraged to access the national training being implemented as part of the National Patient Safety Strategy (NHSE & I, 2019). This in turn would also highlight that the level of harm or risk to the organisation are not factors in determining whether to report. With the right training, which would increase knowledge, this would encourage managers to adopt a more supportive approach that focused on the benefits of incident reporting, rather than apportioning blame.

Findings from the study indicate a lack of available IT systems in the nursing home sector, along with IT connectivity issues. System level facilitation also needs extending to enable investment in IT systems that are fit for purpose and that link into the national systems, so that nursing home incidents and the associated learning can also be reported into the national systems. All of this would help to develop a more supportive culture within the nursing homes that would actively encourage incident reporting. My interpretation from the findings of the study, is that if incident reporting was an organisational priority for the nursing home sector, then this would support not only the macro level themes, but all the other themes identified from the study. Therefore, for the required changes to take place within the nursing homes, there needs to be a

change in the national directives, to actively engage nursing homes with the new National Patient Safety Strategy (NHSE & I, 2019) which actively promotes incident reporting. This could be achieved by adopting a systems thinking approach, to promote equity within the nursing home sector and for incident reporting to be promoted as a national priority in all healthcare providers, not just NHS organisations.

Local engagement

It has been described above how the systems level thinking needs to be adopted at a national level and within the NHS to support the organisational prioritisation of incident reporting at a local level in nursing homes. It is considered that this will then enable nursing home managers to positively influence incident reporting at a local level. At a local level several themes were identified, all of which would be positively influenced by the promotion of incident reporting as an organisational priority: these being limited understanding/lack of knowledge, limited education/training, limited management support, lack of feedback, lack of carer involvement, fear, blame/self-blame, time, paper versus computer, level of risk, level of harm, incident escalation, positive learning culture and benefits.

Nursing home managers can have a significant influence on the approach taken within the nursing homes to promote incident reporting, primarily by the provision of education and training to increase knowledge and understanding. Whilst organisations have a responsibility to provide staff with the relevant education and training to enable them to undertake their role, this will undoubtably be influenced by organisational and national priorities. In the absence of any specific directives in relation to incident reporting, such as contractual requirements like in NHS organisations, it is understandable how incident reporting may not have been prioritised in the nursing home sector. Lack of education/training was identified as a theme by two participants (P2 & P3), both of whom had extensive experience working within the NHS. It is possible that having worked in the NHS where they had access to incident reporting education and training, the lack of education and training in the nursing home sector was more apparent in comparison to the NHS. Education is key to developing knowledge in relation to incident reporting and to improve incident reporting rates. A study involving junior doctors identified that regular education and reinforcement significantly increased the rates of incident reporting (Krouss, Alshaikh, Croft, & Morgan 2019). Although this study was specific to doctors, it is likely that the findings

are transferable to registered nurses and that the provision of training for registered nurses in the nursing home sector may serve to increase the reporting rates. Ogbonnaya, Tillman, & Gonzalez (2018) also argue that to improve staff performance, training should be provided that is related to improving patient safety. It was also identified in the scoping review that more education in relation to incident reporting would help to raise awareness of incidents and serve to encourage incident reporting (Wagner et al., 2012)

Although the lack of education/training was identified as a theme, the reason for the lack of education/training remains unknown. This could be linked to the nursing home managers' experience of incident reporting and organisational priority, which could also be an area requiring further exploration. The provision of education/training is a form of organisational support (Barling, Kelloway & Iverson, 2003), therefore it could be interpreted that a lack of education/training could be linked to the theme limited management support.

Limited management support was identified as a theme, with participants describing being dismissed by managers when trying to report an incident, not feeling supported when an incident occurred, and often a lack of feedback or learning when an incident occurred. When considering the theme limited management support, the organisational culture also needs to be considered. Organisational cultures need to be created that focus on the delivery of high-quality care (West, 2013; West, Loewenthal, Eckert, West, Lee, 2015) and promote learning through a positive learning culture. Findings from the study identified that there was a lack of a positive learning culture, and that this reflected inequity to the NHS. Findings from the Ockenden Report (2022), conducted to investigate failings in an NHS maternity service, identified that a lack of leadership resulted in the failure to learn, and the failure to follow national guidelines. Findings from this review could be compared to some of the findings from the Ockenden Report (2022) in that limited management support was identified as a theme, along with a lack of feedback which prevents leaning, and the absence of a positive learning culture.

Local engagement is key as managers are often responsible for determining the culture within the nursing homes; if incident reporting is not considered a priority and if nursing home managers have a limited understanding of incident reporting, then it is probable that this is an area of practice that will not be promoted as they may fail to appreciate the benefits. The British Medical Association (BMA) define a supportive culture as 'an

environment that supports wellbeing, promotes learning, and encourages the development of systems to improve safety and quality of care (BMA, 2021). A positive learning culture is not a new concept in the NHS and has been documented for many years in various reports, such as 'A promise to learn, a commitment to act' (National Advisory Group on the Safety of Patients in England, 2013), Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), however findings from this study indicate the absence of a positive learning culture in the nursing home environments. A supportive management approach and a positive learning culture would encourage the reporting of incidents and value incident reports as an opportunity to learn and improve practice. The value of supportive leadership was also identified in the scoping review where it was identified that participants were less likely to report incidents if they didn't feel supported (Wagner et al. 2012; Prang & Jelsness-Jorgensen, 2014).

Lack of feedback following an incident was identified as a barrier to incident reporting. P3 highlighted that from their experience within the NHS, feedback was often used as an opportunity to support nurses following an incident and reflected that this is an area in the nursing home where things *"slip down"* compared to the NHS where feedback is provided more regularly, again reflecting inequity between the NHS and the nursing home sector. Feedback following an incident is a key element of a positive learning culture, as in the absence of feedback there is no way for the learning to be shared. The CQC (2015, p.3) advocate feedback post incident, stating that 'all staff should receive feedback on all incidents raised, so that service developments and learning can take place'. P4 interpreted the lack of follow up and learning post incidents to mean that incident reporting was a waste of time and resulted in them being less likely to report. The scoping review also identified that participants were more likely to report an incident if they received feedback from an incident and felt that there was learning from the event (Farag et al., 2020).

Failure to provide staff with feedback following an incident could further reflect limited understanding by the managers. If managers provided feedback to staff post incident, not only would thus help to support staff, and help to reduce any feelings of self-blame, but it would also serve to value incident reporting as a learning process and result in more incidents being reported.

Fear identified by all participants as an experience in relation to incident reporting, also relates to a supportive culture, or in the participants' experience, the lack of a

supportive culture. In the scoping review, psychological safety was identified as the main barrier to incident reporting (Boyazidi et al., 2012; Chegini et al., 2020; Chen et al., 2018; Dyab et al., 2018; Hammoudi et al., 2018; Haw et al., 2014; Lee, 2017; Farag et al., 2020; Mansouri et al., 2020; Mostafaei et al., 2014; Prang & Jelsness-Jorgensen, 2014; Rutledge et al., (2018); Wagner et al., 2012, Wagner et al., 2013; Yung et al., 2016). Participants believed that management had a key role to play in reducing the fears and consequences associated with incidents. P3 reflected on the different and supportive approaches to incident management when they worked in the NHS and struggled to understand why similar approaches had not yet been adopted in the nursing home sector. Despite the wealth of evidence identifying that fear is a key barrier to reporting incidents, nurses working in the nursing home sector continue to experience fear as a direct result of incidents occurring.

If nurses are scared to report, for fear that they will be blamed if something goes wrong, this will only serve to discourage incident reporting. Most patient safety incidents that occur, in nursing homes and NHS organisations, are because of system fallings rather than individual errors. Whilst it is acknowledged that sometimes nurses may blame themselves when something goes wrong (Parker & Davies, 2020; Schelbred & Nord, 2007), managers have a responsibility to create a supportive culture, with a focus on human factors and system learning to support staff and to help minimise the element of self-blame. Enhancing knowledge in relation to incident reporting would help to change the culture within the home to a more supportive and just culture, which in turn would encourage incidents to be reported. The scoping review also identified that if the blame culture was removed then reporting incidents would improve (Dyab et al., 2018).

Whilst the scoping review identified supportive leadership as an essential element to promote incident reporting (Boyazidi et al., 2012; Chegini et al., 2020; Farag et al., 2020; Hammoudi, et al., 2018; Hung et al., 2016; Lee, 2018; Mansouri et al., 2020; Mostafaei et al., 2014; Yung et al., 2016), the managers' knowledge and level of understanding was not explored or identified as a factor. Exploring mangers' experience of incident reporting was not within the scope of this study, however from the findings of this study, this could be considered as an area that requires further exploration.

Another element requiring local engagement in relation to knowledge and understanding, is in relation to the contractual requirements. The findings from this study have highlighted that there are differing incident reporting requirements between

NHS organisations and nursing homes. NHS organisations, as part of their contractual requirements, must provide data in relation to incident reporting activity, such as the numbers of incidents reported, the levels of harms sustained, types of incidents by themes and most importantly how the organisation has learned from the incidents and improved practice. My interpretation from this study is that if similar reporting requirements were in place for nursing homes, this may help to raise awareness and establish incident reporting as a priority, which would serve to encourage nursing homes to engage more with incident reporting.

For nursing homes who admit NHS patients, there will be a contract outlining the specific requirements with either the local authority and/or the local NHS commissioning organisation. It is acknowledged that the contractual arrangements will differ between all local authorities and NHS commissioning organisations across the country. However, it is not clear why the commissioning arrangements differ so greatly between NHS organisations and the nursing home sector. My interpretation is that this reflects a limited understanding in relation to the benefits of incident reporting in both the nursing home sector and the commissioning organisation and this been highlighted as an area requiring further exploration.

At a local level, managers also need to consider the system chosen to report incidents, whether it is a paper or computer system. Participants' views were mixed as to which system was better, but regardless of the system chosen, staff need to be supported to develop the knowledge and understanding so that they can identify incidents and understand the importance of incident reporting, otherwise it is probable that incidents will remain unreported. Findings from the scoping review were also mixed in relation to the preference of paper versus computer (Prang & Jelsness-Jorgensen 2014) and Wagner et al. (2012) also identified that whilst almost half of the participants in their study felt the incident reporting system was inadequate, the lack of an adequate incident reporting system was ranked as the least important barrier to incident reporting.

Participants' experiences identified that when a computer system is used to report incidents, there are limited numbers of computers available to them in the nursing homes compared to in NHS organisations and not all staff can access them. Within the NHS, financial constraints are not as evident as in some of the independent nursing home providers. In the NHS, computer-based incident reporting systems are often the only option available for reporting incidents and all staff are provided with training and

support. Experience of working in the NHS would indicate that staff engage well with computer systems, but the circumstances differ from the independent sector in that there are often multiple computers available, so accessibility is not a problem, and all staff can access them, including care staff. Within the NHS, funding is available to support the financial investment required, training and support are readily available for all staff and connectivity issues do not pose the same degree of challenge as reflected by participants in the study. Findings from the scoping review differed in that they identified that the reporting systems were often too complex and time consuming (Chen et al., 2018; Hong & Li, 2017) rather than accessibility and connectivity issues as identified by participants in this study.

Another barrier in relation to reporting incidents that was identified by all four participants was in relation to carer involvement in the process. All four participants identified that carers do not have access to the incident reporting system. When carers identify an incident, they are required to report the incident to the registered nurse for them to report in the system. Not only would this be more time consuming and place more demand on the registered nurses' time, but it serves to exclude carers from the process. In the NHS, all staff are able, and encouraged, to report incidents regardless of role or qualifications. This suggests that internal processes need to be reviewed as the largest workforce within the nursing home, the carers, do not generally have access to the incident reporting systems in nursing homes, potentially preventing many incidents from being reported. All participants identified this as a barrier to incident reporting. Providing carers with access to the systems and providing training may help to increase the numbers of incidents reported in the nursing homes.

This differs significantly from the findings of the scoping review where it was identified that registered nurses with higher qualifications were more likely to report incidents (Chen et al., 2018; Shmueli et al., 2014; Wagner et al., 2012) and attributed this to them being more likely to identify that an incident had occurred (Chen et al., 2018). However, in direct contrast, P2 and P3 reported that the carers within the nursing home regularly identify incidents, this highlights a significant finding from the study and the generation of new knowledge. Furthermore, in NHS organisations, all staff regardless of role, generally have access to the incident reporting systems and are actively encouraged to report incidents, directly into the system, as well as to verbally escalate any concerns to the senior nurse or line manager.

Carers constitute a significantly larger proportion of the workforce than registered nurses in both the NHS and the nursing home sector. It is estimated that there are in the region of 669,000 registered nurses (all specialities) in the United Kingdom, compared to over 1.2 million carers (Nurses.co.uk, 2021). However, it appears that carers are excluded from reporting incidents in the system in nursing homes. Carers spend a significant proportion of their role delivering face to face care and as such will directly experience patient safety incidents. Enabling carers to access the system so that they can report incidents directly may help to increase the number of incidents being reported.

Level of harm to a resident or level of risk (reputation or litigation) to the nursing home appear to be key factors when determining whether to report an incident. Participants shared experiences where their concerns had been dismissed by managers because the incident had not resulted in any harm, whereas managers were keen for incidents to be reported if harm had been sustained. This theme directly relates to limited understanding/lack of knowledge, as a greater understanding of incident reporting and the associated benefits would encourage incident reporting as an activity to learn, improve practice and reduce harms, regardless of the level of harm or risk to the nursing home. Reporting based on level of harm, risk or escalation could also be related to the statutory duty to report such incidents to the CQC (CQC, 2022). Being a regulatory requirement, it is understandable why managers would be keen to ensure incidents in this category were reported. However, NHS organisations are subject to the same regulatory reporting requirements. The main purpose of incident reporting is to learn and improve practice, and this should be the primary focus.

The level of risk to the nursing home, in terms of external scrutiny, also appears to be a factor in relation to the way in which incidents are viewed by the management team. However, this could be due to the way in which incidents are managed by external organisations such as the safeguarding team and the commissioners. Findings from this study have highlighted an inequity between NHS organisations and the nursing home sector, particularly in relation to the number of incidents which are referred into safeguarding teams. Two participants (P2 & P3) reflected on their experiences in both the NHS and the nursing home and identified that incidents which are reported into safeguarding from the nursing home environment would not have been referred had the same incident occurred in an NHS organisation. Their experience suggests inequity between the amount of external scrutiny received by a nursing home when an

incident resulting in harm occurs, which may reflect the heightened response from nursing home managers.

Additional and disproportionate incident escalation when an incident occurs could be a factor that contributes to the nurses' experience of fear and associated consequences in relation to incident reporting. The inequity within the systems needs to be addressed to ensure a proportionate response and support the adoption of incident reporting as a positive vehicle to facilitate learning. Furthermore, this highlights the need for a greater understanding of incidents by external agencies who work closely with the nursing homes to ensure a more proportionate and equitable response to the incidents that are reported.

With incident reporting not being viewed as an organisational priority within the nursing home sector, it is clear to see how incident reporting could be perceived as an additional, non-essential and time-consuming task to be undertaken. Interestingly, time was identified as a barrier by P1 and P4, both of whom had spent most of their careers working in the nursing home sector. The participants with extensive NHS experience, where incident reporting is more embedded, did not describe time as a factor.

Time was also reported in a number of the studies included in the scoping review: time relating to workload in general, time to complete the incident report and the time taken to conduct an incident investigation post report. Chen et al. (2018) and Prang & Jelsness-Jorgenson (2014) identified that nurses already have a heavy workload and the requirement to complete an incident form placed additional pressures upon them. Furthermore, it was highlighted that that completing an incident report is time consuming (Boyazidi et al., 2012; Hammoudi et al., 2018; Haw et al., 2014; Hong & Li, 2017; Lee, 2018; Rutledge et al., 2018; Wagner et al., 2013; Yung et al., 2016).

Reflecting upon these findings and my previous knowledge and experience of the nursing home environment led me to consider that incident reporting may not be embedded within the culture in nursing homes as nurses view incident reporting as an additional task as opposed to part of their core work. This also relates to the subordinate themes limited understanding/lack of knowledge, lack of carer involvement and positive learning culture and ultimately organisational priority. If incident reporting was deemed a priority, there would be more access to training to develop knowledge which would enable staff to understand that the incident reporting process is a core element of their role. Furthermore, all participants identified that it is often the care staff who identify incidents, but they are not allowed to report incidents into the system,

instead they must verbally report the incident to the registered nurse for them to complete the report. Within NHS organisations all staff, including care and support workers are allowed to report incidents, therefore allowing care staff to report would help to reduce this burden on the registered nurses time.

With the re-prioritisation of incident reporting, nursing homes may need to review their internal processes, to enable all staff to report incidents, not just the registered nurses. However, registered nurses working in nursing homes also need to take accountability for their practice and pro-actively engage with systems designed to promote patient safety, such as patient safety incident reporting, even if this may not be actively promoted by their employer.

Individual accountability

Whilst it is acknowledged that registered nurses are accountable for their own practice, which includes incident reporting to promote patient safety, local engagement, and system level facilitation to prioritise incident reporting within the nursing home sector would serve to enable and further enhance incident reporting.

Registered nurses need to first understand the principles and benefits of incident reporting as a system to promote patient safety, and this can only be achieved by education and training. Whilst P2 and P3, who had extensive NHS experience, were able to demonstrate a good understanding of incident reporting, their interpretation was that the same level of knowledge was not shared by their colleagues in the nursing home sector. As such they were able to identify issues in relation to incident reporting in the nursing home environment. In contrast, the other two participants' knowledge, who had worked predominantly in the nursing home sector, appeared superficial, particularly in relation to what constituted an incident and the importance of reporting and investigating incidents to improve practice and to prevent future harms. Not only does this reflect the inequity between the NHS and the nursing home sector, but these findings also relate to one of the themes identified in the scoping review – limited understanding/lack of knowledge. In the scoping review, it was considered that a lack of knowledge contributed to poor incident recognition which prevented incidents from being reported (Chen et al., 2018; Hong & Li, 2017). The findings from this study support the body of existing knowledge by further highlighting the need for more education to develop the knowledge of registered nurses in the nursing home. This

finding also highlights the inequity between the NHS and the nursing home sector in terms of knowledge and understanding developed by accessing education and training.

One participant (P3) spoke in detail of their frustration at the failure to acknowledge near miss incidents within the nursing home environment. A near miss is described by the WHO (2020, p.4) as “an incident that did not reach the patient.” However, with a near miss there is still the potential for harm, and more importantly, learning can be gained via an appropriate investigation. The WHO (2020) therefore considers the identification and reporting of near misses just as important as the reporting of incidents with harm.

When an incident occurs, it is possible that there may have been near misses which have preceded the incident and if identified and acted upon, could have prevented a more significant incident from occurring. This subordinate theme of limited understanding/lack of knowledge reflects the inability to look at the bigger picture and adopt a more holistic approach to an incident identification and investigation. One participant (P2) recalled how they would report near misses or low harm incidents, which would often be dismissed by the management team in the nursing home, but that they would be received and accepted in NHS organisations.

Lack of knowledge in relation to what constitutes an incident was also identified as a theme within the scoping review (Chen et al., 2018; Wagner et al., 2012; Wagner et al., 2013). It was identified that along with a general lack of knowledge about incident reporting, there was confusion as to what constituted an incident. This is similar to P2’s experience, particularly in relation to the failure to identify and acknowledge near misses. This theme contributes to the wider knowledge base and illustrates the need for more education in the nursing home sector to develop understanding in relation to incident reporting to be targeted within the nursing home sector. This also reflects the inequity that exists between the nursing home sector and the NHS (which is a subordinate theme) as within NHS organisations, training is provided in relation to incident reporting to enable staff to develop an understanding of incidents and the process of incident reporting. Significantly, all participants highlighted a lack of training in relation to incidents within the nursing home sector.

Whilst the provision of training may be considered a corporate responsibility, registered nurses also have a responsibility to ensure they have the knowledge and understanding to enable them to practice within the parameters of the NMC Code

(2018, p. 13) which states that registered nurses must “act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm”. This in effect describes incident reporting, including near misses and the nurse’s responsibility in relation to them. So, whilst the nursing homes have a responsibility to provide training, this does not eliminate the nurse’s responsibility and accountability to develop their own knowledge in the area along with an understanding of the local systems. However, although nursing staff working in nursing homes are often keen to access additional training, there are often barriers such as inadequate staffing and limited access to specialist training for nursing home staff which poses more of a challenge than for NHS staff (Spilsbury et al., 2015).

Sometimes in healthcare things go wrong, the result is that patients may be harmed. It is estimated that just under 10% of inpatient admissions result in a patient harm (Parker & Davies, 2020). Often errors occur because of wider system failings rather than individual failings, but so often healthcare professionals are self-critical and will blame themselves even when there was nothing, they could have been done to prevent the harm (Parker & Davies, 2020; Schelbred & Nord, 2007). Enhancing knowledge in relation to incident reporting as well as nursing homes adopting a just culture may help to reduce the self-blame experienced by staff when things go wrong. The NHS (2019b) suggests that a just culture promotes the “fair treatment of staff and supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.” Supporting staff to be open about mistakes allows valuable lessons to be learnt to prevent similar errors from occurring and will help to minimise the experience of self-blame. Furthermore, supporting staff when they do apportion self-blame will help to support the psychological well-being of staff.

Earlier in this chapter, psychological safety was discussed as a theme from the scoping review, with fear being identified as the main barrier to incident reporting. However, although fear was identified as the main barrier, this was in relation to either fear of disciplinary action or being blamed for the incident; self-blame was not identified as a factor. It has been identified that nurses often blame themselves when something goes wrong (Parker & Davies, 2020; Schelbred & Nord, 2007). Developing knowledge in relation to incident reporting, with a focus on human factors and system learning, may help to support staff, and to help minimise the element of self-blame. Dyab et al., (2018) also identified that removing the blame culture would help to support incident reporting.

Self-blame has therefore been identified as a unique theme and new knowledge in relation to the registered nurses' experience of incident reporting.

If nurses are scared to report, either because of self-blame or the belief that they will be blamed if something goes wrong, this will only serve to discourage incident reporting. Most patient safety incidents that occur are as a result of system failings rather than individual errors (NHSE & I, 2019). Enhancing knowledge in relation to incident reporting would help to change the culture within the home to a more supportive and just culture, which in turn would encourage incidents to be reported.

The main objective of incident reporting is to learn and to improve practice (Donaldson, 2005; Hewitt & Chreim, 2015; Pham et al., 2015), however Hewitt & Chreim (2015) suggest that many incidents are often resolved on the spot and remain unreported which prevents opportunities for learning. In their interview, P1 reflected on an incident in their nursing home that was dealt with at the time but was never reported, in their interview they acknowledged the missed opportunities for learning. Furthermore, if incidents such as near misses, which have the potential to cause harm, are not reported, opportunities to learn are lost. The findings of this study indicate that there is a lack of knowledge and understanding in the nursing home sector in relation to what constitutes an incident, and a near miss, and as such often go unreported. P3 in their interview also described their frustrations of trying to report near miss incidents which were often dismissed by the managers. The findings of the study indicate that the lack of knowledge and associated experiences of the registered nurses stem from incident reporting not being an organisational priority within the nursing home sector.

Conclusions

The findings from this study indicate that from the registered nurses' lived experience, incident reporting does not appear to be an organisational priority within the nursing home sector. My interpretation is that this is due to the fact that incident reporting is not mandated in independent providers of NHS healthcare like in NHS organisations. At a system level there are several factors which need consideration to support and influence incident reporting through local engagement. Primarily, the system needs to promote incident reporting equitably as an organisational priority within all providers of healthcare, not just NHS organisations. Whilst nursing homes have a responsibility to adopt processes which are proven to increase patient safety, the wider healthcare

system has a greater responsibility to support the nursing home sector and to ensure an equitable approach is adopted across the NHS and nursing homes, and there needs to be further consideration as to how this can be facilitated through systems thinking. Furthermore in 2019 the NHS launched its new Patient Safety Strategy (NHSE & I, 2019) with a focus on continuing to develop and improve the patient safety culture, reporting that "better incident reporting and response could save an extra 160 lives and £13.5 million" (NHSE & I, 2019, p. 6). Whilst there is a wealth of support to enable the implementation of the Patient Safety Strategy within NHS provider organisations, support to the independent sector (including nursing homes) is limited.

It is noted that organisational priority, was not identified as a theme from the scoping review, indicating that this reflects new and unique findings in the field. It is therefore recommended that the system level facilitation afforded to NHS organisations, is required in the nursing home sector, to influence incident reporting and to support changes in practice.

Prioritising incident reporting in nursing homes would enable nursing homes to develop their knowledge, by providing education and training, in relation to incident reporting as a process. This would help to reduce factors such as level of harm and risk and ensure a proportionate response to all incidents. Creating a positive learning culture, would enable the benefits to be realised, where feedback is provided and staff feel supported, reducing the fear and blame experienced by the registered nurses. Commissioning organisations also need to adopt an equitable approach to the way in which services are commissioned, to help promote engagement with incident reporting, whilst also managing incidents that occur in the nursing home sector in a manner equitable to the management of incidents in NHS organisations.

The aim of this study was to explore the lived experiences of registered nurses' working in nursing homes in relation to identification and the reporting of incidents, with the objectives being:

- to determine what registered nurses in nursing homes, understand by the term 'incident' in relation to incident reporting
- to explore incident reporting systems and processes in nursing homes
- to explore any barriers and enablers to incident reporting in nursing homes

- to explore any examples where nursing homes have successfully embedded incident reporting in practice

It has been identified that the registered nurses' understanding of 'incident' is variable and it has been interpreted that this is affected by their previous and current lived experiences. Incident reporting systems and processes differ between nursing homes, in some homes there are paper based systems compared to electronic systems in other homes. Depending upon the structure within the homes, some incidents are managed by the nursing home manager, with others being managed through an internal corporate structure. Several barriers to incident reporting were identified, which have been constructed into themes and although all participants involved in the study were able to describe their internal incident reporting system, there appear to be significant differences to the robust incident reporting systems in NHS organisations, resulting in a number of incidents often being unreported.

Using IPA, the study has successfully explored the registered nurses' lived experience resulting in the construction of a number of themes, which reflect their lived experience of incident reporting in the nursing home sector. Incident reporting systems in nursing homes have been explored and barriers identified. Whilst all participants interviewed acknowledged incident reporting systems were in place, it is clear that there are significant differences to the incident reporting systems within NHS organisations.

Part 2 - Methodology

The purpose of the study was to develop an understanding of the lived experiences of registered nurses working in nursing homes in relation to the identification and reporting of incidents. Interpretative phenomenological analysis (IPA) was chosen as the methodological approach to facilitate the research study and to enable the research aims and objectives to achieved. Having completed the study it is considered that the use of IPA, with its central elements of idiography and hermeneutics, effectively enabled the participants experiences to be elicited and constructed.

Idiography focuses on what is unique and specific to an individual as opposed to nomothetic claims that are more generalised. Four participants were interviewed for the study, their experiences varied significantly and length of time qualified as a registered nurse was between three years and over thirty years. It is likely that these

differences contributed to the differing views and experiences, reflecting the idiographic nature of the study. Using IPA, the distilled essence of the participants' lived experiences was interpreted and presented in the subordinate themes. When analysing the data and constructing the themes to reflect the participants' individual phenomenological experiences, there was evidence of both convergence, where a number of participants shared similar experiences, along with divergence. Two subordinate themes were constructed based on the phenomenological experiences of only one participant - the level of risk associated with an incident, and self-blame, but these were still constructed as themes as they were considered relevant to the individual participants and also the study. It is likely that using a different research methodology may have dismissed these as themes as they were only identified by one participant, resulting in key information being discarded. However, in IPA a theme is not dismissed simply because it was only identified by one participant. The themes were considered relevant to the participants and research aims and objectives, therefore included, further reflecting how the idiographic was evident in my study.

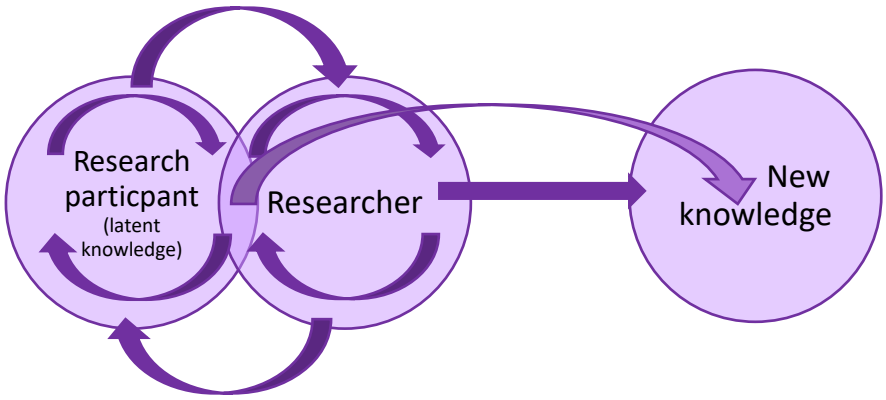
One of the key philosophical elements of IPA is hermeneutics which is defined as the theory and practice of the interpretation of the meaning of texts (Rennie, 2012). IPA is different from other qualitative research methodologies that are not phenomenologically focussed. This is because in IPA research, researchers are required to engage in the process of double hermeneutics, which is required to achieve a deeper understanding and a higher level of interpretation of the phenomenon being explored to develop an understanding of the participant's lived experience. The use of IPA, and hermeneutics facilitated the interpretation of the participants' experiences – the registered nurses' lived experience, to enable a deeper understanding and illumination of the latent data, which may not have been achieved had an alternative research methodology been adopted. The identification of latent knowledge is also a central element of IPA as a research methodology. As previously discussed, hermeneutics are essential to progress the knowledge from the descriptive to the interpreted and constructed, enabling the latent knowledge to be exposed and to contribute to the existing body of knowledge.

Double hermeneutics refers to where the participants are required to reflect and interpret their own experiences, followed by the researcher who then draws upon their own knowledge and experiences to further interpret the participants' narrative. Smith et al. (2009, p. 35) describe this as when 'the researcher is making sense of the

participant, who is making sense of x'. The process of double hermeneutics is also sometimes referred to as the hermeneutic cycle, to reflect the non-linear approach and the interactive relationship between the part and the whole (Smith, 2007).

During the interviews, the research participants were encouraged to reflect on their experiences. Figure 5 is a diagrammatic representation of the double hermeneutics and the hermeneutic cycle, reflecting the nonlinear and dynamic relationship that took place during the interviews between the participants and myself as the researcher to enable the latent to be exposed. The arrows represent the flow of conversation that occurred during the interviews to provoke reflections, and to enable the participants to achieve deeper interpretations resulting in the construction of new knowledge.

Figure 5 – Diagram to represent double hermeneutics, the hermeneutic cycle, and the creation of new knowledge



The first cycle – the research participant - represents the first stage of the double hermeneutics, whereby having reflected the research participants shared their experiences. Reflecting on my own knowledge and experiences, I interpreted and analysed their experiences, and further questioned the participants, reflecting the hermeneutic cycle. This encouraged the participants to further reflect on their experiences to generate a deeper and more meaningful interpretation of what may have been latent in the participant's experience. In the diagram, the overlapping intersection between the research participant and the researcher represents where during the interviews new knowledge was constructed. This completed the first stage of the hermeneutic cycle.

The second stage of the hermeneutic cycle is when the researcher interprets the new knowledge constructed through dynamic interaction with the research participant. Reflecting upon my own knowledge and experiences enabled me to apply an additional level of interpretation. The result being the construction of new knowledge which was doubly interpreted to construct knowledge of the participant's lived experience. Without hermeneutics, it is probable that only superficial descriptive findings would have been presented which may not have contributed to any new findings.

Throughout the analytical and interpretative process, I was conscious that my previous knowledge and experience of working with the nursing home sector will have influenced how I engaged with the data, and that this in turn will have influenced my interpretation of the findings. It therefore must be acknowledged that different researchers, with differing experiences, may draw different interpretations from the data. Furthermore, the idiographic nature of IPA, along with my own interpretations, mean that generalisable claims are not possible, however Smith et al. (2009) supports the use of theoretical generalisability, whereby readers are able to review the findings in the context of their professional knowledge and experience, as opposed to making generalisations.

The theory of double hermeneutics is widely referenced in research literature (Lopez& Willis, 2004; Pietkiewicz & Smith, 2014; Smith et al., 2009). However, having conducted my research, the experience has led me to understand that there are often more than two stages to the hermeneutic cycle, rendering the definition of 'double' hermeneutics inaccurate. During the interviews I conducted, all participants discussed personal experiences along with experiences that had been shared with them by colleagues. Todres (2005) claims that all descriptions of experiences are in fact interpretations as it is not possible to simply describe an experience without an element of interpretation. This suggests that the experience relayed to the research participant by their colleague had already been interpreted by their colleagues which represents the first occurrence of hermeneutics.

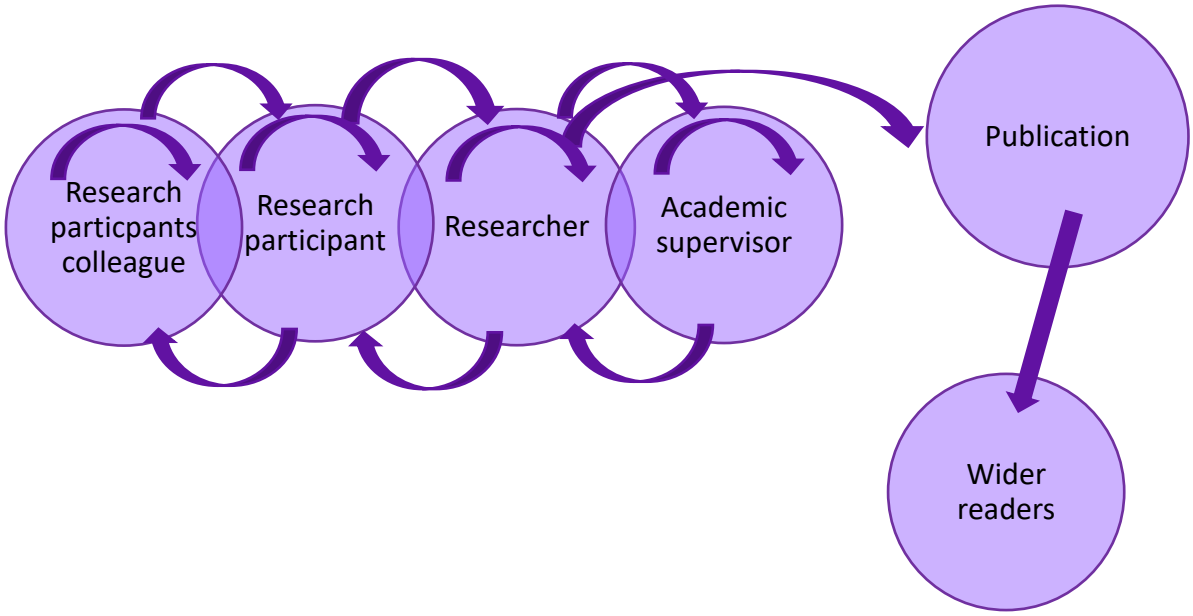
The second (double) hermeneutic element occurred when the research participant further interpreted their colleagues' experience and shared their experiences with me as the researcher. An example of this was in that whilst P2 and P3 were able to demonstrate a good understanding of incident reporting, their interpretation was that the same level of knowledge was not shared by other staff within their nursing home.

The third (triple) hermeneutic element took place when I interpreted the research participants' narrative. Academic discussions between myself and my academic supervisors resulted in additional (multiple) interpretations which could be considered an additional tier of hermeneutics.

Finally, it is envisaged that when the research is published, there will be further (multiple) interpretations of the findings, by the reader. It could be argued that these further interpretations will take place each time the work is reviewed by another reader, as it is likely that readers will reflect on their own experiences and knowledge to apply a further layer of interpretation.

Figure 6 is the Multiple Hermeneutics Model that has been produced to demonstrate the hermeneutics that took place during this research study, along with some additional opportunities for further interpretation.

Figure 6 –Multiple Hermeneutics Model and the hermeneutic cycle



Whilst double hermeneutics is well documented, there is little documented about triple or multiple hermeneutics. In 2011, Mare suggested that the hermeneutic element of IPA could be extended to a triple hermeneutic to consider the reader who is trying to make sense of the researcher, although they did not elaborate or discuss their suggestion in any detail.

This is an approach supported by Weed (2008) who described a similar concept whereby the reader or researcher, interprets the interpretations of the primary researcher's interpretations of the participants interpretations. Montague et al. (2020) also refers to the multiple hermeneutics when research is undertaken by multiple researchers. They argue that the use of multiple researchers enables the data to be interpreted beyond the individual lenses and fore structures and that challenging the interpretations creates deeper insights into the phenomenon. Despite acknowledging an additional layer of hermeneutics, they acknowledge that they do not explore it in any detail and argue that the concept of triple or multiple hermeneutics remains ill-defined in published research (Montague et al., 2020).

Whilst there is limited evidence available to support the concept of multiple hermeneutics in relation to multiple researchers, I have been unable to find any evidence in relation to research participants, interpreting colleagues or peers' experiences, as experienced in my study. Along with the conclusion offered by Montague et al. (2020) about limited evidence, this would further support the argument for the need to explore the use of, and to develop a greater understanding of, multiple hermeneutics in research as opposed to simply double hermeneutics.

The Multiple Hermeneutics Model presented in figure 6 has been produced to reflect the researcher's experience, which differs from the approach described by Mare (2011) and Weed (2008) and highlights a new and unique approach to the hermeneutics required in IPA.

Furthermore, a key element of IPA research lies in the ability to uncover the latent knowledge, and to use this to construct new knowledge. Kondracki, Wellman & Amundson (2002) acknowledges that whilst latent knowledge is often more interesting and provides a broader context, it is more difficult to access. Whilst the need to elicit and expose the latent knowledge is well documented in relation to IPA research, illustrated or working examples of how to conduct this appear superficial and lack detail. As a novice researcher this posed a challenge which was worked through with support and constructive challenge from my academic supervisors to encourage deeper analysis of the research findings. This has been identified as an area requiring further work and guidance in the academic field to support researchers in how to engage with the process, as in the absence of practical guidance, novice researchers may fail to explore the latent content and resort to consider only manifest data, limiting the scope of any new knowledge constructed.

Part 3 - Quality in IPA Research

To ensure quality within research, rigour is essential and refers to the strength of the research design. There are a range of terms used to describe rigour in research including validity and reliability. Validity is concerned with whether the research measures what it is supposed to measure, and reliability refers to the consistency of the measurement (Gerrish & Lacey, 2015). However, these terms are often associated with quantitative research and are considered inappropriate to judge qualitative research (Mays & Pope, 2000). Several approaches have been developed to support the quality assessment of qualitative research (Elliot et al., 2009; Lincoln & Guba, 1985; Yardley, 2000). The approach developed by Yardley (2000) has been described specifically in relation to IPA by Smith et al. (2009) so this approach will be adopted to explore the quality within this IPA study.

Yardley (2000) describes four key principles to assess the quality of qualitative research:

1. Sensitivity to context
2. Commitment and rigour
3. Transparency and coherence
4. Impact and importance

Sensitivity to Context

The first principle described by Yardley (2000) is that of sensitivity to the context in which the study was conducted. Smith et al. (2009) argues that selecting IPA as the research approach reflects a sensitivity to the context in that IPA facilitates close engagement with the idiographic. To demonstrate sensitivity to context, I needed to ensure that I had a wider understanding of the context in which my study was positioned. Conducting the scoping review (chapter 2) helped to develop my knowledge in the research area, as well as reflecting upon my own practical experiences of incident reporting and working with the nursing home sector.

In relation to the data collection, semi-structured interviews were used to collect the data. Before each interview started, I tried to help the participants feel at ease, explaining that there were no right or wrong answers and that I was interested to understand their personal experiences. In recognition of the potential power

imbalance, described by Smith (2009, p.180) as when the 'research expert meets the experiential expert' I explained that the interviews would be semi-structured to allow the participants the freedom to steer the conversation in a direction relevant to their experiences, and also to reflect the idiographic nature of IPA.

Smith et al. (2009) further claims that IPA research demonstrates a sensitivity to the context by working with the raw data and presenting verbatim extracts to allow readers to reflect on the direct quotes, against the interpretations being presented by the researcher. For this reason, several verbatim extracts have been included within the findings, this enables the reader to appraise the researcher's interpretation of the data (Elliott, Fischer & Rennie, 1999).

Commitment and Rigour

Yardley (2000) suggests that another principle which supports the quality of a research study is that of commitment and rigour. Yardley (2000) describes commitment as in-depth engagement with the topic, which can be demonstrated by the engagement with the study for almost six years, and the depth of analysis and interpretation required in IPA studies (chapter 5). Engagement with the data to reflect the hermeneutic cycle was a lengthy and demanding process, which resulted in a challenge being posed to the concept of double hermeneutics, suggesting that multiple hermeneutics is a more accurate description of the process. Only through the commitment to the process, can the findings be interpreted to achieve a higher-level interpretation required in IPA to uncover the latent findings.

Rigour is defined as the 'completeness of data collection and analysis' (Yardley, 2000, p. 221) which not only relates to the depth of analysis as described above but also the adequacy of the sample, how the participants were selected and the questions that were asked (Kitto, Chesters & Grbich, 2008). Selecting an appropriate sample is essential to demonstrate rigour and to enable the aims and objectives of the study to be achieved (Smith et al., 2009; Tracy, 2010). As discussed in the research methods section (chapter 4), a purposive sample was selected with clear inclusion and exclusion criteria, to ensure the participants were able to engage with the study and share examples of their lived experiences. The process undertaken to recruit participants was also described and the interview guide outlining the questions is included as appendix 5 to provide a greater understanding for readers.

To support rigour in qualitative studies, Kitto, Chesters & Grbich (2008) also refer to respondent validation, whereby participants are provided with the opportunity to review the transcript of their interview, however although this was offered to all participants, this was declined by all participants as the interviews were audio recorded.

Transparency and Coherence

Transparency refers to the level of clarity within a study, whilst coherence relates to the appropriateness of the research methodology and philosophical underpinnings, and the ability to answer the research question (Yardley, 2000). To demonstrate both transparency and coherence, I have clearly detailed my methodological approach and methods in chapters 3 and 4, which shows alignment to the research questions, aims and objectives. Transparency is also demonstrated through the process of reflexivity. In IPA research, the researcher adopts an interpretative role, where the researcher's experiences, preconceptions, and assumptions become an integral part of the study findings through the process of interpretation (Koch, 1994), so it is essential that the researcher is able to position themselves in relation to the study. To achieve this my personal reflexivity has been included in chapter 4.

Smith et al. (2009) also argues that in IPA research, to further demonstrate coherence the key principles of IPA – phenomenology, hermeneutics and idiography must be evident within the write up. In the analysis of the findings and subsequent discussions I have reflected the participants' experiences by the inclusion of verbatim quotes to demonstrate the essence of the lived experience. The multiple hermeneutics is evident through the data analysis and the idiographic was reflected in the data analysis process by maintaining sole focus on one participant's experience and completing the analysis before moving to the next. Finally, the inclusion of two themes which were only identified by one participant, further reflects how the idiographic was present.

Impact and Importance

The final principle proposed by Yardley (2000) is that of impact and importance to reflect that ultimately research is judged by its impact and utility. This begins with the selection of a notable subject area (Tracy, 2010). The scoping review highlighted the lack of research conducted in relation to incident reporting in the nursing home sector, suggesting this is an area lacking in research. The nursing home sector also provide

more beds than NHS organisations and care for some of the most vulnerable patients in society, indicating that this is a high-risk group of people and is an area worthy of research with the aim to improve practice.

It is hoped that this research will raise the profile of the nursing homes as an invaluable sector within the wider healthcare system and encourage the NHS as a national body to consider the implications of this study and inspire further research in this area.

Chapter summary

Using IPA to conduct the research has enabled a deeper exploration and understanding of the essence of the registered nurses' lived experience of incident reporting in the nursing home sector. This has only been achieved by the hermeneutic element of IPA, which facilitated a higher-level interpretation to elicit the latent content, which may not have been achieved using an alternative research approach.

The study has also highlighted the need for further exploration of the use of hermeneutics in IPA, to consider the use of 'multiple hermeneutics' as opposed to just double hermeneutics. The requirement to expose latent knowledge is crucial to IPA research, further guidance on how to undertake this would serve to make this more accessible to novice researchers.

Finally, an assessment of the quality of the study has been undertaken based on Yardley's (2000) approach to quality in qualitative studies. Evidence of conformability to Yardley's four key principles are reflected throughout the study, to demonstrate the overall quality of the study.

The final chapter will review the unique contribution that this study has made to the field of knowledge in relation to the registered nurses' lived experience of incident reporting in the nursing home sector. Recommendations for further research, and clinical practice, will be presented along with an acknowledgement of the limitations of this study.

Chapter 7

Recommendations and conclusion.

Introduction

The final chapter will present the unique contributions the study has made to both the specific research area and the research field, along with the recommendations for further research. Recommendations are also provided on how this new and unique knowledge could be used to influence clinical practice and improve incident reporting within the nursing home sector. Finally, the limitations of the study are acknowledged.

Unique contribution

Academic work

This study has made a significant contribution to the existing knowledge base. In relation to academic knowledge, the scoping review failed to identify any studies conducted in England which specifically explored the registered nurses' lived experience of incident reporting in the nursing home sector. Therefore, the use of IPA, as a research methodology, has effectively given a voice to the registered nurses in the nursing home sector and provided them with an opportunity to articulate their reflections and interpretations of their experiences. This has enabled an invaluable contribution to a limited knowledge base, from a sector who are often referred to as the Cinderella service of nursing (Houchin, 2016).

A new model has been developed to support incident reporting in the nursing home sector, the 'Systems Level Facilitation Model for Incident Reporting.' It is proposed that the adoption of this model at a system level would facilitate the effective implementation of incident reporting in the nursing home sector.

Registered nurses' lived experience

The study has also identified seven unique themes relating to the registered nurses' lived experience of incident reporting; self-blame, lack of carer involvement, level of risk, incident escalation, access to IT, fear of the IT systems and organisational priority which are discussed below. The unique findings have been constructed and will

increase the existing body of knowledge in relation to the registered nurses' lived experience of incident reporting in the nursing home sector.

- Self-blame - Whilst blame and fear were identified in the scoping review, self-blame was not identified as a factor in the scoping review. One participant reflected on how they blame themselves when an incident occurred and described the anxiety this caused. Apportioning self-blame when an incident occurs may prevent incidents being reported, therefore posing as a barrier to reporting. Having identified that self-blame is experienced by nurses when mistakes happen may require the adaption of training programmes to address this issue. This may result in staff feeling more confident in reporting incidents, knowing that they will be supported to reflect on any internal concerns they may have, rather than apportioning self-blame.

- Lack of carer involvement - Incident reporting as a system to identify errors and learn from mistakes should be available to all staff that work within the nursing homes and should not be limited to the registered nurses. The scoping review identified that nurses with higher level qualifications were more likely to report (Chen et al., 2018; Shmueli et al., 2014; Wagner et al., 2012), whereas in contrast, the findings of this study identified that it was often the care staff who identified the incidents and reported them to the registered nurses. It was interpreted that this was due to the amount of time the care staff spend with the residents compared to the nursing staff. Whilst registered nurses still have a key role in relation to ensuring the patient safety, incident investigation and supporting the carers who have identified the incident, carers should be enabled to report incidents directly. In NHS organisations, all staff are encouraged to report incidents and a similar approach should be adopted across the nursing home sector to increase the identification of harms and potential harms.

- Access to IT & fear of IT systems - Accessibility to computers, IT connectivity issues and fear of computer systems were all identified as factors within the nursing home environment which require addressing to encourage staff to engage with the process.

- Level of risk - Level of risk to the patient and organisational reputation/consequences appeared to be fundamental when determining whether to report an incident and appeared to be linked to the inequity between the NHS and nursing homes.

- Organisational priority - The most significant unique finding was that of incident reporting as an organisational priority. Organisational priority sits within the concept of system level facilitation at a macro level, but significantly influences the other concepts of local engagement at a meso level and individual accountability at a micro level. It is acknowledged that most of the studies included in the scoping review were international, therefore it is probable that the organisation and provision of healthcare, and the national policies and systems, will differ to those in England. However, within England, healthcare appears to be constructed of a two-tier system, NHS organisations and independent organisations providing NHS care, such as nursing homes. Both are subject to differing commissioning arrangements and support provided by the wider NHS, creating a divide and inequity in what is essentially NHS care. Within the NHS, incident reporting is a priority with contracting arrangements in place to support the implementation, however participants experiences have identified that the same is not reflected across the nursing home sector. National policies need to be reviewed to align the priorities and reduce the inequity across all providers of NHS health care.

The identification of new findings highlights the benefits of undertaking this study, as it is hoped that they will be used to influence policy and change practice. Analysis of the data constructed has also highlighted a number of similarities to the findings from the scoping review to contribute to the existing body of knowledge, for example limited understanding/lack of knowledge, fear, blame, time, level of harm.

IPA as a research methodology

In relation to IPA as a research methodology, whilst the approach adopted was appropriate for this specific research study, undertaking an IPA study has led me to

challenge the concept of double hermeneutics described in IPA. My experiences have led me challenge the well documented principle of double hermeneutics, proposing that the concept of multiple hermeneutics is a more accurate reflection of the hermeneutic process required in IPA studies. It is naive to suggest that there will only be two interpretations of any data, and that to enable a deeper understanding and elicitation of the latent knowledge, central to the participants' lived experience, multiple interpretations are required. This is an area requiring additional research to develop a deeper understanding of the application and use of multiple hermeneutics to further challenge the concept of double hermeneutics.

Furthermore, it has been identified that the absence of worked examples and guidance on how to elicit the latent content poses a challenge for novice researchers. Exposing latent knowledge is pivotal to IPA research, achieved by the hermeneutic element of IPA, however little guidance is available to support novice researchers wanting to engage with IPA research. I recommend the need for further work in this area to support the methodology and to enable researchers to engage more effectively with the latent.

Limitations

A few limitations have been identified in relation to the research study. Limitations of IPA as a methodology were discussed in the methodology chapter so the focus here will be on the wider study.

In IPA research, researchers are encouraged to conduct face to face interviews with their participants to facilitate open communication and to understand the participants' body language (Bryman, 2016). As the study was conducted during the Covid-19 pandemic, interviews had to take place by phone to adhere to the national social distancing guidelines at the time. Furthermore, as I was unable to visit the nursing homes, to engage with the registered nurses to discuss my study, it made it very difficult to recruit participants.

Whilst it is acknowledged that in IPA the researcher is an active participant in the data construction using hermeneutics, it also has to be highlighted that this can result in an element of bias. To minimise this, I have identified my positionality through reflexivity, and participant extracts were included in the findings section to allow the reader to also understand some of my interpretations, although it must be acknowledged that it may

not always have been possible to prevent bias from influencing my interpretations. Furthermore, although extracts from the participants interviews were included, it is recognised that without the wider context they could be misinterpreted (Potter & Hepburn, 2005). My prior knowledge and experience in the field could also be perceived as a limitation as this could have resulted in a less objective interpretation of the findings

Recommendations for further research

The findings of the study have identified additional gaps in the knowledge base relating to the nursing home managers' experience and understanding of incident reporting. Carers also appear to be largely excluded from the incident reporting process, despite it being acknowledged by participants in the study that carers identify many of the incidents that occur. Further exploration in these areas would help to enhance and develop the existing body of knowledge, and to identify strategies that may serve to facilitate incident reporting.

Recommendations for practice

The findings from the study have identified a number of ways in which the registered nurses' lived experience of incident reporting in the nursing home sector could be improved, and how incident reporting could be effectively implemented within nursing homes, as a process to improve patient (resident) safety. Using the (multiple) hermeneutic cycle to explore the participants' idiographic experiences has ensured the recommendations reflect the applicability of the findings when considering practices in relation to the wider nursing home sector.

The recommendations are for:

- NHS strategies, policies and guidance relating to patient safety and incident reporting to be explicitly applicable to independent providers of NHS healthcare, such as nursing homes, for example the NHS Patient Safety Strategy (NHSE & I, 2019).
- Strategies employed to support the adoption of such policies need to be available and promoted within the nursing home sector and other independent

providers of healthcare, with the same level of support and engagement that is available to NHS organisations.

- Commissioning organisations to commission care from the nursing home sector that aligns to the key strategies in the NHS.
- Independent providers of NHS healthcare, such as nursing homes, to horizon scan and explore national policies with a view to local implementation
- Application of the **Systems Level Facilitation Model for Incident Reporting** to support the robust adoption of incident reporting in the nursing home sector

It is considered that the implementation of the recommendations would help to remove the barriers to incident reporting identified in the nursing home sector. For example, the provision of education programmes would enhance knowledge and help to remove the elements of self-blame experienced, whilst also enabling a more positive learning culture to be developed.

The findings have identified important practice gaps which provides the basis for stakeholders, such as commissioning organisations and NHS England to start to consider. Nursing homes, as key providers of healthcare to some of the most vulnerable people in society, should be given the same access and support with regards to the implementation of national strategies, such as the National Patient Safety Strategy (NHSE & I, 2019) to ensure equity of access and to improve the quality of care for all our patients.

It is hoped that the findings from this study will be considered and used to influence national policy to work closer with the nursing home sector and to support the registered nurses who support some of the most vulnerable patients in society.

The ultimate aim would be for national policy to be applied equitably to independent providers of NHS health care, with the same support available to them as NHS organisations receive. This would serve to reduce the inequity for registered nurses who work within the sector and also for the patients who call the nursing home their ‘home’.

Study Conclusion

IPA as a research methodology, underpinned by the philosophical principles of relativism and social constructionism, was adopted to conduct this research. IPA was

found to be an effective approach to gain a deep understanding of the lived world of the participants, facilitated by multiple hermeneutics and a commitment to expose the latent to enable the construction of new knowledge. Three key concepts were identified: individual accountability, local engagement, and system level facilitation, along with the identification of one core theme – organisational priority, in response to the four objectives of the study.

This study is the first study in the United Kingdom to explore the registered nurses' lived experience of incident reporting in the nursing home sector and has identified unique findings to contribute to body of knowledge. Challenges have been posed to the well-established double hermeneutics, a central element of IPA, and gaps identified in relation to exposing the latent, a key element of IPA research.

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Appendix 1 – Charting the data

Author(s), Year & Study Location	Title	Intervention type	Study population & setting	Aims of the study	Methodology	Important findings
Farag, Vogelsmeier, Knox, Perkhounkova, Burant. 2020 USA	Predictor of Nursing home nurses' willingness to report medication near misses	Postal survey	Nurses Nursing home	To determine nursing home nurses' willingness to report medication near misses Specific to medication incidents	Quantitative	Factors found to influence willingness to report medication near misses were identified as: I. Transformational rather than transactional leadership from the home manager II. Non punitive approach to incident investigation III. Staff familiarity with the incident reporting system IV. Trust in the home manager
Mansouri, Mohammadi, Adib, Lili & Soodmand 2020 Iran	Barriers to nurses reporting errors and adverse events	Questionnaire	Nurses Hospital	To assess nurses' views about the major barriers to reporting errors in intensive care units	Quantitative	Three barriers were identified which prevent nurses from reporting adverse events: I. Fear II. Procedural barriers III. Management barriers
Chegini, Kakemam, Jafarabadi & Janati 2020 Iran	The impact of patient safety culture and the leader coaching behaviour of nurses on the intention to report errors: a	A cross sectional survey	Nurses	To examine the perceived patient safety culture and leadership of nurses in relation to intention to report errors.	Quantitative	Multiple barriers to adverse event reporting were identified, the top barriers were: I. Punitive response to reporting II. Lack of teamwork III. Poor communication IV. Learning from incidents

	cross-sectional survey		Hospital			Also identified that in relation to demographic characteristics – more educated nurses were less likely to report
Dyab, Elkalmi, Bux & Jamshed 2018 Malaysia	Exploration of nurses' knowledge, attitudes, and perceived barriers towards medication error reporting in a tertiary health care facility: a qualitative approach	Semi-structured interviews	Nurses Hospital	To explore the implicated barriers and facilitators towards medication error reporting. Specific to medication incidents	Qualitative	Four major themes were identified as barriers to reporting: I. Knowledge about medication errors II. Attitudes about medication errors III. Barriers to reporting medication errors IV. Facilitators to reporting medication errors
Rutledge, Emeritus, Retrosi & Ostrowski 2018 USA	Barriers to medication error reporting among hospital nurses	Survey	Nurses Hospital	To identify barriers to reporting medication error among hospital nurses. Specific to medication incidents	Quantitative	Multiple barriers to adverse event reporting were identified, the top barriers were: I. Time II. Fear III. Lack of feedback post report
Hong & Li 2017 China	The reasons for Chinese nursing staff to report adverse events: a questionnaire study	Questionnaire	Nurses Hospital	To in investigate nurses' perception of patient safety culture and adverse event reporting.	Quantitative	Factors that were perceived to encourage reporting were identified as: I. Positive patient safety culture Factors perceived as a barrier to reporting: I. Management Style II. Punitive culture

						III. Unclear processes for reporting IV. Lack of education specific to incident reporting V. Lack of confidence in using reporting system VI. Time taken to complete the report
Hammoudi, Ismaile & Yahya 2017 Saudi Arabia	Factors associated with medication administration errors and why nurses fail to report them	Cross – sectional survey	Nurses Hospital	To identify the factors contributing to the reporting of medication errors from the nurses' perspective. Specific to medication incidents	Quantitative	Three main themes were identified which prevent nurses from reporting errors: I. Administrative response II. Fear III. Reporting effort
Chen, Wang, Redley, Hsieh, Chu & Han 2017 Taiwan	A study on the reporting intention of medical incidents: a nursing perspective	Survey	Nurses Hospital	To explore factors which influence reporting of incidents.	Quantitative	Factors affecting incident reporting: I. Staff who held managerial positions or with higher levels of education were more likely to report incidents II. Staff with increased age and years of service were more likely to report incidents III. Limited awareness and experience of incident reporting may hinder reporting IV. Support from supervisors can increase intention to report V. Supportive culture found to increase reporting VI. A simplified reporting system

Lee 2017 South Korea	Reporting of medication administration errors by nurses in South Korean hospitals	Questionnaire	Nurses Hospital	To examine the willingness to report errors and identify barriers to reporting. **Specific to medication incidents**	Quantitative	Numerous barriers were identified to reporting incidents I. Lack of clarification about what constitutes an error II. Criticism from peers III. Fear of management IV. Nurses more likely to report the error to a physician rather than complete an incident report
Hung, Lee, Liang & Chu 2016 Taiwan	Factors affecting nurses' attitudes and intention toward medication administration error reporting	Questionnaire	Nurses Hospital	To explore the factors that influence nurses' attitudes and intention towards medication administration error reporting. Specific to medication incidents	Quantitative	Factors found to influence incident reporting were: I. Nurses involved in the study demonstrated altruistic tendencies and positive attitudes towards incident reporting. II. No correlation was identified between the level of nursing expertise and likelihood to report III. Nurses' ability to detect that an error had occurred is more important than a nurse's attitude toward incident reporting IV. Supportive attitude of colleagues and managers increases intention to report incidents V. No correlation was identified between ability and knowledge, time constraints

						and system design and intention to report
Yung, Yu, Chu, Hou & Tang 2016 Taiwan	Nurses' attitudes and perceived barriers to the reporting of medication administration errors	Questionnaire	Nurses Hospital	1. To explore the attitudes and perceived barriers to reporting medication administration errors 2. To understand the characteristics of – and nurses' feelings – about error reports. Specific to medication incidents	Quantitative	Findings in relation to attitudes include: I. Attitudes generally positive in relation to error reporting II. Belief that if a patient was unharmed, it was not necessary to report Barriers to reporting were identified as: I. Fear II. Lack of awareness about reporting Senior nurses more likely to report errors and reported less barriers
Haw, Stubbs & Dickens 2014 UK	Barriers to the reporting of medication administration errors and near misses: an interview study of nurses at a psychiatric hospital	Interview	Nurses Hospital	To explore the reasons why inpatient psychiatric nurses fail to report a medication error made by a colleague and to identify the barriers to reporting near miss incidents. Specific to medication incidents	Qualitative	4 themes were identified: I. Excusing II. Fear III. Knowledge IV. Burden
Shmueli, Noy, Natan, Ben-Israel 2014	Reporting adverse events at geriatric facilities	A retrospective review of incident reports	Nurses	1. To examine which types of adverse events are characteristic of the geriatric centre studies 2. Which of the nursing staff reported these events?	Quantitative	Identified the most commonly reported incident *(Not relevant to this study)*

Israel			Geriatric facility			Positive correlation between seniority of nurse and number of incident reports made
Prang, I.W. Jelsness-Jorgensen, L. 2014 Norway	Should I report? A qualitative study of barriers to incident reporting among nurses working in nursing homes.	Semi structured interviews	Nurses Nursing home	To explore the barriers to incident reporting in nursing homes compared to hospitals.	Qualitative	Barriers identified include: I. unclear outcomes II. lack of support III. culture IV. fear of vilification V. unclear routines VI. technical knowledge VII. time and degree of severity(harm)
Mostafaei, Marnani, Esfahani, Estebsari, Shahzaidi, Jamshidi & Aghamiri 2014 Iran	Medication errors of nurses and factors in refusal to report medication errors among nurses in a teaching medical center of Iran in 2012	Questionnaire	Nurses Hospital	To identify the importance of various factors in relation to failure to report medication incidents. Specific to medication incidents	Quantitative	Barriers to incident reporting included: I. Fear II. Lack of a reporting system III. Lack of definition of an error
Wagner, L.M. Castle, N.G. Handler, S.M. 2013 USA	Use of Health Information Technology (HIT) systems for adverse event reporting in nursing homes: barriers and facilitators.	Postal surveys	Nurses Nursing home	To determine barriers and any health information technology related facilitators to adverse event reporting in US nursing homes.	Quantitative	Numerous barriers to incident reporting were identified, top 5 were: I. Lack of recognition that an incident had occurred II. Fear of blame III. Fear of disciplinary action IV. Forms too long to complete V. Time taken to compete the form

Wagner, Harkness, Herbert & Gallagher 2012 Canada	Nurses' perceptions of error disclosure in nursing homes	Postal survey	Nurses Nursing home	*1.* Nurses' perceptions of disclosure of adverse events to residents and their families *(Not relevant to this specific study)* 2. The effect of the nurse's characteristics and institutional culture on disclosure of incidents.	Quantitative	I. Respondents found error reporting a difficult process II. Registered Nurses more likely to report than other staff III. Nurses personal experience and education are more influential factors to reporting than the organisational culture
Boyazidi, Zarezadeh, Zamanzadeh & Parvan 2012 Iran	Medication error reporting rate and its barriers and facilitators among nurses	Questionnaire	Nurses Hospital	To explore medication error reporting rates and the barriers and facilitators among nurses. Specific to medication incidents	Quantitative	Barriers identified include: I. Fear II. Incompetence III. Time to complete the report IV. Level of harm Facilitators identified include: I. Anonymous reporting II. Clear benefits to reporting III. Level of harm to patient IV. Supportive manager

Appendix 2 – Participant Invitation Letter.

PARTICIPANT INVITATION LETTER

University of Salford
The Crescent
Salford
M5 4WT

DATE:

Dear Colleague

I would like to invite you to take part in a research study that I am undertaking as part of my Professional Doctorate in Health and Social Care. Please find enclosed an information sheet which explains the study.

I hope that you would like to take part in my study and would like to ask you to contact me via email s.mackie@edu.salford.ac.uk or phone to discuss the study.

I look forward to hearing from you

With regards

Sue Mackie

Work mobile: 07501 486848
Email: s.mackie@edu.salford.ac.uk

Appendix 3 – Participant Information Sheet.

University of Salford MANCHESTER

Participant Information Sheet

Study title: Patient safety incident reporting in the nursing home sector.

I would like to invite you to take part in a research study which will explore the experiences of Registered Nurses working in the nursing home sector in relation to reporting patient safety incidents. Before you decide I would like you to understand why the research is being carried out and what it would involve for you. Please take time to read the following information carefully. Please ask questions if anything you read is not clear or you would like more information.

1. What is the purpose of this study?

Patient safety is a cause for concern across health-care systems worldwide with data suggesting that approximately 10% of patients experience harm whilst receiving health care. In the NHS today, incident reporting systems are well established and used to identify risks so that clinical practice can be improved. However, although an increase in the ageing population has resulted in there being far more beds in the nursing home sector than in the NHS, there is little research in relation to incident reporting in nursing homes.

As a student on the Professional Doctorate in Health and Social Care course at the University of Salford, the aim of the research study I am conducting is to understand the practice of incident reporting in the nursing home environment and to understand the Registered Nurses experiences of incidents and incident reporting.

2. Why have I been invited?

You have been invited to take part in this study because you are a Registered Nurse working in a nursing home.

3. Do I have to take part?

It is up to you to decide. I will describe the study and go through the information sheet with you. I will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason. There will be no negative consequences if you withdraw. Interview data cannot be withdrawn once a report of the research has been sent for publication.

4. What will happen to me if I take part?

If you decide to take part in this study, you will be asked to take part in an interview with me. The interview will last approximately 45 to 60 minutes and will take place via Microsoft Teams. You can be interviewed during work time (if work allows) or an alternative mutually agreeable time. I will check that you understand the study before the interview begins. A consent form

will be shared with you via email, and this will be discussed at the start of the interview, verbal consent will be obtained and recorded before the interview begins. At the start of the interview, you will also be advised that if an incident is disclosed which hasn't been reported to the home manager via local policy this may need to be reported to the home manager to ensure that this can be investigated appropriately and to ensure compliance with the NMC Code (2018).

The interview will be semi-structured, so whilst there will be a number of questions to guide the interview there will also be the opportunity for you to talk freely about your experiences. I will ask you a number of questions to generate a discussion about your understanding and experience of incidents and incident reporting in your place of work, there are no right or wrong answers. At the end of the interview, I will ask you if there is anything else you would like to say.

You only have to take part in one interview, but you may be invited to a second interview if any clarification is needed on things that have been discussed during the first interview.

With your permission, your interview will also be recorded via Microsoft Teams. This is to allow for the interview to be reviewed and analysed. The recording and transcript will be stored securely and will not be shared with anyone else. Upon completion of the study, the recordings of interviews will be deleted.

5. Expenses and payments?

As this is a short-term project which has no funding, I am unable to provide any payment for your time.

6. What are the possible disadvantages and risks for taking part?

There should not be any disadvantages or risks for taking part in this study. You are free to withdraw from the study and can request that your data also be withdrawn by contacting the researcher within 4 weeks of being interviewed, otherwise, the data you provide may still be used.

7. What are the possible benefits of taking part?

Taking part in this study may not benefit you directly, however the information obtained from the study will generate knowledge of the experiences of incident reporting in the nursing home sector. The knowledge generated will be used to make recommendations to improve practice, enhancing the care for residents and improving the experiences for staff working in the nursing home environment. This is the first study of this kind to be conducted within the United Kingdom

You can also reflect on the experience of taking part in a research study and use this towards your nursing revalidation.

8. What if there is a problem or I want to complain?

If you have a concern about any aspect of this study, you should ask to speak to the researcher [Suzanne Mackie - s.mackie@edu.salford.ac.uk] who will do their best to answer your questions. If you remain unhappy and wish to complain formally you can do this by contacting the Research Supervisor [Professor Jackie Leigh - j.a.leigh4@salford.ac.uk]. If the matter is still not resolved, please forward your concerns to Professor Andrew Clark, Chair of the Health Research Ethical Approval Panel, Allerton Building, Frederick Road Campus, University of Salford, Salford, M6 6PU. Tel: 0161 295 4109. E: a.clark@salford.ac.uk

9. Will my taking part in this study be kept confidential?

Yes, your details will be kept confidential. Your name will not be stored with the interview data and will be replaced by a code so you will not be identifiable. Direct quotes may be used and published but these will be anonymised. The documents will be destroyed 3 years after the end of the study.

10. What will happen if I don't want to carry on with the study?

You can change your mind at any time and a decision to withdraw or a decision not to take part will not be held against you in any way. However, if you withdraw, data already collected may still be used within the study.

11. What will happen to the results of the research study?

The results of the study will be included in the thesis report as part of my Professional Doctorate course. In addition, I plan to publish the findings in a relevant nursing journal. Anonymised quotes may be used in the research study and publications. If you wish, I will send you a summary of the study findings upon completion of the study.

12. Who is sponsoring the study?

The sponsor for this study is The University of Salford.

Thank you for taking the time to read this information sheet and for considering taking part in the study. Please get in touch if you would like to discuss any aspect of the study further.

Appendix 4 – Participant Consent Form.

University of Salford MANCHESTER

PARTICIPANT CONSENT FORM

Title of study: Patient safety incident reporting in the nursing home sector.

Name of Researcher: Miss Suzanne Mackie

Please complete and sign this form **after** you have read and understood the study information sheet. Read the following statements, and circle 'Yes' or 'No' in the box on the right-hand side.

1.	I confirm that I have read and understand the study information sheet version ***1.2*** dated ***19th February 2021*** for the above study. I have had the opportunity to consider the information and to ask questions which have been answered satisfactorily.	Yes/No
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected.	Yes/No
3.	If I do decide to withdraw, I understand that the information I have given, up to the point of withdrawal, may be used in the research.	Yes/No
4.	I agree to participate by being interviewed, with the interview being recorded in Microsoft Teams.	Yes/No
5.	I understand that my personal details will be kept confidential and will not be revealed to people outside the research team. However, I am aware that if I reveal anything related to criminal activity and/or something that is harmful to myself or others, the researcher must share that information with appropriate personnel.	Yes/No
6.	I understand that my anonymised data will be used in the researchers' research, reports, other academic publications, and conferences presentations.	Yes/No

7. I agree to take part in the study: | Yes/No |

_____	_____	_____
Name of participant	**Date**	**Signature**
_____	_____	_____
Name of person taking consent	**Date**	**Signature**

Appendix 5 – Interview Guide

University of Salford MANCHESTER

Semi-structured interview guide

1. Can you tell me about your nursing career to date?
- How long have you been qualified?
- Why did you decide to work in the nursing home?

2. What do you understand by the term patient safety incident?
- Show definition by from the National Reporting and Learning System, ask if they have seen this definition before?

any unintended or unexpected incident which could have or did lead to harm for one of more patients receiving NHS care (NRLS, n.d.)

- How does your definition/ the homes definition compare with the NRLS definition?
- What do you think Registered Nurses in the home understand by the term incident?
- From your experience what types of incidents happen in the nursing home? Can you tell me about some of the incidents that have been reported?

3. Is there a system in the home for reporting incidents – can you talk me through the process?
- Whose responsibility is it in the home to report an incident within the home?
- Have you reported incidents while working in the care home sector – can you talk me through a couple of them?
- Have you ever had concerns about reporting an incident in the care home sector? Explore answer?

4. What happens when an incident has been reported in the care home?
- Reported internally/externally? To whom?
- Any investigation, learning, actions as a result of the incident
- Can you tell me how the incident and the learning from the incident is shared with other staff in the home?

5. From your experience, do you think all incidents that happen within the home are reported? Based on the conversation so far

6. If YES, what evidence is this answer based on?
- If no – what do you think stops people from reporting them
- Can you think of anything that would encourage/make it easier for staff to report incidents?

7. From your experience, what do you think are the benefits for reporting incidents?
- Improve practice, learn from mistakes?
- Do you think there are any potentially negative outcomes from reporting incidents in the home?

8. From your experience, what do you think would help to improve incident reporting in your home?
- Simpler process, more support?
- From your experience, have you or any colleagues had a negative experience when reporting an incident, if so, can you tell me a little about the experience?

Is there anything further than you wish to add or would like to clarify?

Appendix 6 – Synopsis of each participants lived experience.

Participant 1

Participant 1

Participant 1 has been qualified for over 30 years and has spent the vast majority working in the care sector, only working in the NHS for a short period of time when first qualified. They describe their preference to working in elderly and end of life care and this prompted their move into the care sector.

They work in a small independent home with fewer than 35 beds and use a paper-based system to report incidents. The manger is on site generally Monday to Friday and oversees all incidents that are reported. They do not feel that staff within the home have a good understanding of incident reporting, or even what actually constitutes an incident. They suggested that sometimes they don't have 10 incidents in a month, which suggest a lack of understanding in relation to incidents, but also indicated that not all incidents are reported as staff report that they don't want to get colleagues into trouble.

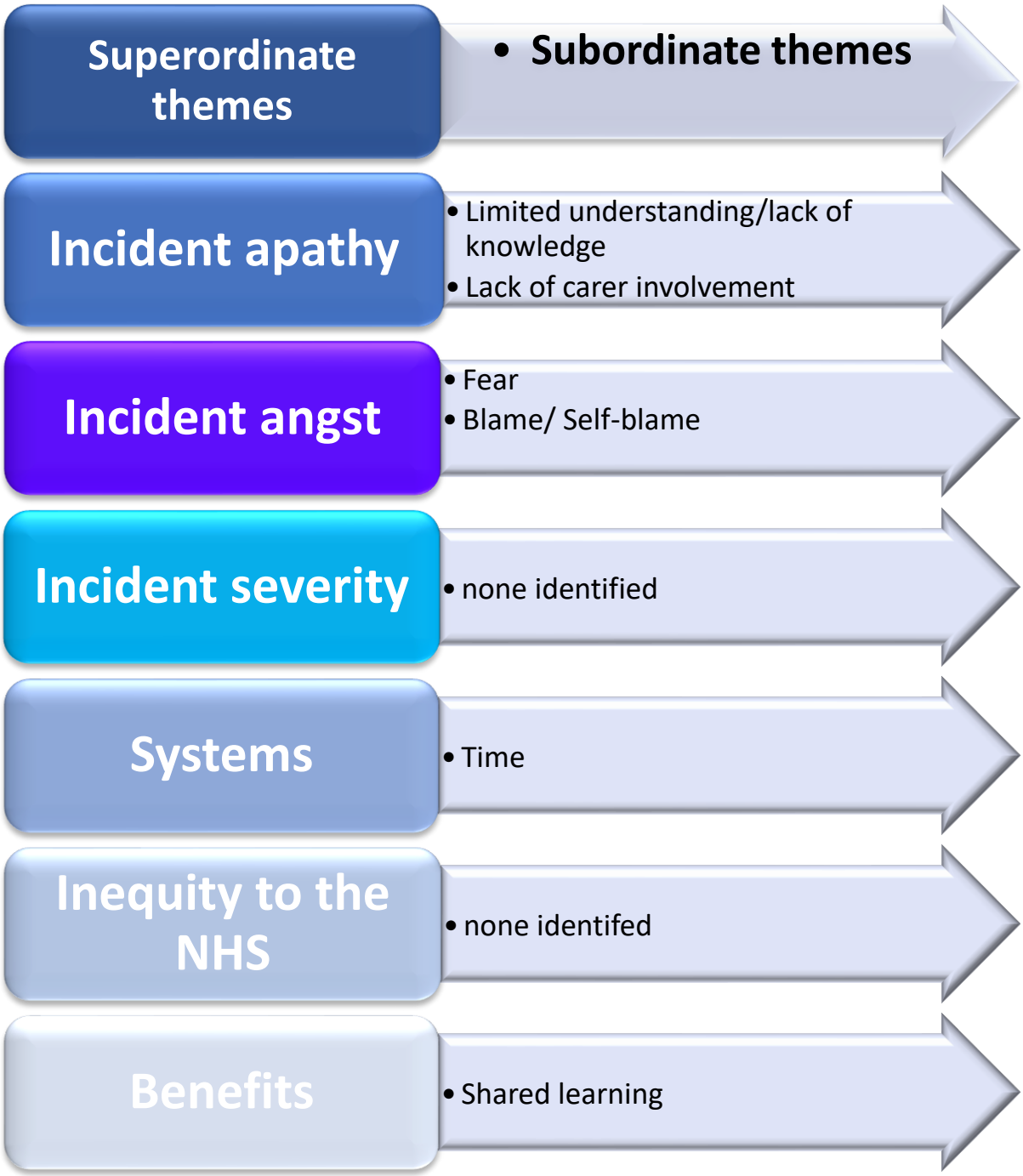
They talked about a couple of incidents that had occurred within their home, one in particular where they personally had made a medication error and the subsequent guilt they felt as a result, although they report that the approach by management did not contribute to the guilt they felt. They talked about how learning following an incident was shared within the home, but the process appears informal.

They also reflected on an incident which progressed to a safeguarding enquiry and how they felt during this process, and again the guilt they felt towards the patient and their family members as the patient had sustained an injury following a fall. They described feeling as though they were being scrutinised.

They described how it might be carers that identify an incident but that they have to verbally report to the nurse in charge for them to report the incident as carers are not allowed to complete incident reports, although they were unable to explain why this was the case.

Participant 1 – idiographic representation of themes

Participant 1's lived experience was reflected in 4 of the superordinate themes and 6 subordinate themes.



Participant 2

Participant 2

Participant 2 has been qualified for over 30 years and has spent the majority of their career in the NHS, before moving to the care sector approximately five years ago. They were employed in ward manger roles for the latter part of their NHS career prior to moving to the care sector.

They were able to demonstrate a good understanding of incident reporting, which is possibly due to their extensive experience in the NHS. They articulate the differences between incident reporting in the NHS and the care sector and how staff working in the care homes feel as though they are under more scrutiny than staff working in NHS organisations. They also highlighted that there did appear to be a lack of knowledge in the care sector compared to when working in the NHS.

They discussed how often within the home it will be the carers that identify the incidents but that they are unable to report, and they have to verbally report the incident to the registered nurse, who will then report in the system. They also discussed how this differed to their experience of working in the NHS where all staff were able to report incidents.

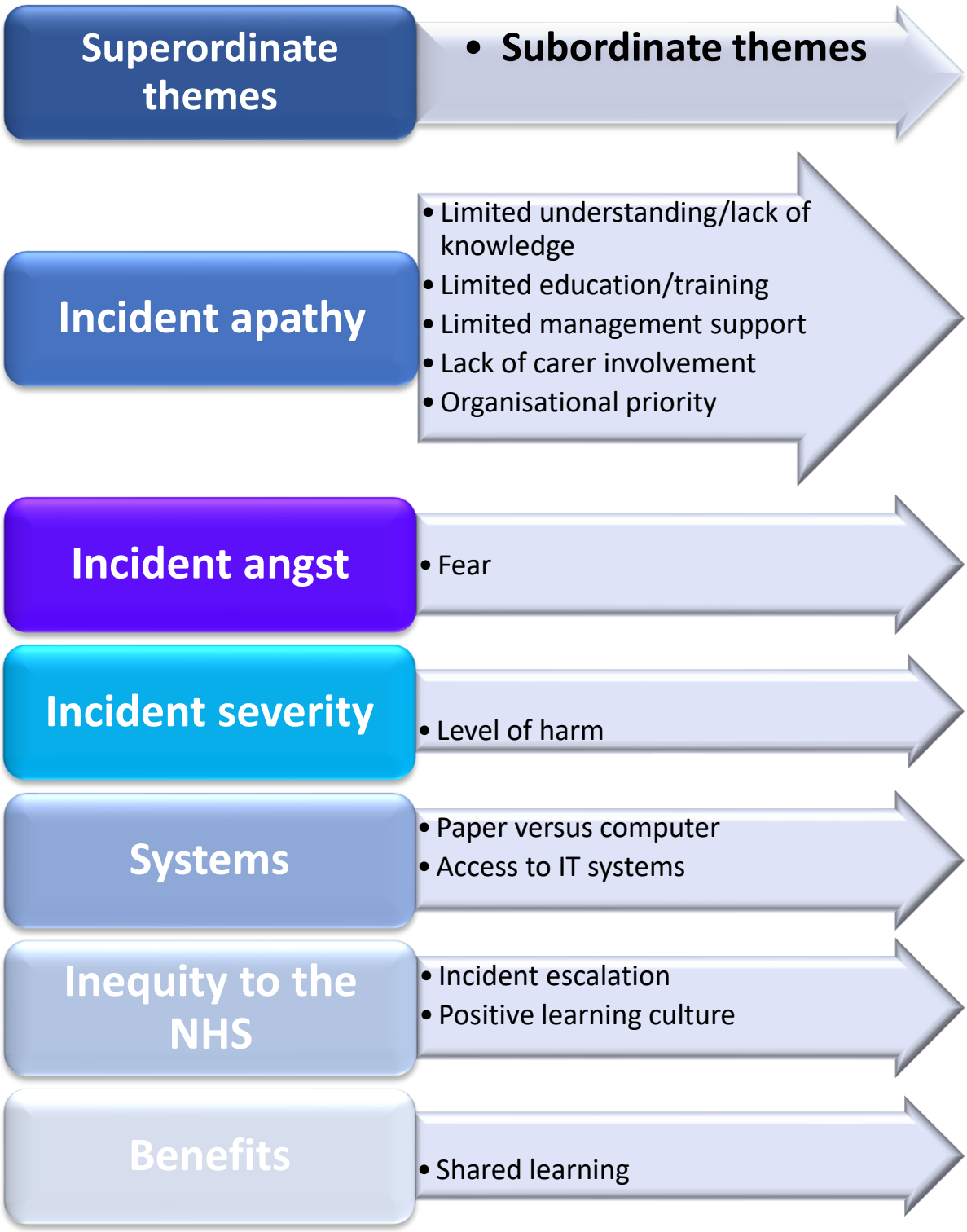
Although various types of incidents are reported, they highlighted that there is often more focus on incidents which have caused serious harm.

In the nursing home they described that the way in which incidents were handled was often down to the manager's perspective and they felt that the approach adopted in the NHS was more open and transparent. They also explained that it was the manager who would determine what actions, if any, were required post incident and that the clinical staff were often felt excluded.

They reflected on how the internal process where they worked required a supervision session to take place post incident and that this was often perceived by staff in a negative manner, despite trying to focus on the learning that was generated.

Participant 2 – idiographic representation of themes

Participant 2's lived experience was reflected in all 6 of the superordinate themes and 12 subordinate themes.



Participant 3

Participant 3

Participant 3 has been qualified for over 30 years and has spent the vast majority of their career working in the NHS. They were employed in senior nursing roles, similar to ward manager level in both the hospital and community settings. They self-reported a good understanding of incident reporting due to their experiences within the NHS and this was evident throughout the interview. They moved to the nursing home sector approximately three years ago as they were keen to work in a role with a greater patient focus.

They report a good understanding of both actual incidents and near miss incidents but also acknowledge that in the nursing home environment, from their experience, there is little recognition of near miss incidents. They feel that there is often a failure to acknowledge near misses and the wider contributory factors and that often although near misses occur, no actions are taken to address the issues until an actual incident has occurred. They report their frustrations in trying to report near miss incidents and also at the lack of acknowledgement from the management team within the nursing home.

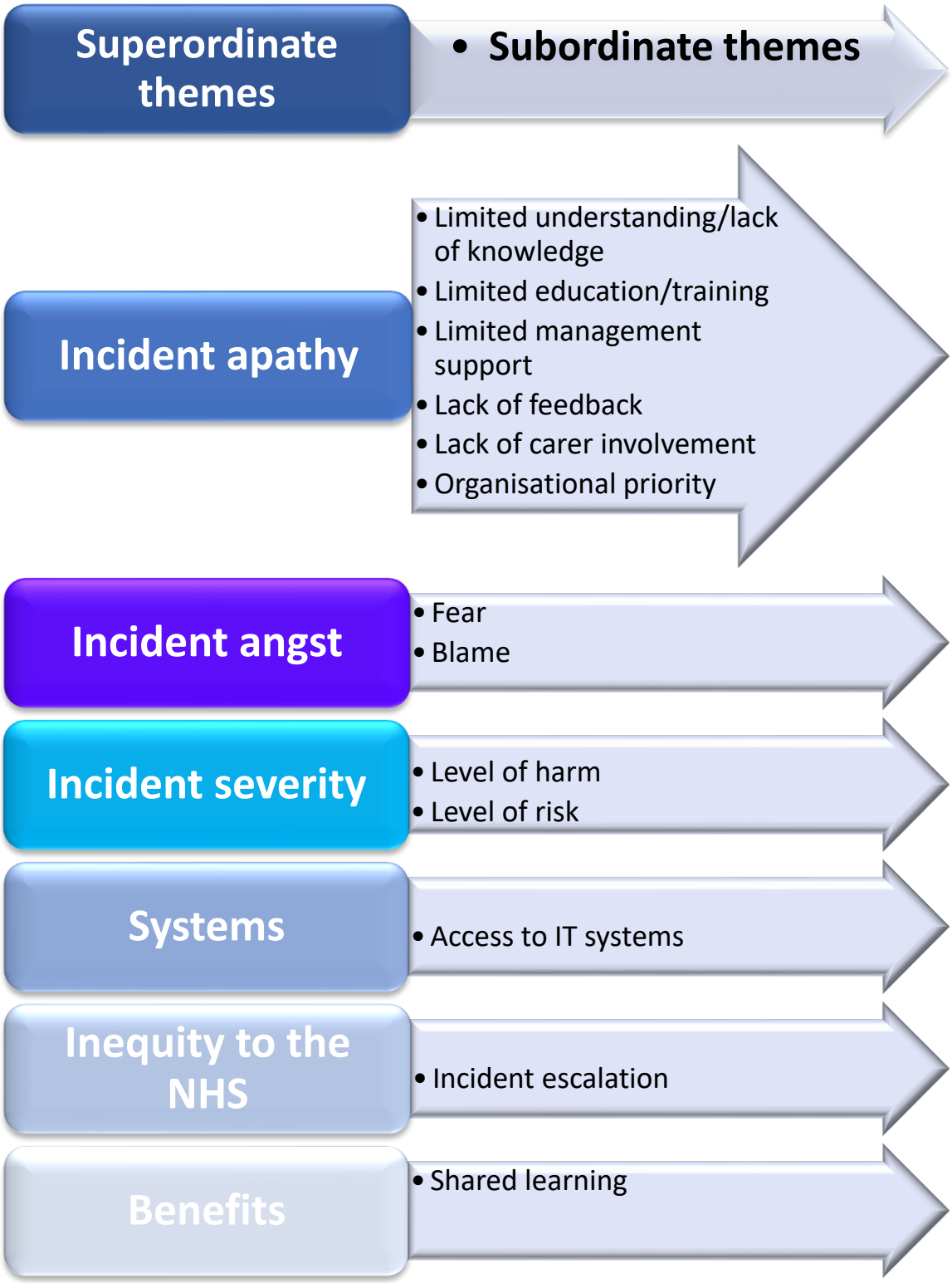
They highlight the lack of training in the nursing home, compared to their experience within the NHS and report that many staff lack understanding of the incident reporting process and also have little experience of completing an incident report. They also describe the fear felt by staff in relation to reporting incidents, highlighting that staff often feel terrified and that reporting an incident often leads to blame and finger pointing rather than using the experience to learn and improve practice, another contrast to their experiences within the NHS.

In the NHS all staff, regardless of role are able to report incidents directly, however from Participant 3's experience this does not happen in nursing homes. Participant 3 reflects on how carers play a vital role in delivering care and are often the first to identify an incident, however they do not have access to the systems to report, placing additional pressure on the registered nursing staff.

Although various types of incidents are reported, participant 3 reports that there is often more focus on incidents which have caused serious harm.

Participant 3 – idiographic representation of themes

Participant 3's lived experience was reflected in all 6 of the superordinate themes and 13 subordinate themes.



Participant 4

Participant 4

Participant 4 has been qualified for almost three years. They started working in the NHS but left to move to the nursing home sector as they felt that they were not allowed sufficient patient focused time in their role in the NHS. They have worked in the nursing home sector for approximately 2 and a half years.

When asked about their understanding of incident reporting their knowledge was very limited. They explained that they had heard of incident reporting in the hospital but not so much since moving to the care sector. They identified that they had not received any training and they highlighted that near miss incidents and incidents of low harm are rarely reported and highlighted the differences from her experience of working in the NHS.

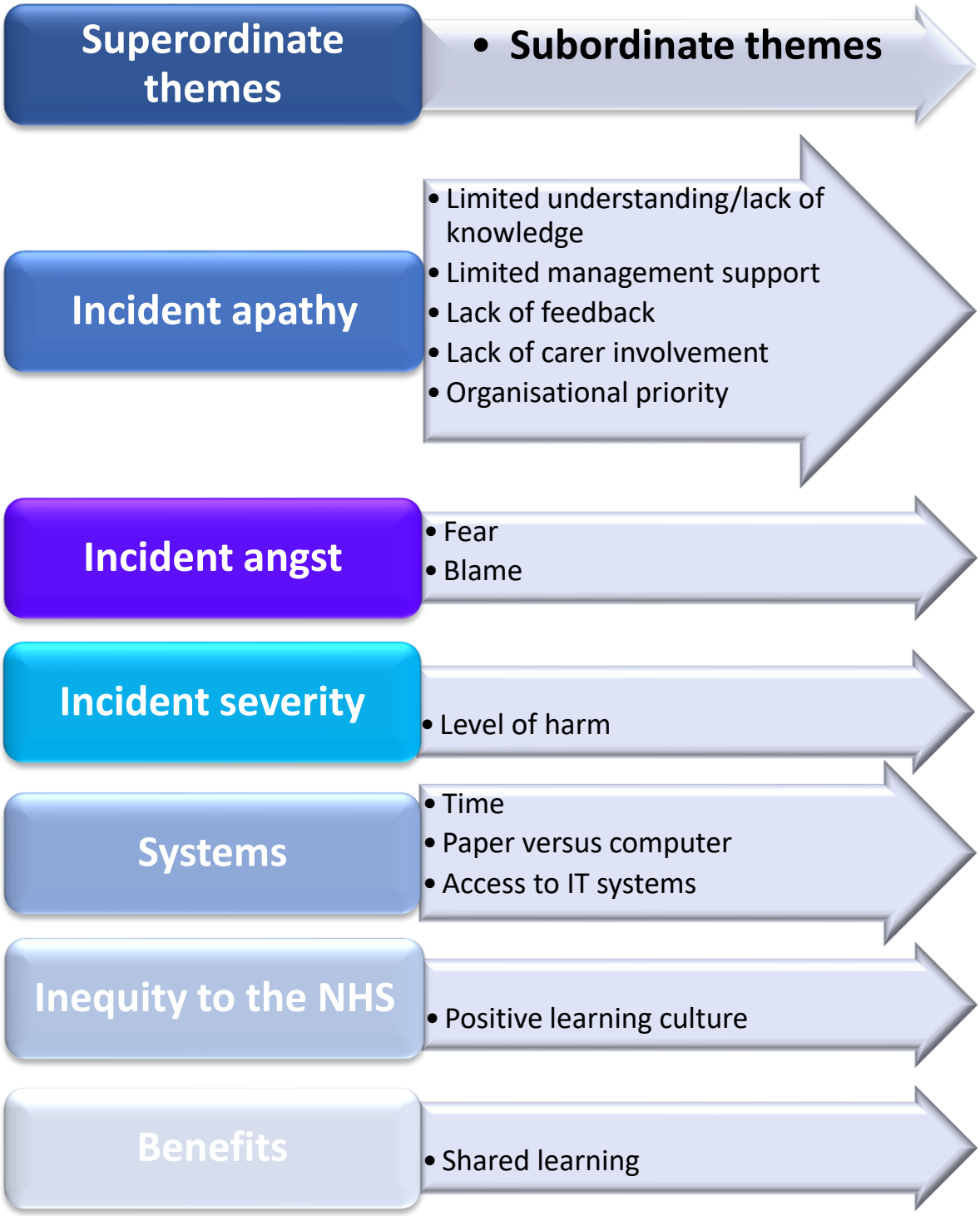
They discussed the challenges of being the only registered nurse on the unit and how care staff were unable to report incidents in the system, which created more work for the registered nurses.

They reflected on the lack of support from management in relation to supporting staff with the incident reporting systems and explained that this often fell to the clinical staff to support colleagues with limited management support. They also identified that they often don't receive feedback post incident which reflects a lack of learning and support from management.

They highlighted technology as a barrier due to staff not being familiar with the IT systems and also the limited availability and connectivity issues in the home. Each unit will often only have one computer which makes it difficult for staff to gain access to report incidents, they felt that the paper system worked better in the home.

Participant 4 – idiographic representation of themes

Participant 4's lived experience was reflected in all 6 of the superordinate themes and 13 subordinate themes.



Appendix 7 - Ethics Approval.

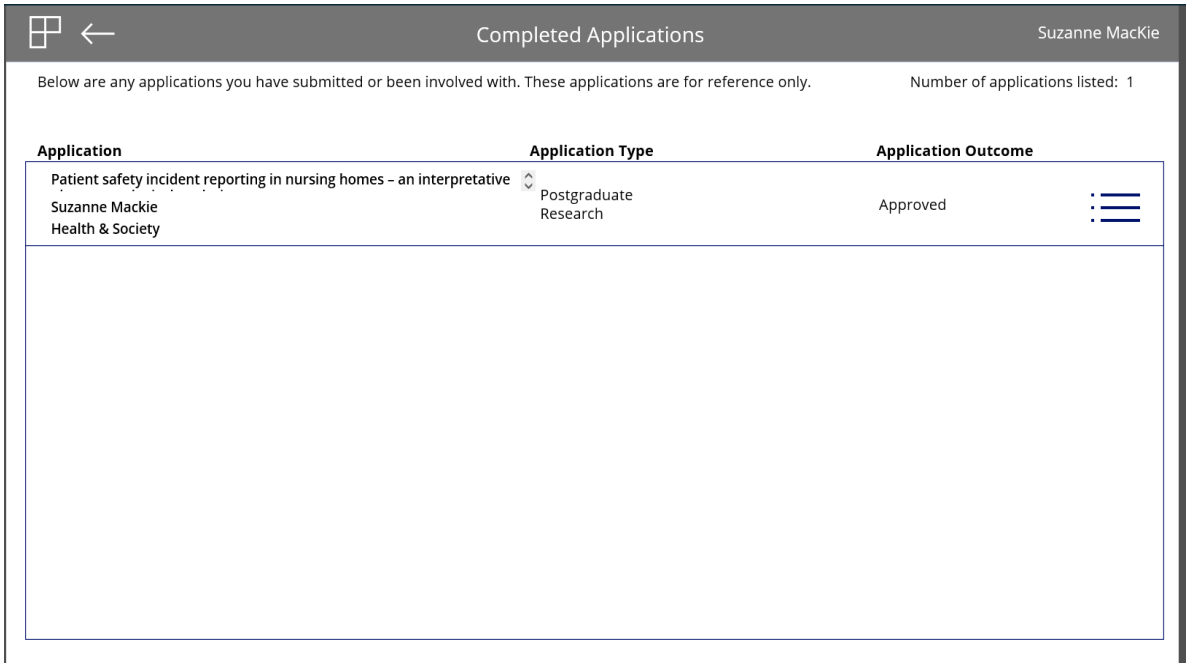
Email confirmation:

From: ethics <ethics@salford.ac.uk>
Date: 19 February 2021 at 17:35:04 GMT
To: Suzanne Mackie <s.mackie@edu.salford.ac.uk>
Subject: Ethics Application: Panel Decision

The Ethics Panel has reviewed your application: Patient safety incident reporting in nursing homes – an interpretative phenomenological analysis.
Application ID: 245

The decision is: Application Approved.

Screenshot of the University of Salford's Ethics application process confirming that ethics approval has been granted



Appendix 8 – Interview extract

		Analysis and interpretations
Researcher	So, thinking about the level of harm. If a patient . . . if there was a medication error where the patient came to no harm, compared to a medication error where a patient came to harm, or a fall with no harm of a fall with harm, do you think it's the level of harm to the patient that affects or can influence whether or not something is reported as an incident?	
Participant 3	*No, I think either way it would be reported as an incident . . . but saying that I'm contradicting myself . . . I think a lot of the time, . . . I think the management people want it more when an incident that say like they're (the patient) covered in bruises or there's a head injury and they actually gone to hospital it's more like right what happened. . . whereas if they've fallen and no injuries it's like oh right they've fallen thanks for your incident report do you know what I mean, it's kind of I think acted on* ***more*** *if you know they've needed some kind of intervention or something has happened more than a fall where I know they're ok but the bp's fine and the pulse and everything is hunky-dory. . . so I do think that they more react on the harmful things. . . yeah*	Initial reaction – but then reflecting . . . and interpreting experiences Management control what is reported – leadership style/ misunderstanding. Are managers scared to report incidents – seems to be greater focus on falls with harm? Exploring incidents with obvious harm – does the level of harm determine whether to report is reporting harm dependent Seeking clarification? Not as interested in lower harm/ no harm incidents Hunky dory – is it really hunky dory? Stressing that it's acted on more if there's harm - harm dependent
Researcher	Once you've completed the incident report will that go up to the manager, what happens then is there an investigation?	

Participant 3	*Yes . . . well I say yes . . sometimes if it's something that needs an investigation yes they'll do all the root cause analysis they'll come and interview you and see what's happened take your support plan look at your witness statements and then obviously the managers discuss it, it goes through to CCG errm . . . and it's just all kinda reports but you kinda get left out then it's kinda like . . .we'll sort it all out we're just going to tell you what's happened so you don't kinda get your say if you understand what I mean . . . it's like they take that report off you they all discuss it they just tell you who they're talking to then they'll come back and say yeah it was ok your incident report has come back ok and we can't find anything and there's no further investigation or anything needed but you're getting thrown out of the picture till all this has gone through which I just don't feel is right.*	Lots of pausing . . reflecting and interpreting Management completes the RCA and incident investigation – why? Leadership style, why are the registered nurses not involved? Registered nurses are excluded from the discussions? Why? Again, excluded from discussions and action planning- lack of involvement post reporting Thrown out of the picture - excluded, doesn't feel right
Researcher	What happens once the investigation has been completed?	
Participant 3	*Well . . . it's just back to work, it's as though nothing has happened sometimes, we don't get feedback*	Reflections – its as though nothing has happened – how would this make me feel – frustrated, what's the point – is this why all incidents are not reported?
Researcher	What if any leaning identified from the incident following the *investigation*, what happens then?	
Participant 3	*You do get feedback errm . . . well . . .I say that . . .if it's something big has happened like a head injury, they've gone into hospital and they're coming back blah de blah so they'll just say like what are you going to put in place how can this be prevented but it's kinda like thrown back at you again then it's not like right were going to do this and errm . . . we're gonna help you and we're gonna bring this in and we feel you need supporting with this, it's kinda right this is what happened we've done all these meetings and we've decided it's a,b,c,d so*	Initial reaction – but then reflecting . . . Blah de blah **–** boredom?? lack of interest??. Only get feedback if it's something big, no feedback for smaller incidents? Managers decide what action to take – nurses not involved Putting the responsibility on the individual to resolve – is this a lack of support or lack of understanding

	I want you to put that in place, it's kinda thrown back to your court kinda thing so they've gone off and decided all this and then it's like see you later you get on whereas in the hospital it was like right we're going to put a,b,c,d in place you were involved in the decisions, in the nursing home it doesn't kind of work like that it's like right that's what you need to do crack on and get on with it you know what I mean it's kinda thrown back to you so it's your responsibility then to sort everything out even though they've had these big meetings and everything.	Thrown back to you -unsupported Not involved in the action planning and decision making but left unsupported to implement any recommendations Comparisons to hospital – more support and involvement Thrown back to you – no choice, no support, your responsibility – accountability Big meetings – oppressive, power divide, excluding staff
Researcher	So, what happens with lower-level incidents?	
Participant 3	*Yeah because it's just kind of . . . to me its you've done this form you've filled it all in you've wrote in the care plan you've informed relatives, you've informed GP, you've phoned next line manager and then that's it . . it just kinda stops . . . it's like why it's kinda like oh right I've read it on **** blah de blah I might put an action plan in place I might not, I might do an audit on it I might not and that's where it slips down to me in a nursing home . . .if its low risk there's not much where as it its high risk there's a lot more investigation CCG are informed everything everybody gets informed but if its low risk of its kinda . . .like right there we go nothing doesn't really get far, no [laughs], so not much feedback really . . no, no*	Done this form – do they see it as just a form? Or an incident to learn and improve practice – education needed? No feedback or actions, not taken seriously - feedback Blah de blah - boredom, lack of interest – incident recognition/incident apathy Inconsistent approaches to dealing with lower-level incidents, often no feedback. Slips down – comparison to NHS, not as good? High risk/harm treated more seriously – harm dependent – why – does this to reputational risk? No action for low risk – laugh?? Does this reflect embarrassed?