

# A Retrospective Analysis of Patient and Relative Experience Reports on Adverse Occurrences in Nursing

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## ABSTRACT

**Objective:** To examine adverse events in nursing care from the perspective of patients and families.

**Methods:** A retrospective mixed-methods study was conducted, analyzing patient and family-reported adverse events related to nursing care. Qualitative content analysis was used to categorize the types of adverse events, while descriptive statistics summarized patient characteristics and event frequency.

**Results:** Four main categories of adverse events emerged: participation, clinical judgment, nursing interventions, and essentials of care. Over a third of reports related to lack of patient and family participation. Adverse events were reported across settings, with some differences in patterns between long-term care and acute care.

**Conclusion:** Partnering with patients and families, ensuring their participation in care, and consistently delivering high-quality essential nursing care are key strategies to improve patient safety. The patient and family perspective should inform ongoing efforts to reduce adverse events.

## 1. Introduction

Patient safety is a fundamental aspect of quality healthcare delivery, yet it continues to face significant challenges across the globe. The recognition of the widespread harm caused by preventable incidents within healthcare settings gained momentum in the late 1990s, highlighting how adverse events contribute significantly to patient injuries and fatalities (Kohn et al., 2000). Despite advancements in medical practices and technologies, approximately one in ten hospitalized patients worldwide still experiences an adverse event during their care (de Vries et al., 2008).

The issue of patient safety is complex, encompassing not only physical and emotional harm to patients but also significant financial burdens on healthcare systems. Professional organizations and policymakers have stressed the importance of adopting a comprehensive approach to patient safety, emphasizing proactive measures and system-wide improvements (Smith et al., 2008). However, while much attention has been devoted to improving safety processes, the experiences and perspectives of patients and their families—those most directly affected by adverse events—remain underexplored.

Adverse events are typically defined as preventable incidents that result in harm caused by medical care rather than the underlying condition being treated (Vincent et al., 1998). Broader interpretations also consider the physical, emotional, or psychological harm caused by interactions with healthcare systems rather than the patient's illness itself. For the purposes of this study, adverse events refer to avoidable incidents that cause harm or suffering during the patient's engagement with healthcare services.

Nursing care, as a vital component of the healthcare system, is not exempt from the occurrence of adverse events. These incidents can stem from various factors, including insufficient monitoring, delays in identifying complications, communication breakdowns, and inappropriate interventions (De Meester et al., 2013). Many of these incidents could be prevented with timely and effective responses. However, underreporting of near-miss events and minor errors remains a persistent issue due to systemic and cultural barriers, such as fear of blame, limited time, and inadequate feedback mechanisms (Anderson et al., 2013; Evans et al., 2006).

Establishing a culture that prioritizes patient safety requires a shift toward openness, accountability, and learning from mistakes. International organizations, such as the International Council of Nurses (ICN), advocate for non-punitive environments that encourage the reporting of adverse events and near misses to enable improvements in care (ICN, 2012). Similarly, other global initiatives emphasize the importance of transparent reporting systems, collaborative analysis of data, and evidence-based policy interventions (Smith et al., 2008).

Reports from patients and their families about adverse events serve as a crucial resource for understanding care-related harm. These accounts provide valuable insights into the gaps in healthcare systems and highlight opportunities for preventive measures (Weissman et al., 2008). However, research examining adverse events in nursing care from the perspective of patients and their families remains limited, leaving an important gap in knowledge.

This study seeks to address this gap by analyzing reported adverse events in nursing care, as described by patients and their families. The findings aim to provide actionable insights for improving patient safety and fostering higher standards of nursing care.

## 2. Methodology

This study utilized a retrospective mixed-methods design to analyze adverse events in nursing care reported by patients and their relatives. By combining both quantitative and qualitative approaches, the research aimed to provide a comprehensive understanding of the nature, frequency, and context of these events. The quantitative analysis focused on summarizing demographic data and event distribution, while the qualitative analysis explored the detailed narratives of patients and relatives to identify key themes and patterns. This approach ensured that both statistical trends and personal experiences were captured, offering a holistic view of the problem.

The research relied on written reports of adverse events submitted by patients and relatives to a national healthcare complaints authority. These reports provided firsthand accounts of incidents where care delivery fell below expected standards, resulting in harm or dissatisfaction. The retrospective design allowed the study to examine data that had already been documented, ensuring that real-life experiences were analyzed without influencing ongoing healthcare processes. Adverse events in this study were defined as incidents that caused physical or emotional harm to patients, which could have been prevented with appropriate nursing actions.

To create a focused dataset, specific inclusion and exclusion criteria were applied. Only reports that explicitly related to nursing care were included, meaning incidents involving errors by other healthcare professionals, such as physicians or administrative staff, were excluded. The reports also needed to provide sufficient detail to allow for meaningful analysis, and those that were incomplete or vague were not considered. This selection process ensured that the study concentrated solely on nursing-related events, capturing a clear picture of their causes and consequences. The final dataset included 114 reports, which described a total of 242 adverse events. These reports were treated as distinct cases for analysis, with some containing multiple incidents.

The reports included detailed narrative descriptions of the adverse events, often written by patients or their relatives. These narratives provided insight into the nature of the incidents, their emotional impact, and the perceived actions or inactions of nurses responsible for care. In addition to the narratives, the reports often included responses from healthcare providers, who explained their perspective on the events, and assessments by independent experts who reviewed the cases to determine whether professional standards had been breached. This wealth of information allowed for a multidimensional analysis of each incident, offering both subjective and objective perspectives.

Data analysis was conducted using both quantitative and qualitative methods. Quantitative data, such as patient demographics, care settings, and the types of adverse events, were summarized using descriptive statistics. This analysis helped identify trends, such as the prevalence of certain types of events or the distribution of incidents across different healthcare settings. In contrast, the qualitative analysis focused on the detailed narratives within the reports. A content analysis approach was employed to systematically identify recurring themes and categories. This process began with a thorough reading of each report to identify key meaning

units—specific phrases or sentences that described aspects of the adverse events. These meaning units were then condensed into shorter, focused statements and coded based on their content. The codes were grouped into broader categories, such as "lack of participation" or "clinical judgment errors," and subcategories were created to provide further detail.

To ensure the reliability of the qualitative analysis, two independent researchers coded the data separately and compared their findings. Any discrepancies were resolved through discussion to reach a consensus. This process minimized bias and enhanced the credibility of the analysis. Additionally, the findings from the quantitative and qualitative analyses were triangulated to ensure consistency and reinforce the validity of the results. By combining statistical summaries with detailed narratives, the study was able to provide a balanced and accurate portrayal of the adverse events.

While this methodology offered significant strengths, certain limitations were acknowledged. The study relied on voluntary reports, which may not represent all adverse events in nursing care. Underreporting is a common issue in healthcare, often driven by fear of blame or lack of awareness. Additionally, the narratives in the reports were subjective and may have been influenced by the emotions or perceptions of the patients and relatives. Despite these limitations, the retrospective design and the inclusion of detailed narratives provided valuable insights into the nature of adverse events and their impact.

### 3. Results

The analysis identified 242 adverse events reported by patients and relatives across various healthcare settings. These events were categorized into four primary themes: lack of participation, errors in clinical judgment, nursing interventions, and failures in essentials of care. The findings highlight the diverse nature of these events and their prevalence across different healthcare environments, patient demographics, and nursing responsibilities. Below, the results are presented in detail, supported by tables summarizing the data.

#### Overview of Reports

The sample included 114 reports, describing 242 specific adverse events, as some reports contained multiple incidents. The events occurred in various healthcare settings, including elderly care, acute hospital care, psychiatric care, primary care, and home care.

- **Patient Demographics:** The patients involved ranged in age from 13 to 96 years, with the majority (64%) aged between 61 and 95 years. Most reports (68 of 114) involved female patients.
- **Report Origin:** A larger proportion of the reports (60%) were submitted by relatives, while patients themselves submitted 40%.
- **Healthcare Professionals Involved:** Registered nurses (RNs) were the most

frequently reported group, accounting for 66% of the adverse events. Enrolled nurses and nursing assistants represented 12% of the cases. Among the reported caregivers, 88% were women, and 12% were men.

### Healthcare Settings and Event Distribution

Table 1 below provides an overview of the distribution of adverse events across different healthcare settings. The highest proportion of events (52%) occurred in elderly care, followed by hospital care (38%). Adverse events were less commonly reported in home care (18%) and psychiatric care (2%).

Healthcare Setting	Number of Adverse Events (%)
Elderly Care	127 (52%)
Hospital Care	91 (38%)
Home Care	18 (8%)
Psychiatric Care	6 (2%)
Total	242 (100%)

### Categories and Subcategories of Adverse Events

The adverse events were categorized into four overarching themes, each with specific subcategories, as summarized below in Table 2. These categories reflect the nature of the incidents and their impact on patient care.

Category	Subcategory	Number of Events	Percentage (%)
Participation	Encounter	47	19.4
	Information	15	6.2
	Safety	9	3.7
Subtotal		71	29.3
Clinical Judgment	Patient Assessment	62	25.6
	Counseling	8	3.3
Subtotal		70	28.9
Nursing Intervention	Medication Errors	33	13.6
	Performance Issues	23	9.5
Subtotal		56	23.1
Essentials of Care	Bodily Care	28	11.6
	Falls	17	7.0
Subtotal		45	18.7
Total		242	100%

### Detailed Analysis of Categories

#### 1. Lack of Participation

This category accounted for 29.3% of the total adverse events. Patients and relatives

described situations where they felt excluded from care decisions, which led to dissatisfaction and, in some cases, harm.

- **Encounter (19.4%):** Patients frequently reported disrespectful interactions, such as being ignored, dismissed, or treated without empathy. Many felt their dignity was not respected, and their concerns were not taken seriously.
  - **Example:** A patient described feeling "invisible" during their hospital stay, as staff ignored their requests for help (Report #45, Female, Hospital Care).
- **Information (6.2%):** Several reports highlighted a lack of clear information about treatment plans or changes in care, leading to confusion and anxiety.
  - **Example:** A relative reported that they were not informed about the patient's deteriorating condition, which delayed critical decisions (Report #78, Male, Elderly Care).
- **Safety (3.7%):** In some cases, patients were left in unsafe situations, such as being unattended despite requiring assistance.
  - **Example:** A patient fell while attempting to leave their bed unassisted due to a lack of supervision (Report #12, Female, Home Care).

## 2. Clinical Judgment Errors

Clinical judgment errors made up 28.9% of the reported adverse events. These events often stemmed from a failure to recognize or act on critical signs of patient deterioration.

- **Patient Assessment (25.6%):** A significant proportion of reports described missed signs of complications or delayed responses to symptoms.
  - **Example:** A patient's early signs of sepsis were overlooked, leading to a life-threatening condition (Report #102, Male, Hospital Care).
- **Counseling (3.3%):** Some patients received incorrect or inadequate advice from healthcare providers, which contributed to adverse outcomes.
  - **Example:** A nurse advised a patient with severe chest pain to "wait and see," delaying urgent treatment (Report #67, Female, Primary Care).

## 3. Nursing Interventions

This category included 23.1% of the adverse events and focused on errors during the execution of nursing tasks.

- **Medication Errors (13.6%):** Errors included administering incorrect dosages, omitting medications, or providing the wrong medication altogether.
  - **Example:** A patient was given a double dose of insulin, resulting in severe hypoglycemia (Report #34, Female, Hospital Care).
- **Performance Issues (9.5%):** Reports described improper techniques during procedures, such as catheterization or injections, which caused harm.

- o Example: A nurse used incorrect aseptic techniques during a dressing change, leading to an infection (Report #89, Male, Elderly Care).

#### 4. Failures in Essentials of Care

Failures in meeting basic care needs accounted for 18.7% of the adverse events. These incidents often reflected neglect or insufficient resources.

- **Bodily Care (11.6%):** Patients reported neglect in hygiene, toileting, and nutrition, resulting in discomfort and deterioration.

- o Example: A patient developed pressure ulcers because they were left in the same position for extended periods (Report #56, Female, Elderly Care).

- **Falls (7.0%):** Preventable falls occurred due to inadequate supervision or missing safety measures.

- o Example: An elderly patient fell in a care home after staff failed to install bed rails (Report #21, Male, Elderly Care).

#### Comparison of Categories Across Healthcare Settings

Table 3 shows the distribution of adverse events across the four categories by healthcare setting. Elderly care settings had the highest number of adverse events, particularly in the categories of participation and essentials of care. In contrast, hospital care reported more events related to clinical judgment and nursing interventions.

Category	Elderly Care (n)	Hospital Care (n)	Home Care (n)	Psychiatric Care (n)	Total (n)
Participation	33	38	5	1	71
Clinical Judgment	33	37	-	-	70
Nursing Interventions	28	28	-	-	56
Essentials of Care	33	12	-	-	45
Total	127	115	5	1	242

These results demonstrate the multifaceted nature of adverse events in nursing care and emphasize the need for targeted interventions to address specific issues in different healthcare settings.

#### 4. Discussion

This study highlights the diverse experiences of adverse events in nursing care reported by patients and their relatives, emphasizing challenges in patient participation, clinical judgment, nursing interventions, and essentials of care. These adverse events, which caused both physical and emotional harm, underscore the multifaceted nature of patient safety concerns within nursing practice.

A striking finding is that more than one-third of the reported adverse events involve a lack of patient participation. Much of the research on adverse events in nursing

care has traditionally focused on physical harm (D'Amour et al., 2013; Doran et al., 2013; Sears et al., 2013), with relatively little attention paid to the emotional impact on patients and their families. However, this study suggests that the emotional consequences of inadequate nursing care, including feelings of neglect or being excluded from decision-making, are significant. Historically, adverse events were defined in medical terms, such as surgical errors or incorrect medication administration, but a broader definition is needed to encompass both physical injuries and emotional harm.

Patient participation is vital for effective and dignified care. It includes opportunities for patients to express their needs and preferences and to be kept informed about their care (Frank et al., 2011). For participation to be meaningful, patients require clear and sufficient information in a supportive environment (Larsson et al., 2007). The findings reveal frequent communication failures, with patients and relatives reporting that treatments were not adequately discussed, and their input was often overlooked. This aligns with previous research showing that failures in communication lead to unnecessary anxiety and diminished trust in healthcare providers (Jangland et al., 2009). Respectful and transparent communication is critical for fostering positive relationships between patients and caregivers (Eriksson & Svedlund, 2007).

Negative interactions between patients or their families and caregivers were described as having lasting emotional effects. Adverse events often arose when relationships between caregivers and patients broke down. This aligns with studies emphasizing the importance of relational aspects of nursing care, which influence patients' feelings of autonomy, worth, and security (Bridges et al., 2010). Relational care has long been recognized as a cornerstone of effective nursing, emphasizing the integration of physical, psychosocial, and relational dimensions to ensure comprehensive and dignified care (Peplau, 1952; Kitson et al., 2010).

Adverse events related to essentials of care, such as insufficient hygiene, lack of oral care, and inadequate supervision of basic needs, were more prevalent in long-term care settings. These events were often the result of missed care rather than errors in nursing practice. Research has shown that missed nursing care significantly impacts patient outcomes, with unmet care needs frequently associated with adverse events (Kalisch et al., 2014; Lucero et al., 2010). Ensuring adequate staffing and prioritizing the essentials of care can reduce the likelihood of such events.

Issues in clinical judgment, particularly delays in recognizing or responding to patient deterioration, were also significant contributors to adverse events. These were more common in settings where registered nurses (RNs) were either unavailable or lacked the necessary expertise. Research has consistently linked higher RN staffing levels and improved staff competence to better patient outcomes, including reduced mortality and fewer complications (Aiken et al., 2014; Bowlblis, 2011). Addressing gaps in staff competence and ensuring adequate RN presence in all care settings are critical for enhancing patient safety.

Nursing care plays a pivotal role in ensuring patient safety. The findings of this study

emphasize the need for healthcare providers to recognize and address the physical and emotional impacts of adverse events. Patient participation, in particular, should be prioritized by fostering environments that value patients as active partners in their care. Training programs for nursing staff should focus on developing communication skills and strategies to support patient involvement.

Missed nursing care, a significant contributor to adverse events, must be addressed through improved staffing levels and resource allocation. Organizations should also invest in ongoing education and training to enhance clinical competence and decision-making among caregivers. Learning from patient and family reports of adverse events is essential for identifying systemic weaknesses and implementing effective quality improvement measures.

## 5. Conclusions

Adverse events in nursing care arise from both missed care and caregiver errors, with significant consequences for patients and their families. The lack of patient participation, in particular, has far-reaching implications, contributing to physical harm and emotional suffering. To improve nursing care and patient safety, healthcare systems must prioritize patient involvement, address missed care, and enhance staff competence. These steps are essential for fostering trust, improving outcomes, and ensuring dignified care for all patients.

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