

NURSES' NEAR-MISS REPORTING BEHAVIOR IN A BLAME-ORIENTED CULTURE: BARRIERS AND FACILITATORS IN PAKISTANI HOSPITAL SETTINGS

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DOI: <https://doi.org/10.5281/zenodo.23366644>

Keywords

Near miss; incident reporting; patient safety; nurses; blame culture; qualitative research; Pakistan

Article History

Received: 25 June 2026

Accepted: 16 September 2026

Published: 12 October 2026

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Abstract

Background: Near-miss reporting lets hospitals find and fix weaknesses before patients are harmed, but it depends on nurses being willing to report. In blame-oriented workplaces, near misses often go unreported. Evidence from Pakistan on why nurses report or stay silent is limited. To explore the barriers and facilitators of near-miss reporting among nurses in a tertiary care hospital in Multan, Pakistan.

Methods: A qualitative descriptive design was used. Nineteen registered nurses from different wards were purposively sampled and interviewed individually using a semi-structured guide. Interviews were audio-recorded, transcribed, translated where necessary, and analysed using reflexive thematic analysis. Trustworthiness was supported using the criteria of Lincoln and Guba, and the study was reported following COREQ.

Results: Four themes described barriers: fear of blame and punishment; a hierarchical and unsupportive climate; no feedback and no visible action; and practical and conceptual obstacles, including workload and uncertainty about what counts as a near miss. Four themes described facilitators: supportive leadership and psychological safety; visible feedback and learning; simple and confidential reporting systems; and professional values, peer support and training. Nurses linked silence to the expectation that management would look for someone to blame, and described the head nurse's first response as a key influence on whether they would speak up.

Conclusion: Nurses' reluctance to report near misses reflected a weighing of cost against benefit shaped by the surrounding culture, not indifference to patient safety. Hospitals should adopt a just-culture approach, train nurse managers to respond without blame, give feedback on every report, and offer

INTRODUCTION

Unsafe care remains one of the leading causes of avoidable harm in health systems worldwide. The Institute of Medicine's landmark report concluded that a large number of patients are harmed or die each year from preventable errors in hospitals, and that most such errors arise from faulty systems and processes rather than from the carelessness of individuals [1]. Leape had argued earlier that medicine's expectation of infallibility pushes clinicians to hide mistakes, and that this reflex blocks the learning that safer systems depend on [2]. The World Health Organization's Global Patient Safety Action Plan 2021-2030 makes the same point on a global scale. It places a culture of safety and learning from incidents among its strategic objectives and recognises that the burden of unsafe care is heaviest in low- and middle-income countries [3].

A near miss is an event that could have harmed a patient but was intercepted, or otherwise did not reach the patient. Reason's account of organisational accidents explains why such events deserve attention. Front-line errors are usually the last link in a chain of latent weaknesses in the system, and every near miss shows where a defence is thin before a patient pays for it [4]. Barach and Small, drawing on aviation and other high-risk industries, observed that near misses occur far more often than harmful events and can be analysed without the defensiveness that follows injury, which makes them a cheap and rich source of safety information [5]. The value of that information, however, depends entirely on staff being willing to report.

Nurses are central to this task. They give most medicines, monitor patients continuously and are often the final barrier between an error and a patient, which puts them in an ideal position to notice a near miss. It also puts them first in line for blame. Wu described the clinician who is personally shaken by an error as a 'second victim', a person who needs support rather than punishment but who commonly receives the opposite [6].

Despite this, reporting is persistently incomplete. In an early qualitative study of doctors and nurses, Kingston and colleagues found that staff doubted that reporting led to change and were worried about the consequences of being identified [7]. A theoretical review by Archer and colleagues identified a wide range of factors that shape whether staff report, from individual beliefs about what is worth reporting to organisational responses and the wider culture [8]. A systematic review of barriers to reporting medication errors and near misses among nurses found that fear of blame and disciplinary action, lack of feedback and heavy workload occurred across settings [9]. Hartnell and colleagues reached similar conclusions in focus groups with hospital staff, noting that fear of reprisal and uncertainty about what should be reported suppressed reporting [10].

Reporting is also a matter of professional judgement rather than a simple reflex. Hewitt and Chreim described a tension at the front line between 'fix and forget', in which nurses correct a problem at the bedside and move on, and 'fix and report', in which the event is also entered into the system [11]. A nurse may fix a near miss quietly precisely because she expects the system to offer little in return and perhaps to cost her something.

Culture sits behind many of these findings. Edmondson showed that teams learn from error when members feel safe to speak up without fear of embarrassment or punishment, a condition she called psychological safety [12]. Dekker's account of a just culture separates honest mistakes, which should prompt learning and support, from reckless behaviour, which warrants accountability. He argues that organisations which fail to draw this line end up punishing the very people who could improve safety [13]. In a blame-oriented culture the line is not drawn. An error, or even a near miss, is treated as evidence of individual failure, and silence becomes the rational response.

These issues are likely to be sharp in Pakistan. Many hospitals operate with high patient loads, thin nurse staffing, steep professional hierarchies and an expectation that the person closest to an error must answer for it. Yet to our knowledge, qualitative evidence on why Pakistani nurses report or do not report near misses remains limited, and findings from other health systems cannot simply be assumed to apply. Understanding the barriers and facilitators in nurses' own words is a prerequisite for designing reporting systems that they will actually use.

This study therefore explored nurses' near-miss reporting behavior in a tertiary care hospital in Peshawar and Multan, Pakistan. It asked two questions: what makes nurses reluctant to report near misses in a blame-oriented culture, and what would make them more willing?

Methodology

Study design

A qualitative descriptive design using individual semi-structured interviews was chosen because it suits the exploration of experiences and perceptions where local evidence is scarce. The study is reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) [14]. The study was conducted in a tertiary care of KPK and Multan, Punjab, Pakistan, with more than 500 beds and 16 main departments.

Participants and sampling

Purposive sampling with maximum variation was used to include nurses from different wards, levels of experience, qualifications and genders. Registered nurses with at least one year of clinical experience in direct patient care were eligible. Nurses in purely administrative roles or on extended leave were excluded. Participants were approached through the nursing office and invited by the researcher in person. Nineteen nurses took part. Recruitment stopped when no new codes emerged in the last two interviews, consistent with published guidance on data saturation [15].

Data collection

Interviews were held between February, 2026 to May, 2026 in a private room in the hospital at a time chosen by the participant. An interview guide was developed from the literature and piloted with two nurses who were not included in the study. Questions covered what participants understood by a near miss, their own experiences of noticing and handling one, what happened when events were reported or not reported, how colleagues and seniors reacted, and what would make reporting easier. Interviews were conducted by [initials, qualification, gender, experience in qualitative research] in Urdu. Each lasted 30 minutes. They were audio-recorded with permission, and field notes were taken.

Data analysis

Recordings were transcribed verbatim and, where necessary, translated into English. A bilingual colleague checked a sample of translations against the originals. Data were analysed using the six phases of thematic analysis described by Braun and Clarke: familiarisation, initial coding, searching for themes, reviewing themes, defining and naming themes, and reporting [16]. Two researchers coded independently, using manual coding, and resolved differences by discussion. Because the aim was to understand both what hinders and what promotes reporting, the final themes were organised into two sets, barriers and facilitators.

2.6 Rigour

Trustworthiness was addressed using the criteria of Lincoln and Guba [17]. Credibility was supported by prolonged engagement with the data, and peer debriefing. Dependability and confirmability were supported by an audit trail of coding decisions and reflexive notes. Transferability was supported by thick description of the setting and participants. The research team reflected on how their own roles in nursing education or practice might shape the interviews and interpretation.

2.7 Ethical considerations

Approval was obtained from institutional review committee. Permission to collect data was given by the concern hospital administration. All participants received an information sheet and gave written informed consent. They were assured that participation was voluntary, that they could withdraw at any time, and that nothing they said would be shared with managers. Names were replaced with codes (P1-P19), and

recordings and transcripts were stored securely, accessible only to the research team.

3. Results**3.1 Participant characteristics**

Nineteen nurses participated 10 female and, 9 males. Their ages ranged from 24 to 35 years, and their clinical experience from 2 to 5 years (Table 1).

Table 1. Characteristics of participants (n = 19)

Characteristic	Category	n
Gender	Female / Male	10 / 9
Age (years)	Range; mean	27.0 ± 3.1
Qualification	Diploma / BSN / Post-RN BSN / MSN	3 / 11 / 4 / 1
Experience (years)	1-5 / 6-10 / >10	19 /
Ward	Medical / Surgical / ICU / Emergency / Paediatric / Other	8/4/3/3/1 each
Designation	Staff nurse / Charge nurse / Senior nurse	19

3.2 Overview of themes

The analysis were performed in to main theme that are barrier and facilitator in near miss reporting, then Analysis produced four themes describing barriers to near-miss reporting (Table

2) and four themes describing facilitators (Table 3). The two sets are presented separately below. Participants did not treat them as opposites. Rather, many facilitators described the conditions under which a barrier would weaken.

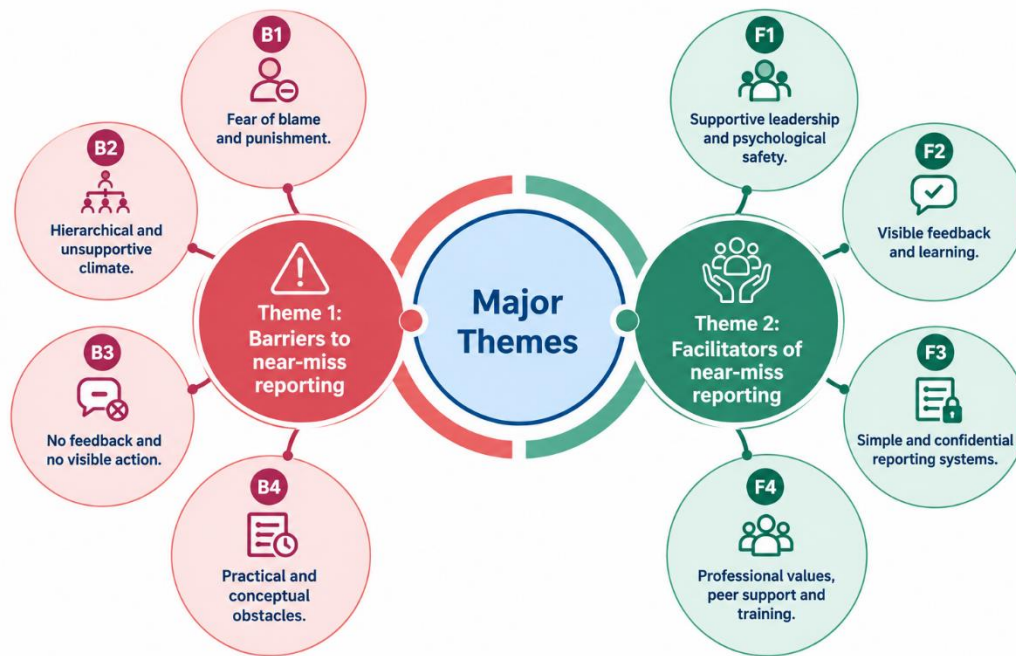


Figure 1: major themes and sub-theme

3.3 Theme 1: Barriers to near-miss reporting

B1. Fear of blame and punishment. Nurses did not hesitate because they thought near misses were unimportant. They hesitated because they expected the response to be about who was at fault, not what went wrong. As P07 put it, nurses fear that management will "blame them instead of looking at what caused the problem." Here the nurse and the system are in competition. A report puts the nurse's name on the event, so she carries the risk while the hospital keeps the lesson. This matches earlier work that found fear of blame to be the most common barrier to nurses' reporting p9.

B2. Hierarchical and unsupportive climate. P12 described a different kind of fear, which was not punishment but being seen as a complainer. In a ward where seniors and doctors hold the authority, a report about a near miss can sound like a criticism of the person involved. Nurses then choose silence to protect their working relationships. The point is that reporting depends

on whether people feel safe to speak up, and this is a feature of the team and its leaders as much as of the reporting system p12.

B3. No feedback and no visible action. P04's words show how silence builds up. Nurses had reported before, nothing changed, and so people concluded that reporting was pointless. This is a loss of trust, not laziness. Each report that goes unanswered teaches the next nurse not to bother. It also helps explain the "fix and forget" habit, in which a nurse corrects the problem at the bedside and moves on p11.

B4. Practical and conceptual obstacles. P15's quote carries two barriers. The first is time. On a busy ward with too few nurses, a form is the last thing on the list. The second is the phrase "something that did not actually harm the patient." It suggests that she, like others, sees a report as something for harm that has happened, not for harm that was avoided. If so, the value of a near miss is not widely understood, and training could address this p5.

Table 2: Barriers to near-miss reporting		
Theme	Sub-themes	Illustrative quotation
B1. Fear of blame and punishment	Fear of disciplinary action or loss of job; being held personally responsible; public reprimand; blame falling on nurses rather than the system	"When something almost goes wrong, nurses hesitate to report it because they are afraid that management will blame them instead of looking at what caused the problem." (P07)
B2. Hierarchical and unsupportive climate	Power gap between nurses and seniors or physicians; reporting seen as complaining; managers who dismiss concerns	"Sometimes we feel that we cannot speak openly to senior staff because they may think we are complaining about them." (P12)
B3. No feedback and no visible action	Reports 'disappear'; nothing changes; sense of futility; normalisation of near misses	"We have reported similar incidents before, but when nothing changes afterward, people start thinking there is no benefit in reporting." (P04)
B4. Practical and conceptual obstacles	Heavy workload and staff shortage; lack of time; unclear definition of a near miss; 'no harm, no report'; cumbersome forms; lack of training	"When the ward is very busy and there are fewer nurses, it becomes difficult to stop and complete a report for something that did not actually harm the patient." (P15)

3.4 Theme 2 Facilitators of near-miss reporting

F1. Supportive leadership and psychological safety. P03's words turn on one condition: the head nurse listens *"without blaming anyone."* The nurses were not asking for protection from accountability. They were asking for a first response that is curiosity, not accusation. When that happens, telling the head nurse about a mistake or near miss feels safe enough to try. This mirrors the barrier in B1, where the fear was that management would look for a culprit before looking for a cause. The head nurse is the person closest to the ward, so she may be the most direct way to build trust, and it is the first response that sets the tone [12].

F2. Visible feedback and learning. P09 describes the reverse of B3. Where B3 showed trust draining away when nothing happened, here the nurse says that being told what action followed *"encourages us to report"* again. A report that leads to a visible response proves that reporting is worth the effort. Feedback is therefore not a courtesy. It is the thing that keeps the reporting

habit going, and it may be the cheapest improvement a hospital can make, since it needs a conversation and not a new system [7,10].

F3. Simple and confidential reporting systems. P18 asked for two things: a form that is "short and simple," and assurance that information *"will remain confidential."* The first answers the time pressure described in B4. The second answers the fear of blame in B1, since a nurse who knows her, report will not travel to the wrong person has less to lose by writing it. Nurses did not ask for a sophisticated system. They asked for one that respects their time and their exposure.

F4. Professional values, peer support and training. P11's quote holds two ideas in one sentence. The first is that duty to the patient comes first: *"our first responsibility is the safety of the patient."* This shows the nurses were not unwilling to report. Their motivation was already there, and the barriers stood between it and action. The second idea is a request for training, so that nurses can tell *"which incidents should be reported."*

This connects to the "no harm, no report" belief in B4, because training would help nurses see that

an event that did not reach the patient is still worth reporting [5].

Table 3. Facilitators of near-miss reporting

Theme	Sub-themes	Illustrative quotation
F1. Supportive leadership and psychological safety	Non-punitive response from nurse managers; approachable seniors; ward-level trust; being listened to	"If the head nurse listens to us without blaming anyone, we feel more comfortable telling her about mistakes or near misses." (P03)
F2. Visible feedback and learning	Being told what happened to a report; changes made as a result; sharing lessons in ward meetings	"When management tells us what action was taken after a report, it encourages us to report similar incidents in the future." (P09)
F3. Simple and confidential reporting systems	Short, easy form; confidential or anonymous option; protected time; a clearly named person to report to	"The reporting form should be short and simple, and nurses should know that their information will remain confidential." (P18)
F4. Professional values, peer support and training	Duty to protect patients; encouragement from colleagues; education on what to report and why	"We report because our first responsibility is the safety of the patient, but training would help nurses understand which incidents should be reported." (P11)

4. Discussion

The present qualitative study identified two main themes that shaped nurses' experiences of near-miss reporting: barriers to reporting and factors that facilitate reporting. The findings indicate that nurses' decisions to report near misses are not determined solely by their individual willingness or sense of responsibility. Instead, reporting is strongly influenced by the workplace environment, including organizational culture, leadership support, feedback after reporting, workload, and the ease of using reporting systems. These findings are consistent with previous research suggesting that nurses' reporting practices are influenced by a combination of individual and organizational factors, particularly their knowledge and attitudes, the prevailing safety culture, leadership practices, and the accessibility and usability of reporting systems.

The dominance of blame is consistent with international evidence. Systematic and theoretical reviews have repeatedly placed fear of disciplinary action and personal blame among the strongest

deterrents to reporting [8,9]. The Pakistani nurses in this study described the same fear, but in a setting where the nurse closest to an event was often assumed to be at fault. This is the opposite of the systems view in which front-line errors are the end point of latent organisational weaknesses [4]. When blame attaches to individuals, a near miss stops being information about the system and becomes a personal risk. Dekker's distinction between honest error and reckless behaviour offers a practical remedy, because it allows an organisation to hold people accountable for the latter while treating the former as a source of learning [13]. In a blame-oriented culture that distinction is rarely drawn, and the nurses' silence is a rational response rather than a lack of conscientiousness. The concept of the second victim adds that a nurse who has already been shaken by an error needs support, and that punishment compounds the harm [6].

The theme of hierarchy deserves particular attention. Participants reported that reporting could be read as complaining about a senior colleague or a physician. This corresponds to

Edmondson's account of psychological safety, in which the willingness to speak up depends on whether people believe the team will punish or embarrass them for doing so [12]. Our findings suggest that in this setting psychological safety was shaped less by formal policy than by the behaviour of individual seniors. This also explains why participants regarded a supportive nurse manager as the most important facilitator. Where managers respond with concern for the patient rather than a search for a culprit, nurses may be willing to speak up within the ward even when the wider institution is not safe.

The lack of feedback links this study to the work of Hewitt and Chreim, who described front-line staff choosing between fixing a problem and forgetting it, and fixing and reporting it [11]. Participants in our study often fixed near misses at the bedside and moved on. This was not carelessness. It reflected a judgement that reporting would cost them something and give nothing back. Earlier studies have also found that staff doubt that reporting leads to change [7,10]. The corresponding facilitator, visible feedback, suggests a low-cost strategy. Telling a nurse what happened to her report, and showing a change that resulted, may do more for reporting than any further exhortation.

The practical obstacles found here, including workload, time, unclear definitions and lack of training, are familiar from other settings [9,10]. The belief that an event without harm is not worth reporting is important because it shows that the value of near misses is not widely understood. This belief is at odds with the argument that near misses are among the safest and richest sources of safety learning [5]. Training that explains what counts as a near miss, and why it matters, is a straightforward response and was welcomed by participants.

The study allowed nurses to openly share their experiences of a sensitive topic, with purposive sampling and careful analysis strengthening the findings. However, the study involved only 19 nurses from one hospital, which may limit the transferability of the results. Participants may also have given socially desirable responses, and

translation between languages may have affected some meanings. Future studies should include multiple hospitals and perspectives from other healthcare professionals, while also evaluating whether approaches such as just-culture policies and structured feedback improve near-miss reporting.

Conclusion

In this tertiary care hospital in Peshawar and Multan, nurses' reluctance to report near misses was driven mainly by fear of blame, a hierarchical climate, the lack of feedback and practical obstacles. Reporting was encouraged by supportive leaders, visible learning from reports, simple confidential systems, and nurses' own sense of duty to patients. Improving near-miss reporting in Pakistani hospitals will require more than another form. It will require a shift from blaming individuals to learning from the system, led by nurse managers and hospital administrators and sustained by feedback that shows nurses their reports matter.

4.1 Implications for practice and policy

The findings point to several actions. First, hospital leaders should adopt and publicize a just-culture policy that separates honest error from reckless conduct and states that reporting a near miss will not lead to punishment. Second, nurse managers should be trained to respond to reports with curiosity and support, because their reaction is the most immediate determinant of whether nurses report again. Third, every report should be acknowledged, and its outcome shared with staff in ward meetings or notices. Fourth, the reporting process should be short, confidential and available in the language's nurses use, with protected time where possible. Fifth, near-miss reporting should be included in nursing curricula and in-service training so that nurses understand its purpose. Finally, hospitals should consider ways of recognising reporting as good professional practice and not as an admission of fault.

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