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DOI: https://doi.org/10.64388/IREV10I2-1722169

# Perception Of Medical Negligence and Safety Outcome Among Residents of Dekina Local Government Area of Kogi State, Nigeria.

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***Abstract-*** ***Medical negligence remains a significant challenge to patient safety and healthcare quality in Nigeria, particularly in resource-constrained settings. This study examined the prevalence, perceived causes, and consequences of medical negligence among residents of Dekina Local Government Area of Kogi State.The study was guided by Systems Theory and Human Factors Theory and adopted a descriptive survey design with a mixed-methods approach. A total of 400 respondents were selected, of which 386 valid questionnaires were analysed, while 15 maternity patients participated in in-depth interviews. A total of 400 respondents were selected, of which 386 valid questionnaires were analysed, while 15 maternity patients participated in in-depth interviews. Data were analysed using descriptive statistics, including frequencies and percentages, while qualitative data were analysed thematically. The findings revealed that medical negligence is widely perceived as a recurring problem, particularly in the form of delayed diagnosis and treatment, medication errors, and inadequate communication between healthcare providers and patients. Respondents identified staff shortages, excessive workload, inadequate supervision, poor coordination, and lack of essential medical equipment as the major causes of medical negligence. The study further established that medical negligence contributes to worsening health conditions, prolonged hospitalisation, increased financial burden, and loss of public trust in healthcare services. The qualitative findings supported these results by demonstrating that patients frequently experienced delays in care and expressed concerns about the quality and safety of healthcare services. The study concludes that medical negligence is largely driven by systemic weaknesses within healthcare facilities. It recommends strengthening healthcare workforce capacity, improving supervision and continuous professional training, ensuring adequate provision of essential medical equipment, and implementing effective patient safety and quality assurance mechanisms to improve healthcare delivery and patient safety outcomes in Dekina Local Government Area.***

***Keywords:*** ***Medical Negligence, Patient Safety, Healthcare Quality, Prevalence, Healthcare Delivery, Nigeria.***

## I. INTRODUCTION

Medical negligence remains a major challenge to healthcare quality and patient safety globally. Healthcare systems are expected to provide safe, effective, and patient-centred services; however, preventable medical errors continue to threaten patient outcomes and public confidence in healthcare institutions. According to the World Health Organization (WHO, 2022), approximately 134 million adverse events occur annually in low- and middle-income countries, contributing to about 2.6 million deaths from unsafe healthcare practices. Evidence further indicates that nearly one in every ten patients experiences harm during healthcare delivery, with almost half of these incidents being preventable. Common forms of medical negligence include delayed diagnosis, medication errors, surgical mistakes, inadequate patient monitoring, and poor communication between healthcare providers and patients.

The burden of medical negligence is particularly severe in low- and middle-income countries where healthcare systems are constrained by inadequate funding, shortages of qualified healthcare personnel, weak regulatory mechanisms, and insufficient healthcare infrastructure (Ameh et al., 2019). These systemic deficiencies increase the likelihood of preventable adverse events and contribute to declining public trust in healthcare institutions. Consequently, patient safety has become a global public health priority, with increasing emphasis on strengthening healthcare systems, improving accountability, and promoting evidence-based safety practices.

Nigeria reflects many of these global challenges. The healthcare system continues to experience inadequate healthcare workforce, poor infrastructure, high patient-to-provider ratios, and weak quality assurance mechanisms that compromise patient safety (Adebayo et al., 2021; Oleribe et al., 2020). Reports of delayed treatment, medication-related errors, poor communication, and inadequate patient monitoring have continued to generate public concern regarding the quality and safety of healthcare services. Although incidents of medical negligence are occasionally documented through institutional reports, media publications, and patient complaints, the true magnitude of the problem remains largely unknown because of underreporting, weak incident reporting systems, and limited empirical documentation, particularly in rural communities.

In Kogi State, healthcare delivery is largely dependent on public healthcare facilities that serve both urban and rural populations. However, disparities in healthcare infrastructure, availability of skilled personnel, equipment, and quality of healthcare services remain evident across local government areas. Dekina Local Government Area, one of the largest rural local government areas in the state, faces challenges related to inadequate staffing, insufficient medical equipment, limited referral services, and infrastructural deficiencies. These conditions may increase the risk of medical negligence and adversely affect patient safety outcomes while simultaneously shaping public perceptions regarding the quality and safety of healthcare services (Kogi State Government, 2025).

Existing empirical studies on medical negligence in Nigeria have largely focused on tertiary healthcare institutions and urban settings, with relatively little attention given to rural and semi-urban communities where healthcare challenges are often more pronounced. Furthermore, previous studies have concentrated primarily on healthcare providers, institutional practices, and medico-legal issues, with limited emphasis on patients' and residents' perceptions of medical negligence and their implications for patient safety outcomes. This gap limits the availability of context-specific evidence needed to strengthen patient safety interventions at the grassroots level.

Against this background, the present study examines the perception of medical negligence and patient safety outcomes among residents of Dekina Local Government Area of Kogi State. The study provides empirical evidence that will contribute to a better understanding of community perceptions of medical negligence and inform policies and interventions aimed at improving patient safety and the quality of healthcare delivery in public healthcare facilities.

## II. AIM AND OBJECTIVES OF THE STUDY

The aim of this study is to examine Perception of Medical Negligence and Safety Outcome among Residents of Dekina Local Government Area of Kogi State, Nigeria. Thus, the specific objectives are to:

1. Determine the prevalence of medical negligence in healthcare facilities in Dekina Local Government Area as perceived by residents of Dekina Local Government Area.
2. Identify the causes of medical negligence as perceived by patients, caregivers and residents in Dekina Local Government Area.
3. Assess the consequences of medical negligence in Dekina Local Government Area.

### Significance of the Study

This study is significant as it provides empirical evidence on perception of medical negligence and safety outcome among residents of Dekina Local

Government Area, Kogi State. The findings were valuable to several stakeholders. First, to Policy Makers and Health Administrators, by providing evidence-based insights that can guide policy formulation, healthcare regulations, and the development of strategies to minimise medical negligence and improve patient safety in rural healthcare settings. Secondly, to Healthcare Providers by identifying the types, causes, and consequences of medical negligence, the study will help healthcare professionals understand areas requiring improvement, promote adherence to ethical standards, and enhance the quality of service delivery.

Thirdly, to Patients and the General Public, understanding the perception of medical negligence will empower patients to make informed decisions about their healthcare, encourage reporting of unsafe practices, and foster a culture of accountability and transparency in healthcare facilities. Fourthly, to Academia and Researchers, the study will contribute to the body of knowledge on medical negligence, patient safety, and healthcare quality in Nigeria, providing a foundation for further research in similar rural or semi-urban contexts. Lastly, to Community Development, by highlighting effective measures adopted to reduce medical negligence, the study may contribute to strengthening trust between healthcare providers and the community, ultimately improving healthcare utilisation and outcomes.

Overall, the study aims to provide practical recommendations to enhance patient safety, reduce medical negligence, and strengthen public confidence in the healthcare system in Dekina Local Government Area.

## III. LITERATURE REVIEW/ THEORETICAL FRAMEWORK

### Medical Negligence

Medical negligence refers to the failure of a healthcare professional to provide the standard of care expected of a reasonably competent practitioner under similar circumstances, resulting in harm or injury to a patient (Bhumi, 2023). It occurs when healthcare providers breach their duty of care through acts of commission or omission, such as misdiagnosis, delayed diagnosis, medication errors, surgical mistakes, failure to obtain informed consent, or poor patient monitoring (Abubakar et al., 2021; Bamgbose, 2017). In contemporary healthcare, medical negligence is no longer viewed solely as an individual professional failure but also as a consequence of organisational and systemic deficiencies, including inadequate staffing, insufficient supervision, poor communication, and limited healthcare resources.

The occurrence of medical negligence has become a major public health concern because it undermines healthcare quality, reduces patients' confidence in health institutions, and contributes significantly to avoidable morbidity and mortality. In developing countries, particularly Nigeria, the challenge is compounded by inadequate healthcare infrastructure, shortage of qualified personnel, weak regulatory systems, and poor adherence to professional standards.

### Types of Medical Negligence

Medical negligence manifests in several forms within healthcare practice. Diagnostic negligence involves delayed diagnosis, misdiagnosis, or failure to diagnose diseases appropriately despite available clinical evidence. Treatment negligence includes medication errors, surgical mistakes, inappropriate treatment decisions, and poor post-operative management. Communication negligence arises from ineffective communication among healthcare professionals or between healthcare providers and patients, often resulting in misunderstanding of treatment plans or medication instructions.

Another important category is systemic negligence, which results from institutional failures such as inadequate staffing, poor supervision, obsolete equipment, inadequate funding, and weak healthcare management systems. Procedural negligence includes failures in obtaining informed consent, improper execution of medical procedures, and inadequate patient monitoring before, during, or after treatment (Opara, 2025). These different forms of negligence collectively threaten patient safety and healthcare quality.

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DOI: https://doi.org/10.64388/IREV10I2-1722169

Patient Safety

Patient safety refers to the prevention of avoidable harm during healthcare delivery through the implementation of evidence-based clinical practices, effective communication, risk management, and continuous quality improvement (WHO, 2021). It is regarded as a fundamental component of healthcare quality because every patient has the right to receive safe, effective, and timely healthcare services.

Contemporary approaches to patient safety emphasise the establishment of a strong safety culture where healthcare professionals openly report errors, learn from adverse events, and continuously improve healthcare processes. Patient safety also requires collaboration among healthcare providers, patients, families, and healthcare institutions to minimise preventable errors and improve healthcare outcomes (Biresaw et al., 2023).

Prevalence and Predisposing Factors of Medical Negligence

Medical negligence remains a significant healthcare challenge globally. The World Health Organization (2023) estimates that millions of patients experience preventable adverse events annually during healthcare delivery. The burden is particularly high in low- and middle-income countries due to weak healthcare systems, inadequate funding, shortage of skilled healthcare workers, and poor regulatory mechanisms.

In Nigeria, several studies have reported that medical negligence is associated with long waiting times, inadequate staffing, poor communication, limited access to modern medical equipment, weak patient safety systems, and insufficient professional training (Ogundiran et al., 2023; Ogueji et al., 2024). Healthcare worker burnout, excessive workload, inadequate supervision, and poor adherence to clinical guidelines further increase the likelihood of medical errors. These challenges are more severe in rural and semi-urban communities, where healthcare facilities often operate with limited personnel and inadequate infrastructure.

Consequences of Medical Negligence

Medical negligence has serious consequences for patients, healthcare professionals, and healthcare institutions. For patients, negligence may result in preventable injuries, prolonged illness, disability, psychological trauma, increased healthcare costs, or death (Sharma et al., 2021). Victims often lose confidence in healthcare providers, leading to delayed healthcare-seeking behaviour and poor compliance with medical recommendations.

Healthcare institutions also experience significant financial and reputational consequences arising from negligence claims. Litigation costs, compensation payments, declining public trust, and increased administrative responsibilities place additional pressure on already resource-constrained public healthcare facilities (Amoah et al., 2023). Healthcare workers involved in negligence cases may experience emotional distress, burnout, professional sanctions, and defensive medical practice, all of which may negatively affect healthcare quality.

Patient Safety Measures

Ensuring patient safety requires healthcare workers to consistently observe established clinical standards and safety protocols. These include adherence to evidence-based treatment guidelines, accurate documentation, effective communication among healthcare teams, proper medication administration, infection prevention and control measures, and continuous professional education (Poku et al., 2023). Healthcare institutions should also establish effective incident reporting systems, encourage non-punitive responses to medical errors, provide adequate staffing and equipment, and promote continuous quality improvement programmes. These measures help reduce preventable adverse events, improve patient outcomes, and strengthen public confidence in healthcare services.

Empirical Review

Several empirical studies have examined different dimensions of medical negligence and patient safety in Nigeria. Kaware et al. (2022) reported poor patient safety culture among nurses in Northwest Nigeria,

particularly in staffing adequacy, communication openness, and non-punitive error reporting. Lawal et al. (2024) identified inadequate staffing, poor communication, insufficient training, and weak institutional policies as major barriers to medication safety in Kaduna State public hospitals.

Similarly, Nwosu et al. (2019) found that although surgeons possessed high awareness of patient safety principles, compliance with the WHO Surgical Safety Checklist remained low. Jafaru and Abubakar (2022) observed poor medication administration practices among nurses due to inadequate coordination and weak institutional policies. Arute et al. (2024) further reported deficiencies in communication and documentation of medication errors among pharmacy staff in Delta North.

Collectively, these studies demonstrate that inadequate staffing, poor communication, limited training, weak patient safety culture, and insufficient institutional support remain major contributors to medical negligence in Nigeria. However, most previous studies concentrated on healthcare workers and institutional practices, with limited attention given to patients' perceptions of medical negligence and how such perceptions influence patient safety outcomes.

Gap in the Literature

A review of existing literature reveals that most studies on medical negligence have focused on healthcare workers, institutional safety culture, medication errors, or the legal dimensions of malpractice. Few studies have investigated public perception of medical negligence and its relationship with patient safety outcomes, particularly within rural and semi-urban communities.

Furthermore, there is limited empirical evidence from Kogi State, especially Dekina Local Government Area, where healthcare facilities face significant resource constraints. Existing studies have largely been conducted in urban centres or tertiary healthcare institutions, limiting the generalisability of their findings to rural settings. Consequently, this study addresses this knowledge gap by examining the perception of medical negligence and its implications for patient safety outcomes in selected healthcare facilities in Dekina Local Government Area of Kogi State, thereby providing context-specific evidence to support healthcare policy and patient safety improvement initiatives.

Theoretical Framework

This study is anchored on Systems Theory and Human Factors Theory because both theories provide complementary explanations for the occurrence of medical negligence and its implications for patient safety. While Systems Theory explains how organisational structures and processes influence healthcare outcomes, Human Factors Theory focuses on the interaction between healthcare workers, their work environment, and patient safety.

Systems Theory

Systems Theory was developed by Ludwig von Bertalanffy in the 1940s and later expanded by Daniel Katz and Robert Kahn (1966) in organisational studies. The theory views organisations as open systems comprising interconnected components that continuously interact with their internal and external environments. It assumes that changes in one component of a system affect the performance of the entire system, while effective feedback mechanisms are necessary to maintain organisational stability and improve performance.

Within healthcare, Systems Theory suggests that medical negligence should not be viewed solely as the result of individual healthcare workers' mistakes but as the outcome of weaknesses within the healthcare system. Inputs such as qualified personnel, medical equipment, drugs, funding, and institutional policies influence healthcare processes, while these processes ultimately determine patient safety outcomes. Consequently, failures in any component of the healthcare system may increase the likelihood of medical negligence.

The theory is particularly relevant to this study because public healthcare facilities in Dekina Local Government Area operate under significant resource constraints, including inadequate staffing, insufficient medical equipment, irregular drug supply, and weak

quality assurance mechanisms. These systemic deficiencies can adversely affect healthcare delivery and increase the occurrence of preventable medical errors. Systems Theory therefore provides a useful framework for understanding how organisational and institutional factors contribute to medical negligence and patient safety outcomes.

Despite its usefulness, Systems Theory has limitations. It is often criticised for being too broad and abstract, making it difficult to identify the relative contribution of individual factors to organisational outcomes. The theory also provides limited guidance on specific interventions required to address particular healthcare problems.

Human Factors Theory

Human Factors Theory originated from the work of industrial psychologists and ergonomics researchers, including Alphonse Chapanis, Paul Fitts, Donald Norman, and James Reason, between the 1940s and 1990s. The theory assumes that human beings possess natural cognitive limitations in attention, perception, memory, and decision-making. Rather than attributing errors solely to individual incompetence, the theory argues that most human errors occur because work environments and organisational systems fail to accommodate normal human limitations.

In healthcare settings, Human Factors Theory explains that medical negligence often results from excessive workload, fatigue, poor communication, stressful working conditions, inadequate equipment design, and environmental distractions. These conditions increase the likelihood of medication errors, diagnostic mistakes, communication failures, and other adverse events that compromise patient safety.

The theory is applicable to this study because healthcare workers in many public healthcare facilities within Dekina Local Government Area frequently work under difficult conditions characterised by staff shortages, heavy workloads, inadequate infrastructure, unreliable electricity supply, and limited medical resources. Such conditions reduce healthcare workers' ability to consistently provide safe and effective care, thereby increasing the risk of medical negligence. Human Factors Theory therefore helps explain how workplace conditions and organisational environments influence healthcare workers' performance and patient safety outcomes.

However, the theory has some limitations. It tends to place greater emphasis on system design than on individual accountability and professional competence. Furthermore, implementing human factors interventions may require substantial financial and technological investments that are often difficult to achieve in resource-constrained healthcare settings.

Relevance of the Theories to the Study

The combination of Systems Theory and Human Factors Theory provides a comprehensive framework for understanding medical negligence and patient safety in public healthcare facilities. Systems Theory explains the influence of organisational structures, healthcare resources, and institutional processes on patient safety, while Human Factors Theory explains how workplace conditions, human limitations, and environmental factors contribute to medical errors. Together, the two theories provide an appropriate theoretical foundation for examining the perception of medical negligence and its implications for patient safety outcomes in selected public healthcare facilities in Dekina Local Government Area of Kogi State.

## IV. METHODOLOGY

Research Design

This study adopted a descriptive cross-sectional survey design to examine the perception of medical negligence and patient safety outcomes among residents of Dekina Local Government Area, Kogi State, Nigeria. The design enabled the collection of quantitative data at a single point in time to assess respondents' perceptions of the prevalence, types, causes, consequences, and preventive measures relating to medical negligence.

Study Area

The study was conducted in Dekina Local Government Area of Kogi State, Nigeria. Dekina is one of the largest local government areas in Kogi State, comprising both urban and rural communities with a projected population of 419,396. The area has a network of public and private healthcare facilities serving a predominantly rural population. Its diverse healthcare settings make it appropriate for investigating issues relating to medical negligence and patient safety.

Study Population

The study population comprised adult residents (18 years and above), patients (both in-patients and out-patients), and caregivers in Dekina Local Government Area. These groups were selected because of their direct or indirect experiences with healthcare delivery and their ability to provide relevant information on medical negligence and patient safety outcomes.

Sample Size and Sampling Technique

A sample size of 400 respondents was determined using the Taro Yamane formula. A multi-stage sampling technique was employed. Six wards were purposively selected based on the availability of functional healthcare facilities and population concentration. Public and private healthcare facilities within the selected wards were also purposively selected. Patients and caregivers were recruited purposively at the selected facilities, while adult residents were selected using simple random sampling. Additionally, fifteen participants were purposively selected for in-depth interviews to provide qualitative insights into medical negligence and patient safety.

Method of Data Collection

Data were collected using a structured questionnaire and an in-depth interview guide. The questionnaire consisted mainly of closed-ended items measured on a five-point Likert scale, while the interview guide contained semi-structured open-ended questions that explored participants' experiences and perceptions in greater detail. Secondary information was obtained from relevant textbooks, journal articles, government publications, and other scholarly sources.

Validity and Reliability of the Instrument

The questionnaire and interview guide were subjected to expert review to establish face and content validity. Three experts in sociology assessed the instruments for clarity, relevance, and adequacy of coverage of the study objectives. The overall Scale Content Validity Index (S-CVI) was 0.89, indicating high content validity.

Reliability was established through a pilot study involving thirty respondents outside the study area. Test-retest reliability produced an overall coefficient of 0.81, while Cronbach's Alpha yielded an overall reliability coefficient of 0.85, demonstrating satisfactory internal consistency of the instrument.

Administration of Data Collection

The questionnaires were administered by the researcher with the assistance of six trained research assistants. Completed questionnaires were retrieved immediately where possible to minimise non-response and incomplete responses. The in-depth interviews were conducted with selected participants after obtaining their informed consent.

Method of Data Analysis

Quantitative data were analysed using the Statistical Package for the Social Sciences (SPSS) version 25. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarise the data. Independent Samples t-test and One-Way Analysis of Variance (ANOVA) were employed to test the study hypotheses at a 0.05 level of significance. Qualitative data obtained from the in-depth interviews were transcribed verbatim, organised into themes, and analysed using NVivo software.

Ethical Considerations

Ethical approval for the study was obtained from the Prince AbubakarAudu University Teaching Hospital Ethics Committee. Participation was voluntary, informed consent was obtained from all respondents, confidentiality and anonymity were maintained throughout the study, and participants were assured of their right to withdraw from the study at any stage without any consequences.

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DOI: https://doi.org/10.64388/IREV10I2-1722169

Presentation of Data Analysis

Among the 400 questionnaires distributed, 386 were successfully retrieved and analysed, representing a response rate of 96.5%. In addition, fifteen (15) in-depth interviews were conducted with selected maternity patients to complement the quantitative findings.

Socio-demographic Characteristics of Respondents

TABLE 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENT

| Variable | Category | Frequency (N= 386) | Percentage (%) |
|---|---|---|---|
| Sex | Male | 198 | 51.3 |
| | Female | 188 | 48.7 |
| Age(Years) | 18-25 | 74 | 19.2 |
| | 26-35 | 102 | 26.4 |
| | 36-45 | 96 | 24.9 |
| | 46-55 | 53 | 13.7 |
| | 56+ | 46 | 11.9 |
| Marital Status | Single | 118 | 30.6 |
| | Married | 214 | 55.4 |
| | Divorced | 21 | 5.4 |
| | Widowed | 33 | 8.6 |
| Education | None | 29 | 7.5 |
| | Primary | 45 | 11.7 |
| | Secondary | 148 | 38.3 |
| | Tertiary | 143 | 37.0 |
| Religion | Christianity | 276 | 71.5 |
| | Islam | 94 | 24.4 |
| | ATR/Others | 16 | 4.1 |
| Category | Out-Patient | 121 | 31.3 |
| | In-patient | 58 | 15.0 |
| | Resident | 89 | 23.1 |
| Ethnic Group | Igala | 248 | 64.2 |
| | Ebira | 54 | 14.0 |
| | Yoruba | 39 | 10.1 |
| | Bassa | 28 | 7.3 |
| | Others | 17 | 4.4 |
| Duration of Interaction with Healthcare Facilities | <6 months | 41 | 10.6 |
| | 6-12 months | 138 | 35.8 |
| | >1 year | 151 | 39.1 |
| Frequency of Hospital Visits (Past 12 Months) | 1 time | 42 | 10.9 |
| | 2-3 times | 149 | 38.6 |
| | 4-5 times | 60 | 15.5 |
| | >5 times | 78 | 20.2 |
| Facility Mostly Visited | Primary Health Centre | 118 | 30.6 |
| | General Hospital | 146 | 37.8 |
| | Private | 82 | 21.2 |
| | Mission | 40 | 10.4 |
| Income (#) | <20,000 | 91 | 23.6 |
| | 20,000-60,000 | 158 | 40.9 |
| | 61,000-150,000 | 97 | 25.1 |

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DOI: https://doi.org/10.64388/IREV10I2-1722169

| | | | |
|---|---|---|---|
| | >151,000 | 40 | 10.6 |

The respondents comprised 51.3% males and 48.7% females, indicating a balanced gender distribution. The majority (51.3%) were between 26 and 45 years of age, while 55.4% were married. Most respondents had attained at least secondary education (75.3%), and Christianity (71.5%) was the predominant religion. Out-patients (31.3%), residents (30.6%), caregivers (23.1%), and in-patients (15.0%) were all represented, providing diverse perspectives on healthcare experiences. The majority of respondents were of Igala ethnic origin (64.2%), reflecting the demographic composition of the study area.

Regarding healthcare utilisation, 39.1% had interacted with healthcare facilities for more than one year, while 38.6% had visited a healthcare facility two to three times within the previous twelve months. Public health facilities were the most frequently utilised, with 37.8% patronising General Hospitals and 30.6% Primary Health Centres. Furthermore, most respondents (64.5%) earned ₦60,000 or less per month, indicating that the study population was largely within the low- and middle-income groups.

Overall, the socio-demographic profile suggests that the respondents possessed sufficient healthcare experience to provide informed perceptions of medical negligence and patient safety outcomes in Dekina Local Government Area.

Prevalence of Medical Negligence in Dekina Local Government

TABLE 2: Distribution of Responses according to the Prevalence of Medical Negligence in Dekina Local Government (N= 386)

| Items | Never | Rarely | Sometimes | Often | Very Often | Total |
|---|---|---|---|---|---|---|
| Awareness of Medical Negligence in Dekina LGA. | 28 (7.3%) | 64 (16.6%) | 118 (30.6%) | 102 (26.4%) | 74 (19.2%) | 386 (100%) |
| Encounters with medical errors in healthcare facilities in Dekina LGA. | 34 (8.8%) | 79 (20.5%) | 121 (31.3%) | 95 (24.6%) | 57 (14.8%) | 386 (100%) |
| Experience or observation of delayed diagnosis or treatment in Dekina LGA. | 26 (6.7%) | 58 (15.0%) | 129 (33.4%) | 101 (26.2%) | 72 (18.7%) | 386 (100%) |
| Incidence of patients receiving wrong medication or incorrect dosage in Dekina LGA. | 41(10.6%) | 73 (18.9%) | 122 (31.6%) | 94 (24.4%) | 56 (14.5%) | 386 (100%) |
| Bypassing of informed consent before medical procedures in Dekina LGA. | 52(13.5%) | 81 (21.0%) | 117 (30.3%) | 86 (22.3%) | 50 (13.0%) | 386 (100%) |

The findings indicate that medical negligence is widely perceived as a recurring problem in healthcare facilities within Dekina Local Government Area. Delayed diagnosis or treatment recorded the highest prevalence, with 78.3% of respondents reporting that it occurred sometimes, often, or very often. Similarly,

76.2% indicated awareness of medical negligence, while 70.7% reported recurring medical errors. Wrong medication or incorrect dosage was reported

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by 70.5% of respondents, whereas 65.6% perceived that informed consent procedures were frequently bypassed.

Overall, all five indicators recorded prevalence rates above 65%, suggesting that residents perceive medical negligence as a persistent rather than isolated occurrence. The consistently low proportions of respondents selecting "Never" further reinforce the widespread perception of negligence within the healthcare system.

The qualitative findings supported the survey results. One participant remarked,

"We usually wait for hours before anyone attends to us during labour, and sometimes no one explains what they are doing." (IDI 1, Female, 34 years, maternity patient).

This statement reflects the recurring concerns about delayed treatment and inadequate communication reported by respondents, lending further support to the quantitative findings.

Causes of Medical Negligence in Dekina Local Government Area

Table 3: Causes of Medical Negligence in Dekina Local Government Area (N=386)

| Item | SA | A | U | D | SD |
|---|---|---|---|---|---|
| Staff Shortage contributes to medical negligence. | 102 (26.4%) | 121 (31.3%) | 38 (9.8%) | 79 (20.5%) | 46 (11.9%) |
| Heavy workload contributes to error. | 95 (24.6%) | 128 (33.2%) | 32 (8.3%) | 83 (21.5%) | 48 (12.4%) |
| Poor supervision increases error. | 88 (22.8%) | 117 (30.3%) | 41 (10.6%) | 92 (23.8%) | 48 (12.4%) |
| Inadequate training contribute to negligence. | 90 (23.3%) | 120 (31.1%) | 37 (9.6%) | 89 (23.1%) | 50 (13.0%) |
| Fatigue due to long working hours causes mistakes. | 104 (26.9%) | 123 (31.9%) | 29 (7.5%) | 82 (21.2%) | 48 (12.4%) |
| Lack of essential equipment leads to negligence. | 110 (28.5%) | 125 (32.4%) | 27 (7.0%) | 78 (20.2%) | 46 (11.9%) |
| Corruption or unethical practices contributes to negligence. | 97 (25.1%) | 118 (30.6%) | 40 (10.4%) | 81 (21.0%) | 50 (13.0%) |
| Poor documentation practices increase patient safety risk. | 92 (23.8%) | 126 (32.6%) | 34 (8.8%) | 86 (22.3%) | 48 (12.4%) |
| Patient complaints are rarely taken seriously or followed up properly. | 101 (26.2%) | 119 (30.8%) | 33 (8.5%) | 82 (21.2%) | 51(13.2%) |
| Poor coordination among staff contributes to negligence | 94 (24.4%) | 124 (32.1%) | 35 (9.1%) | 85 (22.0%) | 48 (12.4%) |

The findings indicate that respondents perceived medical negligence to be primarily associated with

systemic and organisational challenges within healthcare facilities. Lack of essential equipment recorded the highest level of agreement (60.9%), followed by fatigue due to long working hours (58.8%), heavy workload (57.8%), staff shortage (57.7%), patient complaints not being taken seriously (57.0%), poor coordination among healthcare workers (56.5%), poor documentation practices (56.4%), corruption and unethical practices (55.7%), inadequate training (54.4%), and poor supervision (53.1%). Overall, more than half of the respondents agreed that each of these factors contributes to medical negligence, indicating that the problem is perceived as largely systemic rather than attributable to individual healthcare workers alone.

The qualitative findings corroborated the survey results.
One participant stated,

"There were times when nurses attended to many patients at once, and medications were delayed because the staff were overstretched." (IDI 4, Female, 31 years, maternity patient).

This account supports the quantitative findings that staff shortages, heavy workload, and inadequate resources are major contributors to medical negligence in healthcare facilities within Dekina Local Government Area.

Consequences of Medical Negligence on Patient Safety Outcomes

Table 4: Consequences of Medical Negligence on Patients' Safety Outcomes in Dekina Local Government Area of Kogi State (N= 386)

| Items | SA | A | U | D | SD |
|---|---|---|---|---|---|
| Negligence worsens patients' health condition | 104 (27.0%) | 122 (31.6%) | 31 (8.0%) | 81 (21.0%) | 48 (12.4%) |
| Medical negligence has resulted in avoidable patient death. | 100 (25.9%) | 113 (29.3%) | 35 (9.1%) | 86 (22.3%) | 52 (13.4%) |
| Patients may experience prolonged hospital stay due to negligence. | 102 (26.4%) | 116 (30.1%) | 34 (8.8%) | 87 (22.5%) | 47 (12.2%) |
| Patients often lose trust in the healthcare system due to negligence | 108 (28.0%) | 120 (31.1%) | 28 (7.3%) | 81 (21.0%) | 49 (12.6%) |
| Increase in Patients' complaints | 95 (24.6%) | 116 (30.1%) | 36 (9.3%) | 87 (22.5%) | 52 (13.5%) |
| Families of patients are emotionally affected by negligence. | 97 (25.1%) | 114 (29.5%) | 38 (9.8%) | 81 (21.0%) | 56 (14.6%) |
| Fear of negligence discourages people from visiting hospitals | 104 (26.9%) | 110 (28.5%) | 33 (8.5%) | 84 (21.8%) | 55 (14.3%) |
| Medical negligence increases the financial burden on patients and their families | 105 (27.2%) | 117 (30.3%) | 29 (7.5%) | 83 (21.5%) | 52 (13.5%) |
| Some patients avoid certain hospitals due to past negligence experience. | 98 (25.4%) | 111 (28.8%) | 34 (8.8%) | 89 (23.1%) | 54 (13.9%) |
| Patients who experience negligence are likely to seek future medical help. | 86 (22.3%) | 119 (30.8%) | 43 (11.1%) | 90 (23.3%) | 48 (12.5%) |

The findings revealed that respondents perceived medical negligence to have significant consequences for patient safety and healthcare utilization. Loss of trust in the healthcare system recorded the highest

level of agreement (59.1%), followed by worsening of patients' health conditions (58.6%), increased financial burden on patients and their families (57.5%), prolonged hospital stay (56.5%), fear of visiting healthcare facilities (55.4%), avoidable patient deaths (55.2%), increased patient complaints (54.7%), emotional distress among patients' families (54.6%), avoidance of certain hospitals due to previous experiences (54.2%), and reduced willingness to seek future healthcare (53.1%). Overall, more than half of the respondents agreed that medical negligence adversely affects patients, their families, and confidence in the healthcare system.

The qualitative findings supported these results. One participant stated,

“Sometimes people are afraid to go back to the hospital after seeing mistakes happen to friends or relatives. You feel like you cannot trust anyone.” (IDI 6, Female, 28 years, maternity patient).

This finding reinforces the survey results, indicating that medical negligence not only compromises patient safety but also erodes public trust and discourages timely utilization of healthcare services.

## V. DISCUSSION OF FINDINGS

The findings indicate that medical negligence is widely perceived as a recurring challenge in healthcare facilities within Dekina Local Government Area of Kogi State. Respondents commonly identified delayed diagnosis and treatment, medication errors, inadequate informed consent, and other clinical lapses as frequent occurrences, suggesting persistent concerns regarding patient safety. These findings imply that negligence is perceived as a systemic issue rather than isolated incidents involving individual healthcare providers.

The findings are consistent with those of Kaware et al. (2022), who reported weaknesses in patient safety culture associated with staffing shortages, communication gaps, and ineffective error management among healthcare workers in Katsina State. Similarly, Arute et al. (2024) found that poor communication and inadequate documentation contributed to patient safety challenges in healthcare facilities in Delta North, Nigeria. The consistency of these findings suggests that organisational and institutional factors remain major contributors to medical negligence in Nigerian healthcare settings.

These findings further support the assumptions of System Theory, which posits that healthcare delivery functions as an interconnected system in which failures in one component, such as staffing, communication, or supervision, can adversely affect overall service delivery and patient safety. The recurring perception of medical negligence observed in this study therefore underscores the need for comprehensive health system strengthening rather than interventions directed solely at individual healthcare workers.

The findings revealed a shared perception among respondents that medical negligence is primarily driven by systemic factors, including staff shortages, excessive workload, inadequate supervision, poor communication, and insufficient healthcare resources. The broad agreement across respondent groups suggests that these challenges are widely recognised within the study area and are perceived as major contributors to patient safety risks.

This finding is consistent with Tamuno-Opubo et al. (2024), who identified inadequate resources, weak regulatory mechanisms, and insufficient staff training as significant barriers to patient safety in Nigeria. Similarly, Sampson et al. (2024) reported that many primary healthcare facilities failed to meet national quality standards because of persistent staffing and funding constraints. These similarities reinforce the view that organisational and structural deficiencies remain central to the occurrence of medical negligence.

The findings also support the assumptions of System Theory, which posits that deficiencies in key components of the healthcare system, such as human resources, supervision, and infrastructure, increase the likelihood of medical errors and compromise patient safety outcomes. Consequently, addressing medical negligence requires comprehensive health system reforms that strengthen workforce capacity, resource availability, and institutional management.

The results also showed that medical negligence is significantly associated with negative patient outcomes, including complications, prolonged illness, dissatisfaction, and loss of trust in healthcare providers. These consequences highlight the broader impact of negligence on both patient health and public confidence in healthcare institutions. Okafor et al. (2018) similarly found that a strong patient safety culture improves patient satisfaction, while poor safety practices reduce trust in healthcare systems. Queen et al. (2023) also noted that inadequate patient safety practices in Nigerian healthcare facilities undermine public confidence. In System Theory terms, these negative outcomes represent system outputs resulting from inadequate inputs such as staffing, training, supervision, and resources.

## VI. CONCLUSION

The study concludes that medical negligence is widely perceived as a persistent challenge affecting patient safety and the quality of healthcare services in Dekina Local Government Area of Kogi State. Respondents identified delays in treatment, medication errors, inadequate communication, and lapses in informed consent as common manifestations of negligence. The findings further indicate that systemic factors, including staff shortages, excessive workload, inadequate supervision, poor coordination, and limited healthcare resources, are the major drivers of these challenges.

The study also established that medical negligence has important consequences for patients and the healthcare system, including deterioration of health conditions, prolonged hospitalisation, increased financial burden, erosion of public trust, and reduced healthcare utilisation. Strengthening the healthcare workforce, improving supervision and continuous professional training, enhancing communication with patients, and ensuring the availability of essential medical resources are critical measures for reducing medical negligence and improving patient safety outcomes in the study area.

## VII. RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made:

1. Healthcare authorities should strengthen patient safety systems through regular clinical audits, effective incident-reporting mechanisms, and continuous monitoring of healthcare quality to reduce medical negligence.
2. Healthcare facilities should address systemic challenges by improving staffing levels, reducing excessive workload, strengthening supervision, and providing continuous professional training for healthcare workers.
3. Standardised clinical protocols for diagnosis, treatment, medication administration, and informed consent should be strictly implemented to minimise preventable medical errors and improve the quality of care.
4. Government and healthcare managers should ensure the provision of adequate medical equipment and other essential resources required for safe and effective healthcare delivery.
5. Healthcare institutions should establish responsive patient feedback and complaint-resolution mechanisms

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