Patient Safety Culture as Perceived by Nursing Staff

Thesis

Submitted for Partial **Fulfillme***nt of the Requirement*
of Master Sciences in Nursing Degree
(Nursing Administration)

By

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2015

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بسم الله الرحمن الرحيم

قَالُوا سُبْحَانَكَ لَا عِلْمَ لَنَا إِلَّا مَا عَلَّمْتَنَا
إِنَّكَ أَنتَ الْعَلِيمُ الْحَكِيمُ

صدق الله العظيم

سورة البقرة
اية (٣٢)

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Dedication To

would like to dedicate this thesis to my great Mother and sole of my Father; for whom I will never find adequate word to express my gratitude also for my dear Husband who always makes my life full of happiness and to my lovely family Rawan, Jana and Youssef my life smile.

Ghada Mohamed Abd Elfattah

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AHA	**:**Advancing Health in America **.**
AHRQ	: Agency for Health care Research and Quality**.**
AMA	: American Medical Association
CCHSA	: Canadian Council on Health Services Accreditation's
CPSI	: Canadian Patient Safety Institute
CRM	: Crew Resource Management
EMRO	: Eastern Mediterranean Regional Office
HMC	: Hamad Medical Corporation
HSC	: Health and Safety Commission
HRO	: High Reliability Organization
HSOPSC	: The Hospital Survey on Patient Safety culture
INSAG	: International Nuclear Safety Advisory Group
IOM	: Institute of Medicine
JCAHO	: Join Commission on Accreditation of Healthcare Organization
NCQA	: The National Committee for Quality Assurance
NPSA	: National Patient Safety Agency
RN	: Registered Nurses
TQM	: The theory of total quality management
VHA	: Voluntary Hospitals of America
WHO	: World Health Organization

Abstract

Safety culture, an important concept in providing a safe environment for employees and patients. It is important to understand nurses' patient safety perceptions and to comprehend what factors influence their views**. Aim**: The study aims to assess patient safety culture as perceived by nursing staff. **Setting**: The study was conducted in El-Helal Hospital (trauma hospital) using a descriptive design. **Sample** :(20) head nurses, and (70) staff nurses. **Tools:** Hospital survey of patient safety culture (HSPSC) used to collect the data. **Results**: nursing staff perceived patient safety culture positively. Moreover head nurses perceived patient safety culture more positively than staff nurses. There was a statistically significant difference between positive responses of staff nurses and head nurses in five dimensions related to Supervisor/ manager expectations and actions promoting patient safety dimension, Organizational learning dimension, Overall perception of patient safety dimension, Feedback and communication about error dimension, and Staffing dimension. **Conclusion:** Head nurses perceived patient safety culture more positively than staff nurses. The majority of the nursing staff reported 1-2 events over the past 12 months. **Recommendation:** Patient safety culture must be an integral part of the orientation and on job educational staff development programs, and further studies are recommended to assess nursing staff perceptions regarding to patient safety culture in a wider scale.

Keywords: patient safety culture, perception, nursing staff.

Introduction

Patient safety and quality is the core of the delivery of healthcare. For every patient, carer, family member and healthcare professional, safety is pivotal to diagnosis, treatment and care. Doctors, nurses and all those who work in the health system are committed to treating, helping, comforting and caring for patients and to excellence in the provision of health services for all who need them. As human beings we all make mistakes and no system is perfect, however, all of us working in the delivery of healthcare owe it to our patients and to ourselves to do all that we can to minimize errors and maximize quality. The best way to do this is to accept and describe honestly where and how mistakes and failures have occurred in order to learn and to improve **(Commission on Patient Safety and Quality Assurance, 2008)**.

It is clear that patient safety has become both a national and international imperative in the recent years, with increased emphasis across the world on patient safety. Studies of adverse events in numerous countries around the world demonstrate that, between (4%) and (16%) of patients have admitted to hospital experience one or more adverse events, of which up to half are preventable. Understanding why preventable errors occur is a key to develop strategies by which they can be addressed and minimized **(Commission on Patient Safety and Quality Assurance, 2008).** So that, The World Health Organization (WHO), World Alliance for Patient Safety have already developed strategies to intervene on this issue, proposing plans and legislation on the subject**(Pamela, 2012).**

Today's healthcare environment is increasingly fraught with patient problems and concerns. Payment reductions, increased workloads, turnover and professional conflicts have created environments that stress healthcare providers and affect patient safety. Nurses are central to these issues, their personal control over practice increases their ability to assure patient well-being **(Ramanujam et al, 2008)**, and other research finds that nurses perceive the healthcare environment in which they provide care as presenting an escalating risk to patients. Workload, staffing shortage, restructuring, systems issues (such as management strategies, administrators' communication styles and their support to nurses and their views of safety, career development programs for nurses, physical environment and technology) seem to increase patient risk**(Chang et al, 2007).**

While adverse patient event can cause physical and emotional harm for patient, families and affected staff. They also generate a significant financial and social burden .it has been estimated that the direct costs alone associated with managing adverse patient event **(Ehsani et al, 2006),** a good safety system depends on having a culture that supports and encourages employees to report their errors and near miss**(Al- Ishaq, 2008).** For that, emphasis on implementing systems of care delivery that prevent errors, learn from errors and promote a culture of safety that involves health professionals and the organization as a whole to prevent harm in health care (**Arvid, 2010).**

So that, a strong safety culture can help minimize medical errors, and hospitals' leaders have been encouraged to take responsibility for

assuring patient safety **(Institute of Medicine, 2005[IOM]; Joint Commission on Accreditation of Healthcare Organizations, 2006)**. Errors in the process of care can result in injury, sometimes the harm that patients experience is serious and sometimes people die. Various studies have investigated the extent of adverse events **(Johnstone & Kanitsaki, 2006;WHO, 2008 and Markowitz, 2009).** In developing and transitional countries, it is likely that millions of patients worldwide suffer disabling injuries or death every year due to unsafe medical care **(David et al, 2005, and Espin et al, 2006).**

It is a challenge for any healthcare organization to implement new practices to improve the quality of the system, patient care, and/or safety. The first challenge relates to complexity of healthcare organizations. These organizations tend to be more complex than other industries for several reasons. First, essential practices of healthcare workers are often invisible. Secondly, commitment requires major changes in individual behavior from the traditional blame toward a non-blame approach to errors, and a focus from bad people to bad systems. A third reason related to healthcare professionals‟ fear of losing others‟ confidence and trust, and their personal reputation **(Leap &Berwick, 2005).**

Leap & Berwick, 2005, have reported that nearly all experts in health care, from physician and healthcare administrator to health services researchers' government, and privately insured agree that our current healthcare system is not working well and will have to be revised, if not revolutionized. Certainly, our patients' safety must play extremely important in this endeavor, so that changing the culture, or even a few

practices and policies, requires healthcare professionals an especially the top level administrators to share a common vision with their employees.

However, **Hwang et al, 2006**, have stated, that healthcare providers are not expected to make errors, mistakes do occur, and some mistakes have in serious injury or death. Each year approximately 1.3 million patient are injured because of error during their hospitalization, so that patient safety is a critical component of the healthcare quality. As health care organizations continually strive to improve, there is a growing importance of establish a culture of safety. Achieving a culture of safety requires an understanding of the values, beliefs, and norms about what is important in an organization and what attitudes and behaviors related to patient safety are expected and appropriate **(AHRQ, 2008)**.

Patient safety has always been a central focus of nursing practice. Current research makes it increasingly clear that what occurs in the surrounding health care environment impacts patient safety. The protracted nursing shortage and nurse turnover may adversely affect patient outcomes and are exacerbated by an environment of disruptive behavior, conflict, and poor communication in the nursing workplace. The Joint Commission has identified these behaviors as key elements that jeopardize the "culture of safety" necessary to assure safe, quality patient outcomes. A culture of safety includes the attributes of teamwork, communication openness, collaboration, and a manager's positive focus on prevention of errors, there is currently no consensus on the best and practical method of patient safety culture educational intervention for practicing nurses **(AHRQ, 2010).**