Assessment of Patient Safety Culture

"An Example from a Governmental Hospital"

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بسم الله الرحمن الرحيم

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صدق الله العظيم

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Abstract

Patient safety is a critical component to the quality of health care. As health care organizations strive to improve their quality of care, there is a growing recognition of the importance of establishing a culture of patient safety. The aim of this study was to assess the culture of patient safety within one of the governmental hospitals in Giza Governorate. Descriptive cross sectional study was conducted in Om-El massryeen general hospital over a period of three months using an AHRQ adapted questionnaire.

Hospital staff stratification was done into four main job categories; physicians, nurses, technical and administrative staff. The survey was completed and returned by two hundred and five (205) hospital staff from different categories. Eighteen (18) surveys were excluded from this study so the net number of the surveys entered in this study was one hundred eighty seven (187)

The survey measured fourteen (14) dimensions related to the aspects of safety culture through 44 items in addition to seven (7) items as background variables related to the staff demographics. Internal consistency reliabilities were examined for 12 safety cultures dimensions and found to have an acceptable reliability and the last two are single-item dimensions used to check the validity.

There are only two dimensions show positivity above 50% which were Organizational Learning and Continuous Improvement 53% and Teamwork within Hospital Units 66%. The rest of the dimensions are below 50% with the lowest positivity in three dimensions which are the

non-punitive response to errors is 22%, the frequency of event reporting is 23% and hospital hands-offs and transition is 25 %.

Key Words

Patient Safety

Safety Culture

Medical Error

Adverse Event

Learning from Error

Patient Safety Goals

Reporting System

Research Priorities

List of Abbreviations

ACSNI	Advisory Committee on the Safety of Nuclear Installations
AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
FMEA	Failure Modes and Effects Analysis
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NPSA	National Patient Safety Agency
NPSGs	National patient Safety Goals
NRLS	National Reporting and Learning System
OPD	Out Patient Department
OR	Operating Room
RCA	Root Cause Analysis
RFI	Requirement for Improvement
WHO	World Health Organization

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List of Important Definitions

Term	*Definition*
Active failures	Unsafe acts (i.e. errors and violations) committed by those at the human system interface. Staff actions at the "sharp end" of patient care may slips (e.g. picking up wrong syringe), cognitive failures (e.g. memory lapse or misreading of information) and violations (deviation from standard procedures and protocols).
Adverse Event	Unintended injury to a patient resulting from a medical intervention; generally with lesser degree of severity that may be a precursor to a sentinel event.
Clinical Incident	Any event or circumstance which has actually or could potentially, lead to unintended and/or unnecessary mental or physical harm to a patient.
Error	The failure of a planned action to be completed as intended (i.e. error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning).
Error of Commission	Incorrect action, such as wrong drug to wrong patient.
Error of Omission	Failure to act.
Failure Modes and Effects Analysis	A prospective technique, usually taken early in the development of a product that seeks to imaginatively identify potential failures and their effects.
Latent failures	Stem from decisions, essentially made by management and more senior clinicians within the healthcare setting that provide conditions in which unsafe acts may occur (e.g. inadequate

	system of communication, inadequate supervision, understaffing and unworkable procedures.
Near Miss	An incident which could have, but did not, result in harm, either by chance or through timely intervention.
Patient safety	The avoidance and prevention of patient injuries or adverse events resulting from the process of health care delivery.
Patient Safety Solution	Any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.
Root Cause Analysis	A retrospective technique, in which analysis of what went wrong when an adverse event has occurred
Safety Culture	Refers to shared beliefs, attitudes, values and norms of behavior; it is the way things are done around here as well as the ways things are understood, judged and valued. Culture is the foundation for patient safety.
Safety sciences	Refers to the methods by which knowledge of safety is acquired and applied to create high-reliability designs.
Sentinel Event	An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.
Systemic Mindfulness	Refers to focused attention at each level of the health care system on how its functions affect patient safety.
Violation	Deviation from standard procedures and protocols.

Introduction

The assumption of safety in the provision of healthcare is as fundamental as care itself. “First do no harm” is the main phrase we all know and can quote from the Hippocratic Oath taken by physicians. Safety is the most basic dimension of performance necessary for improvement of healthcare quality. It is the underlying reason for risk management, infection control and environmental management program. There has been significant investment in recent years in the improvement of services, the enhancement of the capacity of the system, the recruitment of highly trained professionals and the provision of new technologies and treatments (***Brown, 2004).***

Knowledge about the burden of unsafe care in non-hospital settings, where the majority of health care is delivered is generally not enough. Even more importantly, we have very little evidence about the burden of unsafe care in developing countries where there may be greater risk of patient harm due to the limitations of infrastructure, technology and resources. Patient safety means the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes. Essentially, patient safety is about constantly working to avoid, manage and treat unsafe acts within the healthcare system (***CCHSA, 2008).***

It is estimated that between 44,000 and 98,000 Americans die each year from medical system failure. In Australia, 16% of admissions were associated with adverse events; 51% of these were considered highly preventable ***(Wilson et al., 1995 and Kohn et al., 1999***).

World Health Organization (WHO) defines a patient safety incident as an event that could have resulted, or did result, in unnecessary harm to a patient. Incidents may arise from either intended or unintended acts. An adverse event is an incident that results in harm to a patient. Patient safety is a global issue affecting countries at all levels of development. Although estimates of the size of the problem are scarce, particularly in developing and transitional countries, it is likely that millions of patients worldwide suffer disabilities, injuries or death every year due to unsafe medical care. Health care-associated infections, misdiagnosis, delays in treatment, injury due to the inadequate use of medical devices, and, adverse events due to medication errors, are common causes of preventable harm to patients. Reducing the incidence of patient harm is a matter for everyone in health care and there is much to be learned and shared between developed nations, developing countries and countries in transition ***(WHO, 2009).***

Culture is the foundation for patient safety. Safety culture refers to shared beliefs, attitudes, values and norms of behavior; it is the way things are done around here as well as the ways things are understood, judged and valued (***Guldenmund, 2000).***

Patient safety strategies and plans will not succeed in a culture that does not support the values, attitudes and behaviors necessary for safety. Safety requires new ways of thinking, acting and commitment to see safety as a priority from all levels of the organization (***McKnight and Lee 2001).***

According to the Institute of Medicine (IOM), the biggest challenge to moving toward a safer health system is changing the culture from one blaming individuals for errors to one in which errors are treated not as