Original Research Paper

Management

ASSESSING PATIENT SAFETY CULTURE IN HOSPITALS: FEASIBILITY TRIAL

P.Premkumar	Student, MBA in Hospital Management, Annamalai University, Chithambaram, Tamilnadu, India Corresponding Author
N. Junior Sundresh	Associate Professor of Surgery, Raja Muthiah Medical College, Annamalai University, Chithambaram, Tamilnadu, India

ABSTRACT

Introduction; Patient safety culture is determined by the requirement of understanding of values, attitudes, competences and patterns behavior and focus on organization's care processes and involved workforces.

Aim: This study aimed to examine the extent to which the dimensions of patient safety culture in a tertiary care hospital

Methods: This observational study was conducted in a tertiary care hospital. Structured questionnaire was used to access the safety culture in hospital. Percentages of positive responses were calculated for each item and each dimension.

Results: In our study 51 staffs were answered the questionnaire. 57% of them are Nursing staffs, there are from various departments in the hospital. 81% of positive response for teamwork in safety of the patients in a ward. 80% of responses were about training programs and drills to prevent events during various activities regarding patient's safety. 60% of positive response for the management support and implementation of patient safety measures in the hospital.

Conclusion: patient safety culture within the hospital it is necessary to increase awareness and motivation to participate in further surveys. This survey can be used as a reference value for further patient safety climate surveys within the hospital.

KEYWORDS : patient safety, hospital care, quality culture, quality management, surveys

INTRODUCTION

Patient safety is one of the crucial aspects of quality of healthcare and a determining factor in patients' health and lives. While in developed countries patient safety is now recognized as a top priority in their healthcare systems [1], the medical adverse events still remain as a global challenge and no country has yet overcome all of its patient safety problems [2]. Data from well-funded and technologically advanced hospitals confirm that one in every ten patients admitted to hospitals is affected by an adverse event (incident rate of 10%). The situation is thought to be more challenging in developing countries with higher risk of patient harm due to the limitation of resources and lack of adequate infrastructures [3]. Medical error is unacceptably among the five most common causes of preventable death [4] and millions of patients are hurt each year due to unsafe care practices [5]. The use of effective communication among patients and healthcare professionals is critical for achieving a patient's optimal health outcome. Communication with regards to patient safety can be classified into two categories: prevention of adverse events and responding to adverse events.[6] Use of effective communication can aid in the prevention of adverse events, whereas ineffective communication can contribute to these incidences. If ineffective communication contributes to an adverse event, then better and more effective communication skills must be applied in response to achieve optimal outcomes for the patient's safety. There are different modes in which healthcare professionals can work to optimize the safety of patients which include both verbal and nonverbal communication, as well as the effective use of appropriate communication technologies.[7]

AIM

This study aimed to examine the extent to which the dimensions of patient safety culture in a tertiary care hospital

MATERIALS AND METHODS

This observational study was conducted in a tertiary care hospital. Structured questionnaire was used to access the safety culture in hospital. Percentages of positive responses were calculated for each item and each dimension. Negatively worded items were recoded. The percentages represent the average percentage of positive responses. To obtain the dimension scores, item percent positive scores were computed first and then the scores were averaged, which gives equal weight to each item in a composite. Questionnaires with missing responses on all of the non-demographic items were excluded from the analyses.

RESULTS

In our study 51 staffs were answered the questionnaire. 57% of them are Nursing staffs, there are from various departments in the hospital. 41% of nursing staffs are from Medicine and Surgery departments; where as 12% of them are from Intensive care unit. 10% of doctors were included in the study, they are from various departments. 81% of positive response for teamwork in safety of the patients in a ward. 80% of responses were about training programs and drills to prevent events during various activities regarding patient's safety. 60% of positive response for the management support and implementation of patient safety measures in the hospital.

Table 1 Percentages of sample characteristics: hospitals and staff respondents

Sample Characteristics		Number of Participants	Percentage
Staff position	Nursing staff	29	57%
	Medical staff	5	10%
	Management and administrative staff	5	10%
	Other	12	24%
Work area/unit type	Surgery	7	14%
	Medicine	14	27%
	Intensive care	6	12%
	Radiology	2	4%
	Emergency	3	6%
	Laboratory	1	2%
	Obstetrics	3	6%
	Rehabilitation	1	2%
	Pharmacy	2	4%
	Paediatrics	3	6%
	Psychiatry/mental health	2	4%
	Anaesthesiology	4	8%

Other	3	6%

Table 2 Percentage of safety culture dimension

Safety culture dimensions	Average percentage positive responses
Teamwork within units	81%
Supervisor/manager's expectations and actions promoting patient safety	65%
Organizational learning—continuous improvement	80%
Management support for patient safety	60%
Overall perceptions of patient safety	52%
Feedback and communication about error	44%
Communication openness	40%
Frequency of events reported	31%
Teamwork across units	56%
Staffing	40%
Handoffs and transitions	43%

CONCLUSION

Conducting patient's safety culture to identify opportunities for improvement is an important area for research with potentially useful implications for practice. To show a homogenous picture of a patient safety culture within the hospital it is necessary to increase awareness and motivation to participate in further surveys. This survey can be used as a reference value for further patient safety climate surveys within the hospital.

REFERENCES

1. Aspden P, Corrigan J, Wolcott J. Patient Safety, Achieving a New Standard for Care. Washington, DC: The National Academies Press 2004.
2. WHO. African Partnerships for Patient Safety. Geneva: World Health Organization 2009.
3. WHO. WHO Patient Safety Research. Geneva: World Health Organization 2009.
4. Kohn LT, Corrigan JM, Donaldson MS. To err is human: Building a safer health system. Washington, DC: Institute of Medicine 2000.
5. WHO. Summary of the Evidence on Patient Safety: Implication for Resaerch Geneva: World Health Organization 2008.
6. Frank JR, Brien S (August 2009). "The Safety Competencies - Enhancing Patient Safety Across the Health Professions" (PDF) (first ed.). Canadian Patient Safety Institute. ISBN 978-1-926541-15-0.
7. David Marx. "Patient Safety and the "Just Culture:" A Primer For Health Care Executives" (PDF). University of California Los Angeles. Retrieved 30 October 2014.