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Study of Patient Safety Culture Among Staff at a Tertiary Care Teaching Hospital - A Cross Sectional Study

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Abstract

Focus on patient centred team work is essential in providing quality care through sharing culture of values and principles among the health care professionals. The knowledge, perception and culture of staff need to be understood, assessed and behavioural change is vital in implementing patient safety programme in a hospital.The objective of this study includes the evaluation of knowledge, team work, management support, supervisory skills and event reporting system in the hospital.A Descriptive-cross sectional and questionnaire study was conducted on 49 staff members.77.6% opined that procedures are in place for preventing errors.66.66% felt supervisors are supportive and encouraging.57.20% agreed that there is freedom for discussion and decisions. 59.2% informed that the errors are caught and corrected before incident.83.70% agreed that the tangibles are good for work environment.67.40% agreed that patient safety is the highest priority.58.15% informed that information gap during the shift changes. Constant vigilance and monitoring during shift changes to enhance sharing of information. The reporting of errors should be encouraged and fear of punishment be mitigated. The root causes analysis of events at frequent intervals for preventing further.

Key Words: Patient safety, Errors, Incident reporting, Knowledge.

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Introduction

Patient safety is to protect the patients from errors,injuries,accidents,infections etc., during patient diagnosis, treatment and management in the hospital setting. As many as 4,40,000 people die every year from preventable hospital errors.[1] All the stake-holders who are involved in the patient care should understand the factors responsible and act on identifying the root causes and prevent further to classify as variants,near miss and to prevent events.[2] The initiative required by the practising hospital administrators with top management support is to assess the status of the issue by assessing the knowledge among the staff and the incident reporting system in the hospital.[3,4] To assess the knowledge on patient safety and incident reporting system among the staff.[5,6] The objectives of the present study were: (1) To understand the knowledge level among staff; (2) To evaluate the reporting system of the incidents; (3) To draw inferences and make recommendations accordingly.

Methodology

A cross-sectional and patient safety questionnaire based study was conducted on 49 employees of Private Medical College & Hospital, during the month of June, 2019. Agency for healthcare research and quality (AHRQ) questionnaire on patient safety culture taken in this study. Approval taken from the institutional ethics committee. Consent has been taken from staff before collection of questionnaire (Annexure Table 1). The investigator being medical administrator trained in basic research methodology has followed.The data has beenprepared and analyzedby usingMS-Excel to draw conclusions and recommendations.7

Results and Discussion

The results were divided into seven sections i.e. section A to section G and this study was conducted

on work area/unit (Section-A), Focuses on the supervisory style (Section-B), Communication programme on patient safety (Section-C), frequency of events reported (Section-D), About Your Hospital (Section-E), Number of events reported (Section-E) and patient safety grade (Section-G).

Table 1: Hospital Survey on patient safety Section-A

Section-A	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Q1	4 (8.2%)	4 (8.2%)	4 (8.2%)	33 (67.2%)	4 (8.2%)
Q2	5 (10.2%)	18 (36.7%)	7 (14.3%)	18 (36.7%)	1 (2.0%)
Q3	0 (0.0%)	8 (16.3%)	9 (18.4%)	24 (49.0%)	8 (16.3%)
Q4	3 (6.1%)	1 (2.0%)	7 (14.3%)	28 (57.1%)	10 (20.4%)
Q5	3 (6.1%)	3 (6.1%)	4 (8.2%)	23 (46.9%)	16 (32.7%)
Q6	2 (4.1%)	19 (38.38%)	13 (26.5%)	13 (26.5%)	2 (4.1%)
Q7	2 (4.1%)	8 (16.3%)	16 (32.7%)	20 (40.8%)	3 (6.1%)
Q8	1 (2.0%)	12 (24.5%)	8 (16.3%)	28 (57.1%)	0 (0.0%)
Q9	4 (8.2%)	13 (26.5%)	8 (16.3%)	23 (46.9%)	1 (2.0%)
Q10	1 (2.0%)	2 (4.1%)	5 (10.2%)	28 (57.1%)	13 (26.5%)

Q1, Q3, Q4, and Q5:- 55.05% agreed that peoples support each other

Q2: 1/3rd of sample perceived that staffs are sufficient, whereas another 1/3rd of sample perceived that staffs are inadequate may lead to error.

Q7: 40.8% agreed that they are working in crisis mode

Q8: 57.1% Agreed that patient safety is never sacrificed against to get more work done

Q9: 46.9% agreed that staff worry that mistakes they make are kept in their personal files.

Section A: -Work area/Unit

Patient safety requires a team approach to safeguard the patient through implementing protocol. The supervision and coordination by the treating is essential part of care. The co-operation among the staff determines the ultimate efficiency of the total team.

Q10: 77.6% agreed that procedure and systems are good from preventing the errors.

Section B:-Your Supervisor

Focuses on the supervisory style and skill of the team leader i.e., the departmental head or unit head or nursing supervisor. Patient safety should be treated as an important aspect of care which needs constant supervision and supporting the staff in monitoring the reporting system of incidence and taking appropriate action for quality improvement.

Table 2: Hospital Survey on patient safety Section-B.

Section-B	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Q1	1 (2.0%)	2 (4.1%)	7 (14.3%)	34 (69.4%)	5 (10.2%)
Q2	2 (4.1%)	1 (2.0%)	5 (10.2%)	33 (67.2%)	8 (16.3%)
Q3	1 (2.0%)	8 (16.3%)	5 (10.2%)	31 (63.3%)	4 (8.2%)

Table 3: Hospital Survey on patient safety Section-C.

Section-C	Never	Rarely	Sometimes	Most of times	Always
Q1	1 (2.0%)	10 (20.4%)	17 (34.7%)	9 (18.4%)	12 (24.5%)
Q2	14 (28.6%)	8 (16.3%)	17 (34.7%)	7 (14.3%)	3 (6.1%)
Q3	1 (2.0%)	5 (10.2%)	20 (40.8%)	10 (20.4%)	13 (26.5%)
Q4	2 (4.1%)	10 (20.4%)	9 (18.4%)	21 (42.9%)	7 (14.3%)
Q5	3 (6.1%)	5 (10.2%)	18 (36.7%)	6 (12.2%)	17 (34.7%)

Q1, Q2, Q3:- 66.66% overall agreed that subordinates were felt that the supervisor are supportive and encouraging and respect their suggestions about patient safety.

Section C:-Communication

Communication is said to be vital part in patient safety programme. This studies indicate the communication errors are one of the reasons leading to errors. The information and communication channels in the clinical areas with the supportive services like laboratory, radiology and pharmacy etc., were identified to ensure patient safety.

Q1-Information about changes-38% sometimes agreed. Q2-Freedom for communication-34.7% sometimes agreed. Q3-Information about errors-46.9% sometimes agreed

Q4-Free to question the decisions-57.20% most of the times agreed

Q5-Ways to prevent errors-46.9% always agreed

Section D:-First do no harm is the objective of all members of health care team. Even though, to err is human the incidence whether near miss or event has to be documented, reported, and discussed for root cause analysis. The objective is not punitive action but only for learning from mistakes and preventing further. The quantity (no) and quality (type) of incidence should be reported to the concerned authorities at appropriate schedule times.

Table 4: Hospital Survey on patient safety Section-D.

Section-D	Never	Rarely	Sometimes	Most of times	Always
Q1	8 (16.3%)	10 (20.4%)	19 (38.8%)	5 (10.2%)	7 (14.3%)
Q2	2 (4.1%)	21 (42.9%)	10 (20.4%)	11 (22.4%)	5 (10.2%)
Q3	10 (20.4%)	17 (34.7%)	8 (16.3%)	7 (14.3%)	7 (14.3%)

Q1-59.2%-caught and corrected before affecting the patient

Q2-63.3% (rarely, sometimes),32.6%(most of the time, always)-No potential to harm the patients.

Q3-50% (rarely, sometimes), 28.6%(most of the time, always)-Could harm the patient

Section E: - The tangibles/Environment/ Infrastructure.

The physical infrastructure, Equipment and the management should ensure a comfortable environment for all categories of staff.

Table 5: Hospital Survey on patient safety Section-E.

Section-E	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Q1	2 (4.1%)	1 (2.0%)	5 (10.2%)	29 (59.2%)	12 (24.5%)
Q2	2 (4.1%)	22 (44.9%)	7 (14.3%)	16 (32.7%)	2 (4.1%)
Q3	2 (4.1%)	4 (8.2%)	5 (10.2%)	22 (44.9%)	16 (32.7%)
Q4	1 (2.0%)	9 (18.4%)	14 (28.6%)	23 (46.9%)	2 (4.1%)
Q5	3 (6.1%)	6 (12.2%)	23 (46.9%)	15 (30.6%)	2 (4.1%)
Q6	4 (8.2%)	6 (12.2%)	6 (12.2%)	19 (38.8%)	14 (28.6%)
Q7	6 (12.2%)	7 (14.3%)	7 (14.3%)	22 (44.9%)	7 (14.3%)
Q8	2 (4.1%)	1 (2.0%)	5 (10.2%)	27 (55.1%)	14 (28.6%)
Q9	3 (6.1%)	20 (40.8%)	14 (28.6%)	6 (12.2%)	6 (12.2%)

Q1- 83.7% (Agree, strongly agree)-Agreed to strongly agree that hospital work climate is good.

Q2- 44.9% Agreed that hospital units co-ordinates well.

Q3- 77.6% agreed that good cooperation.

Q4, Q9-58.15% Agreed that information lost during shift changes

Q6-67.4%-Agreed patient safety is the top priority

Q7-59.2%-opined that hospital management shows interest after the incident(knee jerk reaction) followed by to prevent further incident.

Section F:-

38.8% informed that 1 to 2 event reports

Table 6: Hospital Survey on patient safety Section-F.

Section-F	No event reports	1-2 event reports	3-5 event reports	6-10 event reports	11-20 event reports
Q1	16 (32.7%)	19 (38.8%)	3 (6.1%)	5 (10.2%)	6 (12.2%)

Section G:-Overall grade of hospital

Table : Hospital Survey on patient safety Section-G.

Section-G	Excellent	Very Good	Acceptable	Poor	Very Poor
Q1	5 (10.2%)	27 (55.1%)	16 (32.7%)	0 (0.0%)	1 (2.0%)

98%-Felt overall patient safety is maintained. 2% felt, it is poor

Conclusions and Recommendations

83.70% of the sample agreed that the tangibles are facilitating working environment. 77.60% opined policies and procedures are in place for preventing errors. Two thirds of staff opined that supervisor or unit heads are supportive and allowed for their input for decision making.59.20 % informed that the errors are caught before incident happens. Rest of them opined there is scope to enhance systems in place to identify, monitor and reporting errors.

One third of staff opined the staff; patient ratio and work load impedes the process .the documentation and reporting the incidents is about 2 to 3 in each area. 58.15% agreed that sharing information during shift changes is adequate.

Constant vigilance and monitoring by the supervisors especially during shift changes to enhance the sharing of information .The reporting of errors should be encouraged and fears of punishments are mitigated. The Root cause analysis of events at frequent intervals for preventing further.

Limitations of the Study

Any questionnaire study will have subjective bias and the opinion/perception depends on the individual knowledge, experience and education background.

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References

1. James JT. A new, evidence-based estimate of patient harms associated with hospital care. J Patient Saf. 2013 Sep;9(3):122-8.
2. Iqbal U, Syed-Abdul S, Li YC. Improving quality of care and patient safety as a priority. International Journal for Quality in Health Care, 2015; 27(5):335.
3. Parand A, Dopson S, Renz A, Vincent C. The role of hospital managers in quality and patient safety: a systematic review. BMJ open. 2014 Sep 1;4(9):e005055.
4. Mahajan RP. Critical incident reporting and learning. British journal of anaesthesia. 2010 Jul 1;105(1):69-75.
5. Lawati MH, Dennis S, Short SD, Abdulhadi NN. Patient safety and safety culture in primary health care: a systematic review. BMC family practice. 2018 Dec;19(1):104.
6. Stavrianopoulos T. The Development of Patient Safety Culture. Health Science Journal. 2012 Apr 1;6(2).
7. AHRQ Hospital Survey on Patient Safety Culture: User's Guide, http://www.ahrq.gov by: Westat, Rockville et al.