

Patient safety in a hospital - research



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Attitudes toward incident reporting. Attitudes and perceived barriers to incident reporting among tertiary level health professionals were researched by Malik, Alam, Mir, & Abbas (2010) to address the limited incident reporting framework in Pakistan. A random sample of 217 doctors and nurses in Shifa International Hospitals were given a modified version of the AHRQ's questionnaire to determine various factors that influence health professionals' reporting behaviors, with an important focus of the study on barriers to incident reporting. Results of the study found that only 20% of house officers are willing to report, and greater than 95% of consultants, registrars, medical officers, and nurses are willing to report incidents related to them. 'Administration sanction' was identified as a common barrier among doctors (69%) and nurses (67%). Additionally, reporting to the head of the department was preferred by doctors (60%) and nurses (80%). Based on the study's findings, the researchers suggest that implementation of future incident reporting systems should consider supportive work environments, prompt feedback, and immunity from administration (Malik, Alam, Mir, & Abbas, 2010).

Intensive Care Unit Registered Nurses' perceptions of patient safety climate and potential predictors for patient safety perception and incident reporting were explored in a cross-sectional study by Ballangrud, Hedelin, & Hall-Lord (2012). In ten ICUs in six hospitals in Norway, 220 nurses (72%) responded to the questionnaire, The Hospital Survey on Patient Safety Culture. The questionnaire measured seven unit level and three hospital level patient safety climate dimensions, along with two outcome items. Of the 12 dimensions, 7 achieved a RN proportion of positive scores (over 55%), and 5

achieved a lower proportion. Among types of units and between hospitals, significant differences in RNs' perceptions of patient safety were found. Unit level variables were found to have had significant impact on the outcome dimensions, "overall perception of safety" and "frequency of incident reporting," in which both had a 32% total variance. However, among the outcome variables, differences were found in positive scores on "overall perception of safety" (69%) and "frequency of incident reporting" (18%). In all dimensions, the total average of positive scores was 55%. This study concluded that patient safety climate was most positive among ICU RNs at the unit level, and areas for improvement include: "incident reporting, feedback and communication about errors, and organizational learning and continuous improvement" (p. 352). This study identifies several limitations. In contrast to other Norwegian HSPOSC studies, which included various health care professionals, this study's sample only included RNs. Additionally, generalizability is limited since the hospitals in this study were small and within a limited area of Norway. Another limitation to this study that may have impacted the results was the known implementation of reorganization across units that were to occur after data collection.

Perceptions of patient safety culture. In China, healthcare workers' attitudes and perceptions of patient safety culture were explored using a modified version of the Hospital Survey on Patient Safety Culture (HSPSC), which measured 10 patient safety culture dimensions. Out of the 1500 questionnaires that were distributed to primarily internal physicians and nurses among 32 hospitals in China, valid responses were received from 1160 health care workers. Statistical analysis was done using SPSS 17.0 and

Microsoft Excel 2007, including descriptive statistics, along with analysis of the survey's validity and reliability. Two separate investigators entered and verified data independently. For each item, results included a positive response rate range of 36% to 89%. On 5 dimensions (Teamwork Within Units, Organization Learning-Continuous Improvement, Communication Openness, Non-punitive Response and Teamwork Across Units), the positive response rate was higher when compared to AHRQ data ($P < 0.05$). Overall, a positive attitude towards patient safety culture within organizations was found among the surveyed health care workers in China. Based on their findings, the researchers emphasized, "the differences between China and the US in patient safety culture suggests that cultural uniqueness should be taken into consideration whenever safety culture measurement tools are applied in different culture settings" (Nie, Mao, Cui, He, Li, & Zhang, 2013, p. 228). Several strengths and limitations were noted. This study had a relatively high response rate of 77%. Additionally, this study is different from other published Chinese studies in that it was conducted among different cities in different hospitals in China, and surveyed different health care workers as opposed to those that focused only on nurses or assessment of the scale of the HSPSC. However, the survey was modified, with deletion of 13 original items, potentially changing the framework of the original patient safety culture survey. Also, limited representation of hospital management in the sample may provide an incomplete picture of patient safety culture in China.

In a research study among 42 Taiwan hospitals, the HSOPSC questionnaire was used by Chen & Li (2010) to examine the 12 patient safety culture

dimensions. A total of 788 physicians, nurses, and non-clinical staff completed the survey. Statistical analysis was done using SPSS 15.0 for Windows and Amos 7 software tools. Positive perceptions were found toward patient safety culture among Taiwan hospital staff, in which percentage of positive response rates were highest among “teamwork within units,” and lowest in the “staffing” dimension. Taiwan and the US differed in the following three dimensions: “Feedback and communication about error”, “Communication openness”, and “Frequency of event reporting”. Several strengths and weaknesses were identified in this study. When compared to the original AHRQ database, which included large samples in various health care organizations, this study’s data had a lower internal consistency. The use of the HSOPSC questionnaire is both a strength and limitation in this study. Although the HSOPSC’s strong psychometric properties and broad safety culture coverage are considered strengths, the use of this questionnaire in Taiwan is also a limitation of this study because of its use in a cultural setting different from where it was developed. However, it is important to note that the application of the HSOPSC in Taiwan was found to be a good fit according to most of the confirmatory factor analysis indices. Based on their findings, Chen & Li (2010) point out that, “the existence of discrepancies between the US data and the Taiwanese data suggest that cultural uniqueness should be taken into consideration whenever safety culture measurement tools are applied in different cultural settings” (p. 1). Not only is future research recommended to expand the survey in Taiwan, but also to consider measurements that will decipher individual and group perceptions and interactions related to patient safety culture.