Department of Pharmacy
National Center for Cancer Care and Research (NCCCR) & Heart hospital (HH)

Employee Perceptions of Patients Safety Culture in the National Center for Cancer Care and Research (NCCCR) and Heart Hospital (HH)

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Problem

770,000 patients' injuries and as many as 44,000 deaths happen in hospitals each year as a result of preventable adverse drug events [1]. Considering the high cost of medical errors in terms of human lives, loss of trust in the health care system, patient safety has become a major focus for most healthcare institutions. Several studies associate a positive culture with improved reporting of medication incidents; however , incident reporting rates in NCCCR and HH are less than adequate which deprives the management in both hospitals of the necessary information to identify error prone processes and develop the appropriate improvement strategies. Mistakes can best be prevented by designing the health system at all levels to make it safer which emphasizes the imperative to shift the focus towards systems and processes rather than individuals. This requires a dramatic change in the way healthcare organizations handle medical events.

Aim

- To assess staff perceptions of organizational culture of safety in, the National Centre for Cancer Centre and Research (NCCCR), and Heart Hospital (HH) to help the management develop focused strategies for improvement.
- Develop baseline data of the current level of safety culture in both hospitals for future reference and tracking of the impact of the improvement interventions over time.

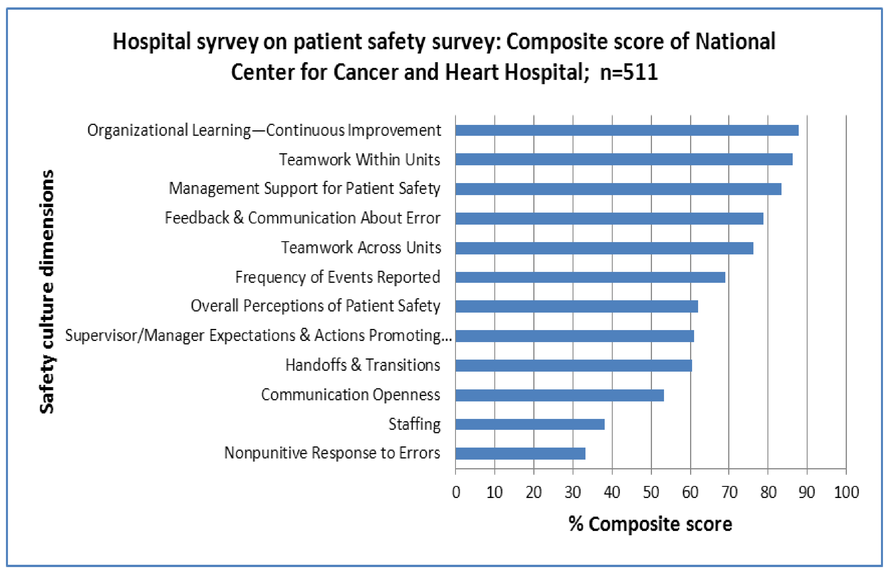
Interventions

A cross sectional study was designed for all healthcare providers and clinical administrators at HH and NCCCR. The survey was conducted using a piloted and validated questionnaire on July, 2012 over six week period of time. The questionnaire consists of 8 parts: eighteen statements regarding the respondent work area, four statements regarding the respondents supervisors, six communication statements, three statements about frequency of events reported, one statement regarding the respondents agreement towards the patient safety grade, eleven statements about the hospital, one statement about the number of events reported and background information. Data analyzed by SPSS version20 using descriptive analysis.

Results

A total of 511 staff members participated in the survey; 64% (n=327) from HH, and 36% (n=184) from NCCCR. The majority of participants were nurses 66.3% (n=339), followed by pharmacists 9.4% (n=48), administrative staff 4.5% (n=23), technicians 3.5% (n=18), physicians 2.9% (n=15) and the rest of the respondents were in other positions. Approximately 400 (78.2%) of the participants have been working between 1-10 years in their current hospitals. Majority of the respondents (n=469; 91.8%) worked between 40 to 59 hours per week). More than one-third (n=188; 36.8%) of the respondents reported that they have not filled out and submitted any event reports in the past 12 months, while around half (n=257; 50.3%) have filled out and submitted between 1-5 event reports.
[Figure 1]

Figure 1



Conclusion:

The data indicate that, staff is comfortable with organizational learning and quality improvement, team work, and management's commitment to patient safety, however; it reveals also some potential areas for improvement;

- Non-punitive response to errors and communication openness , both of which imply a predominance of a name and blame culture, as perceived by participants.
- Staffing levels

Next steps

Develop and implement improvement strategies and repeat the same survey after twelve months to assess the impact they had on organizational culture of safety.

References

1. The Institute of Medicine (IOM), To Err is Human: Building A Safer Health System, November 1999

Middle East forum on Quality Improvement in Health Care- Doha, Qatar, April, 2014