

**A STUDY ON ASSESSMENT OF PATIENT SAFETY CULTURE IN
ADITYA BIRLA MEMORIAL HOSPITAL.**

Dissertation Submitted to



The IIHMR University, Jaipur

For the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

by

Dr. Koyal Kela

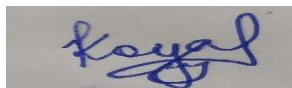
Under the Supervision and Guidance of

Dr. Daya Krishan Mangal
Professor, IIHMR

2022

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **A study on assessment of patient safety culture in Aditya Birla Memorial Hospital** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.



Name of Student: Dr. Koyal Kela

Date: 01/07/2021



Ref. No. : ABMH/Academics/Internship/038
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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. Koyal Kela**, has successfully completed her **03 months** Internship at **Aditya Birla Memorial Hospital, Pune** in **Human Resource Department** from **28th March 2022 to 25th June 2022**.

During her tenure, she has been hardworking, sincere and eager to learn.
We wish her "All the Best" in her future endeavor.

For Aditya Birla Health Services Pvt. Ltd.



Dr. Sati Nath Mohanty
Director,
Anesthesiology & Academics
DR. SATI NATH MOHANTY
MBBS, MD (ANAESTHESIA), FCCP, FICA, FIPM
DIRECTOR, ANAESTHESIOLOGY &
ACADEMICS
REG. NO. : 2019030891
ADITYA BIRLA HEALTH SERVICES PVT. LTD.
CHINCHWAD, PUNE-411 033.



Ramesh Kumar Dixit
Deputy General Manager-HR



ADITYA BIRLA HEALTH SERVICES PRIVATE LIMITED
MAHARASHTRA'S FIRST JCI AND NABH ACCREDITED HOSPITAL
Aditya Birla Hospital Marg, P.O. Chinchwad, Pune - 411 033, Tel. : +91-20-30717500 to 04
Fax No. +91-20-30717755 For Emergency Call +91-20-30717777
CIN:U85199PN2001PTC019881, Email: healthcare@adityabirla.com, Web: www.adityabirlahospital.com



CERTIFICATE

This is to certify that **Dr. Koyal Kela** has undertaken the research work on "**A study on assessment of patient safety culture in Aditya Birla Memorial Hospital**" in partial fulfillment of the requirements for the award of the degree of **MBA (Hospital and Health Management)** from the **IIHMR University, Jaipur**. She did the study under my guidance and supervision, and her approach to the research study was sincere, scientific, and analytical.

Faculty Guide
IIHMR University, Jaipur

Date

School Dean
IIHMR University, Jaipur

Date

ABSTRACT

- **Study objectives:** Patient safety is becoming a crucial component of medical care and global concern and understanding the values, beliefs, and conventions about what matters in an organization and what qualities and behaviours are connected to patient safety and appropriate for establishing a safety culture. This survey aimed to find out how ABMH staff members feel about the patient safety culture.
- **Methodology:** A descriptive cross-sectional survey was conducted among 300 staff members, including doctors, nurses, and paramedical staff and support services selected by using the purposive sampling technique. The Agency for Healthcare Research and Quality's (AHRQ) 2019 paper-based Hospital Survey Patient Safety Culture Questionnaire (Version 2.0) was used to collect data.
- **Key results:** There were 300 participants in the survey, with the majority (49.33%) being nurses (n= 148), doctors (n= 50), technicians (n= 52), and others (n= 50), such as pharmacists, dieticians, and patient service personnel. The total response rate was 71.87 %. Staffing, which relates to insufficient personnel strength hurting patient care, received the lowest percentage of positive responses (45.08 %), while the dimension teamwork received the greatest percentage of positive responses (85.25 %).
- **Conclusion:** Instilling patient safety cultures among all staff members involved in healthcare delivery is of utmost importance since patient safety is a priority for every healthcare facility on moral and legal grounds. The study's findings showed that although there is a strong sense of teamwork among the units, ICU staffing has to be improved since healthcare personnel is overworked owing to a staffing shortfall. Holding routine interdisciplinary focused group meetings and staff training sessions, patient safety culture simulation exercises, and bolstering awareness campaigns for the blame-free, online, and handwritten error reporting system, are just a few strategies that can improve outcomes in these weaker dimensions.
- **Keywords:** Patient safety, Patient safety culture, AHRQ, Hospital survey

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To develop professionalism in personality, practical experience plays a leading role, and this experience I will cherish for my lifetime.

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Dr. Koyal Kela

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ABBREVIATIONS

HCP	Healthcare Providers
AHRQ	Agency for Healthcare Research and Quality
HSOPSC	Hospital Survey on Patient Safety Culture
ABMH	Aditya Birla Memorial Hospital
PSC	Patient safety culture
ICU	Intensive care units
OT	Operation theatres

CHAPTER 1: INTRODUCTION

A critical element of the quality of healthcare is patient safety. Hospitals and other healthcare institutions work hard to make improvements. This has led to a growing recognition of the organization so that one can expect and get sustainable patient safety in their organization. Understanding the values, beliefs, and conventions about what matters in an organization and what qualities and actions connected to patient safety are expected and appropriate are necessary for establishing a culture of safety.

In healthcare, the protection of patients (clients), as well as healthcare providers (HCPs) is referred to as patient safety. The reporting, investigation, and avoidance of medical errors which commonly have negative health outcomes are the focus of patient safety. For a hospital to assess the state of their patient safety culture and address areas of weakness, patient safety is essential.⁽²⁾

Providing safe patient care serves to minimize mortality, morbidity, hospital stay length, and expense. Patient safety, defined as the prevention of harm caused by medical mistakes, is strongly connected to HCP attitudes, with those who have more positive attitudes achieving greater levels of patient safety. Healthcare organizations should develop operational processes and procedures that lessen the risk of errors and enhance the possibility of avoiding them before they happen in order to preserve patient safety.⁽²⁾

The commitment to, and style and competency of, a company's health and safety management are determined by individual and group beliefs, attitudes, perceptions, skills, and patterns of behavior. This is how an organization creates its safety culture. The psychological, behavioral, and situational components of a company's safety culture are all interconnected. The psychological components of the organization are concerned with "how people feel" about the safety environment and safety management systems, which include their beliefs, attitudes, values, and perceptions. Individuals and groups at all levels are involved in these psychological factors. Individuals' perceptions of their social milieu inside the company influence the safety climate, which has an impact on their psychological well-being. An organizational commitment occurs when individuals of an organization have similar insights of an event or an environment.⁽⁴⁾

The behavioral part of safety culture is concerned with "what individuals do" in the workplace. This category includes safety-related practices like cleaning your hands

before treating a patient. The universal standards for patient care's operational guidelines, management communications, and workflow systems are situational characteristics of a company's culture, and they are "what the organization has."⁽⁴⁾ Communication within organizations with a strong safety culture is based on mutual trust, a common understanding of how important safety is, and assurance in the effectiveness of preventative measures.

Safety culture in the organizations take care of patient safety which includes not only medical errors (Judgemental, diagnostic, prescribing, administration, etc) but also overall safety aspects like – Physical safety, fire safety, accidents, patient handling error, and error reporting. This has a positive impact on the overall organizational climate and culture too. It fosters the branding of the organization, its credibility in the market and society, and employee satisfaction.

Patient safety has grown to be a crucial component of medical treatment and global concern, and many nations have worked hard to address associated challenges. According to several medical error studies, one out of every 10 patients is harmed while receiving hospital care. "According to worldwide surveys, the rate of adverse events ranged from 3.2 to 16.2 per 100 hospital admissions. The rate of adverse events affecting patients varies by state- in the United States, it ranges from 3.2 percent to 5.4 percent, 11.7 percent in the United Kingdom, 9 percent in Denmark, and an estimated 13 percent of patients in India." Not just between hospitals, but also within institutions, there were considerable differences in safety culture. ^(1,3)

Staff time and resources must be committed to implement a safety culture evaluation. New tools for patient safety enhancement include safety culture assessments. These methods may be used to plan and assess safety improvement actions in healthcare organizations as to quantify organisational variables that result in adverse events and patient damage. They give a mechanism to measure implicit understandings of "the way we do things around here" and make them visible so that they may be used as a basis for change. Even in the same medical setting (e.g., divisions, operating rooms, and labs), physicians and nurses may experience distinct duties and obstacles in practice, and their attitudes toward patient safety fluctuate based on the specific events they encounter. As a result, it's crucial to know what different hospital staff members think about patient safety. Thus, surveys using validated questionnaires are frequently used to assess PSC.

⁽⁵⁾ In 2019, the United States "Agency for Healthcare Research and Quality (AHRQ)" updated the older version of the "Hospital Survey on Patient Safety Culture (HSOPSC)" which was developed in 2004 -to Version 2.0 (2019) which has been validated for use.
(13)

Even though patient safety is a major issue in the provision of healthcare, there are limited research on this topic, particularly in developing nations like India. Because there is a scarcity of information on this topic, this study was designed to investigate how employees perceive patient safety culture. This study aims to evaluate the patient safety culture among the employees of Aditya Birla Memorial Hospital in Pune, Maharashtra.

1.1– RATIONALE:

A healthcare organization's commitment to continuous improvement of patient care should be a top focus. As most adverse events are avoidable, the long-standing concept of 'First do no harm' should serve as the cornerstone of nursing and medical care. The importance of a patient safety culture in reducing disputes and improving patient safety has been demonstrated in several studies. The first stage in identifying and explaining a logical safety culture is to examine patient safety culture in hospitals. India currently lacks a regulated structure for medical error prevention and required reporting. Patient safety is a key concern in healthcare delivery, and it is a widespread problem in all health centers. ⁽²⁾

In India, there are minimal studies concerning patient safety culture. As a result, the rationale of this research is to learn about the patient safety culture at ABMH and to focus on improving patient safety-related factors.

1.2– AIM: To evaluate the organization's present patient safety culture and recommend further improvements from the perspective of patients, employees, and management.

1.3 - OBJECTIVES:

- Using the Hospital Survey on Patient Safety Culture Questionnaire, assess the patient safety culture among several categories of hospital employees.
- To compare the cultural variations in patient safety among diverse hospital employees.
- To examine the disparities in the staffing levels of intensive care units and other units in the composite response rate.

CHAPTER 2: REVIEW OF LITERATURE

Authors (Year)	Study location	Sample size	Sampling techniques	Salient features
1. Michael D et al. (2021) ^[12]	Tertiary Care Hospital, Kerela	A total of 174 people, including 14 physicians and 160 nurses, took part in the study. (Cross- Sectional descriptive study)	Convenience sampling	• The primary objective of the study was to assess the state of the patient safety culture in a tertiary care facility in southern India. • Over a month was spent doing the study in a tertiary centre hospital in south India. The information was gathered using an AHRQ (Agency for Healthcare Research -Version 1.0) survey on patient safety culture. • The average percentage of unit/department patient protection is 91.03 percent, according to the results. • The organization has a solid organizational learning, Feedback, and communication structure, as well as effective coordination inside and between units, according to the findings. • The survey did,

				however, uncover flaws in staffing and the nonpunitive attitude to mistakes.
2. Ealamurugan E et al. (2015) ^[6]	Tertiary care hospital, Puducherry	A total of 141 nurses were randomly chosen for the study.	Random Sampling method	• This study's objective was to learn how nurses felt about the safety culture in each of their workplaces. • The Hospital Survey on Patient Safety Culture Questionnaire (Version 1.0), produced by AHRQ, was used to gather information on the safety culture among nurses. • Teamwork within units was evaluated as being of the utmost importance by nurses in the survey (80.2%), followed by supervisor conduct that promoted patient safety (74.7%), while nonpunitive reaction to mistakes was assessed as being of the least importance (42.7 %).

3. Meena KS et al. (2021). ^[2]	AIIMS, Bhubaneswar, which is a tertiary care institution.	A descriptive study design was chosen as the best way; 380 participants, including physicians, nursing officers, and other technical professionals.	Convenience sampling	• Data was collected using the AHRQ-developed Hospital Survey on Patient Safety Culture Questionnaire (Version 1.0). • The composite response rate was 57.37 percent on average. The dimensions of unit teamwork, organizational learning, and feedback and communication error had the highest percentages of favorable replies, with 81.25 percent, 79.91 percent, and 70.61 percent, respectively. • With favorable answers of 15.06 %, 41.64 %, and 18.77 %, respectively, the staffing characteristics related to patient safety, handoffs and transitions, and nonpunitive response error had the least positive replies.
4. Stoyanova R et al. (2021) ^[5]	The survey was organized in 50 out of a total of 346 multispecialty private or public hospitals	A countrywide cross-sectional survey of 384 HCPs (B-HSOPSC) was performed.	In the chosen 28 units, there were around 5,300 medical personnel. For sample selection, a snowball sampling	• The survey was conducted using an online version of the Hospital Survey on Patient Safety Culture (Version 1.0) created by the AHRQ.

	were randomly selected from all 28 administrative areas in Bulgaria.	The physicians represented 37.50% (144) of the sample and other HCPs 62.50% (240).	approach was utilized.	• The categories "Staffing" and "Nonpunitive response to the mistake," which had the lowest percentage of positive response rates (PRRs), were the most troublesome. • In both physicians and other HCPs, however, "Handoffs and transitions" and "Supervisor/manager expectations and actions supporting safety" had the highest mean values. Also, 76.0 percent of all participants have never reported an unpleasant event or mistake.
5. Dr Ennas Chowdhary et al. ^[7] (2020)	Tertiary Care Hospital, Srinagar	The study included 780 participants, the majority of whom (56.4%) (n=440) were physicians, followed by 307 nurses, and 33 technicians.	Convenience sampling	• Inpatient areas, ICUs, OTs, and the Emergency Department were all subjected to a one-year prospective study. The study included doctors, nurses, and technicians working in this unit. • The Agency for Healthcare Study and Quality's (AHRQ) patient safety culture questionnaire, Version 1.0, was used as a research

				tool. • The most positive response (77.3%) was given to the departmental teamwork component. This was followed by a positive (76.1%) rating for organisational learning-continuous development and a negative (34.6%) rating for staffing. • 42.8 percent of participants said their work unit's dimension patient safety score was very excellent, and 84.5 percent said there had been no incidents in the previous 12 months.
6. Goyal RC et al. (2018) ^[8]	AVB Rural Hospital, Wardha, Maharashtra	Initially, 200 hospital employees were included in the study. However, the study's final sample/study participants were 156 employees who filled out the proforma completely.	Convenience sampling	• To ensure that a wide range of job categories and hospital units were represented, the study participants were hospital personnel, including doctors, nurses, and attendants who worked in a variety of clinical work areas/units, including various critical care units. • The Agency for Healthcare Research and Quality (AHRQ)-Version 1.0

				validated Hospital Survey on Patient Safety Culture (HSOPSC) instrument was utilised as an evaluation tool. • For the component of safety culture at the unit level, organisational learning and continuous improvement received the highest overall composite score of favourable comments (67 percent). • Only 48% of survey participants agreed that Feedback and communication regarding errors was important. The dimension "Teamwork across Hospital Units" had a response rate of 62% for the hospital-wide dimensions, while the score for the dimension "Hospital Handoffs & Transitions" was 55 %.
7. Rajalatchumi A et al. (2018) ^[3]	Jawaharlal Institute of Post Graduate Medical Education and Research, Puducherry, India	Out of the 421 front-line HCPs that were randomly chosen, 386 (doctors, nurses, pharmacists,	Using a computer-generated random number, staff members from various cadres were fairly chosen	• The Agency for Healthcare Study Quality in the United States developed the Hospital Survey on Patient Safety Culture (HSOPSC)-

		and operating room technicians) completed the questionnaire and participated in the study.	to take part in the study (proportionate stratified random sampling).	Version 1.0 to investigate research participants' impressions of patient safety culture. • 58 percent of the institute's HCP gave the patient safety culture an overall good evaluation. The characteristics of "unit collaboration," "organizational learning and continuous development," and "supervisor or officer-in-charge expectations" had the most favorable answers, with 80.1 percent, 77.8 percent, and 71.5 percent, respectively, responding positively. • The characteristics of "handoffs," "number of occurrences reported," and "communication openness" had the least favorable replies, with 41.8 percent, 41.2 percent, and 40.8 percent, respectively, of positive responses.
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8. Alqattan H et al. (2018) ^[9]	Secondary care setting, Kuwait	• The response rate was 75.2 percent (1008 out of 1340 questionnaires delivered) . The bulk of respondents (60.1 percent) were nursing staff, followed by technicians (22.3 percent), and doctors (22.3 percent) The remaining 4% of respondents were employed as pharmacists (7.2%), dietitians (2%), office workers (1.2%), administrators and managers (1.1%), physical therapists (0.8%),	Samples from all levels of employees, from front-line care providers (nurses and physicians) through support services such as pharmacy, nursing, labs, and diagnostic imaging, as well as management, including directors and department heads were taken.	• The cross-sectional questionnaire survey was carried out in Kuwait's main hospital medical division. • To compare their findings with those from the other Gulf States in particular, they devised a method that would enable them to compare findings across contexts. Patient safety culture has been evaluated using data from the Arabian Hospital Survey on Patient Safety Culture (HSOPSC). • To find patient safety culture determinants, researchers utilized multiple linear regression analyses. To analyze the differences between participants' overall scores and the scores they earned in each dimension, grouped by nationality, an ANOVA and a Kruskal Wallis test were used. • Staffing, communication transparency, and nonpunitive reactions to errors
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		and other jobs.		were named as the three main areas for patient safety culture reform. Unit collaboration and organizational learning with continuous development were noted as strong points. Kuwaiti and Gulf State respondents showed a worse impression of the hospital's patient safety culture compared to Asian respondents. The respondents' countries of origin, occupations, age, and attendance at patient safety courses/lectures were all strongly connected with their evaluations of the hospital's patient safety culture, according to regression analysis.
9. Rao MV et al. (2014)^[10]	Teaching Hospital (Kamineni Institute of Medical Sciences), Telangana.	It was pilot research so 90 participants (20%) were covered.	Convenience sampling.	• To assess the levels of patient safety awareness among chosen hospital staff in a 1060-bed teaching hospital, a cross-sectional survey was undertaken. The results were used to construct the Safety Culture Dimensions. • The "Hospital Survey On Patient

				Safety Culture (HSOPSC) Questionnaire" was used as the research tool. • The study's participants were medical interns who had spent at least six months in the department and had rotated through all of its clinical divisions. • According to the survey questionnaire's results, the average patient safety culture in the subject sample was 48% across all dimensions and levels of culture.
10. Kaware MS (2022) ^[11]	Katsina Public Hospitals, Northwest Nigeria	Using the single-proportion formula and PS Power and Sample Size Calculation software, the sample size for the study was estimated based on the study goals. As a result, the research sample size was based on the highest value obtained (460).	Simple random sampling	• In this cross-sectional study, patient safety culture among nurses was assessed using the Hospital Survey on Patient Safety Culture (HSOPSC), developed by the Agency for Health Research and Quality (AHRQ). • The Hospital Survey on Patient Safety Culture was used to survey 460 nurses from 21 secondary health institutions, and the response rate was 93.5 %.

				The data was analyzed using descriptive statistics and multiple logistic regression. The three composite measures that received the most unfavorable Feedback were staffing (30.5 percent), nonpunitive response to error (42.8 percent), and number of incidents recorded (43.1 percent). With odds ratios of 3.15, 1.84, 2.26, and 2.39, respectively, multiple logistic regression analysis indicated that, except organizational learning, all three categories were strongly associated with overall unfavourable raunfavorableient safety culture.
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CHAPTER 3: METHODOLOGY

3.1 - RESEARCH QUESTION:

- How do various employees perceive patient safety culture in different aspects and as per quality standards in Aditya Birla Memorial Hospital?
- Do healthcare professionals' perceptions of the patient safety culture at Aditya Birla Memorial Hospital differ noticeably?
- o Is there a discernible difference between the staffing levels of intensive care units and other units in the composite response rate?

3.2 - STUDY DESIGN & SETTING:

A descriptive cross-sectional survey was conducted among various staff including doctors, nurses, and paramedical staff, and support services selected using the purposive sampling technique in Aditya Birla Memorial Hospital. The Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (HSOPSC) Version 2.0, a validated instrument, was used as an assessment tool. ⁽¹³⁾

3.3 - STUDY POPULATION:

A representative sample of healthcare providers from different job categories in the selected units - Doctors, nurses, pharmacists, technicians, dieticians, and Patient service staff from all clinical departments—were enrolled in our study after their approval for participation.

3.4 – STUDY TOOL:

The Agency of Healthcare Research and Quality's AHRQ Hospital Survey Patient Safety Culture Questionnaire (Version 2.0), created in 2019, was utilized as a research instrument. Using Crohn Bach's alpha, the internal consistency of each variable was calculated. The composites' Cronbach's alpha values varied from 0.67 to 0.89, with an average of 0.77. All composites, with the exception of the staffing composite (0.67), demonstrated acceptable reliability (0.70 or above). ⁽¹³⁾ Version 2.0 of the AHRQ Hospital Survey on Patient Safety Culture includes 40 survey questions, including:

- Eight single-item measurements

- One survey question inquiring how many patient safety occurrences the respondent has recorded.
- One survey question asked participants to rate the general level of patient safety in their workplace or unit.
- Six survey questions on respondents' background information (staff job, unit/work area, hospital tenure, unit/work area tenure, work hours, patient interaction).
- 32 survey questions, each of which assesses a different aspect of patient safety culture, were combined into ten composite measures or dimensions. (Table 3.1)

Table 3.1: SOPS Hospital Survey 2.0 Patient Safety Culture Composite Measures

Patient safety culture composite measures	Definition	Number of items
• Communication About Error	Staff are informed when errors occur, discuss ways to prevent errors, and are informed when changes are made.	3
• Communication Openness	Staff speak up if they see something unsafe and feel comfortable asking questions.	4
• Handoffs and Information Exchange	Important patient care information is transferred across hospital units and during shift changes.	3
• Hospital Management Support for Patient Safety	Hospital management shows that patient safety is a top priority and provides adequate resources for patient safety.	3
• Organizational Learning— Continuous Improvement	Work processes are regularly reviewed, changes are made to keep mistakes from happening again, and changes are evaluated.	3
• Reporting Patient Safety Events	Mistakes of the following types are reported: (1) mistakes caught and corrected before reaching the patient and (2) mistakes that could have harmed the patient but did not.	2
• Response to Error	Staff are treated fairly when they make mistakes and there is a focus on learning from mistakes and supporting staff involved in errors.	4
• Staffing and Work Pace	• There are enough staff to handle the workload, staff work appropriate hours and do not feel rushed, and there is appropriate reliance on temporary or float staff.	4
• Supervisor, Manager, or Clinical Leader Support for Patient Safety	Supervisors, managers, or clinical leaders consider staff suggestions for improving patient safety, do not encourage taking shortcuts, and take action to address patient safety concerns.	3
• Teamwork	Staff work together as an effective team, help each other during busy times, and are respectful.	3

3.5 - DURATION OF STUDY:

The survey for the study was conducted from March 28 to June 27, 2022.

3.6 - SAMPLE SIZE:

The sample size was estimated to be 300 Healthcare providers, around 50% of staff from each category.

3.7 - SAMPLING TECHNIQUE:

A purposive sampling technique was adopted to recruit respondents for the study. Respondents comprised nurses, physicians, other medical staff, laboratory technicians, pharmacists, dieticians, and front desk office staff. (50% of employees from each category were included in the study. All employees were included in a department with less than 10 employees.)

3.8 - DATA COLLECTION & ANALYSIS:

Due to the existing setup making a web-based survey impractical, data was gathered via a paper-based technique. The AHRQ developed a survey on patient safety questionnaire was circulated to employees from various departments like Wards, ICUs, OT, Labour room, pharmacy, Dietetics, Physiotherapy, Pathology lab, Radiology, Emergency Department, and Front desk staff and then collected at the next visit. The survey was completely anonymous to protect respondents' privacy. The hospital's management board officially approved each participant's participation in the survey, and each participant's verbal agreement was obtained before the questionnaire was distributed.

Responses regarding various aspects of patient safety culture were graded on a five-point LIKERT scale (Strongly disagree, disagree, neither, agree, strongly agree /Never, rarely, sometimes, most of the time, always) and include a "Does not apply or Don't know" response option. The survey has a section at the end for open-ended comments. For positively worded items, percent positive scores are the combined percentage of respondents within a hospital who answered, "Strongly agree" or "Agree," or "Always," or "Most of the time." For negatively worded items, the percent positive response is the combined percentage of

respondents within a hospital who answered, "Strongly disagree," or "Disagree," or "Never," or "Rarely," because a negative answer on a negatively worded item indicates a positive response.

The measurement of Patient safety was rated as excellent, very good, decent, fair, and poor. The number of reported incidents was recorded according to event reports from the previous 12 months: none, one to two, three to five, six to ten, and eleven or more.

The percentage of affirmative responses to questions in each dimension was used to create composite scores for the 10 dimensions. The safety culture aspects will subsequently be connected following the computation of the composite scores. Areas of strength and potential will be determined using dimensions with a positive response rate of greater than 75%. Weaknesses will be noted in any dimensions that have a positive response rate under 50%. MS Excel (MS Office version 2007 developed by Microsoft, Redmond, WA) was used for data analysis. Every category variable was displayed as a frequency and percentage.

3.9 - INCLUSION & EXCLUSION CRITERIA:

This study included employees who have direct patient contact as well as those without patient contact such as nurses, physicians, pharmacists, laboratory technicians, and front desk. Still, it will exclude employees not involved directly in patient care, such as drivers, office staff, etc.

Also, those study subjects who did not return the questionnaire and filled the form partially (incomplete questionnaire) were excluded from the study.

3.10 - OPERATIONAL DEFINITIONS:

- "A Patient safety event is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether it results in patient harm."
- "Patient safety is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery."

CHAPTER 4: RESULTS

Table 4.1: Background information about the survey respondents

Sr. No	Variables	No (n=300)	Percentage (%)
1.	Hospital staff category		
	Nurses	148	49.33
	Doctors	50	16.67
	Technicians	52	17.33
	Dieticians	2	0.67
	Pharmacist	15	5
	Patient Service Staff	33	11
2.	Current departmental work area/unit tenure (years)		
	<1 year	146	48.67
	1 to 5 years	132	44.00
	6 to 10 years	17	5.67
	>11 years	5	1.67
3.	Tenure in Hospital		
	<1 year	132	44.00
	1 to 5 years	134	44.67
	6 to 10 years	23	7.67
	>11 years	11	3.67
4.	Working hours per week		
	<30 hours	6	2.00
	30 – 40 hours	19	6.33
	>40 hours	275	91.67
5.	Direct interaction or contact with patients		
	Yes	274	91.33
	No	26	8.67

A total of 310 survey forms were given out, and 300 valid replies were obtained, yielding a response rate overall of 96.77 percent. The hospital had employed the majority of participants for between one and five years (44 percent each), and 48.67 percent of staff members had been engaged in their present department for less than a year. In a similar vein, 91.67% of respondents claimed they worked more than 40 hours per week, while only 2% of respondents indicated they worked fewer than 30 hours per week. Additionally, it was noted from the findings that 91.33 percent of the research participants had direct contact or interaction with patients, while just 8.67 percent did not. On average, 49.33 percent (n= 148) of the 300 participants were nurses, 50 were doctors, 52 were technicians, and 50 were other participants, such as pharmacists,

dietitians, and patient service staff.

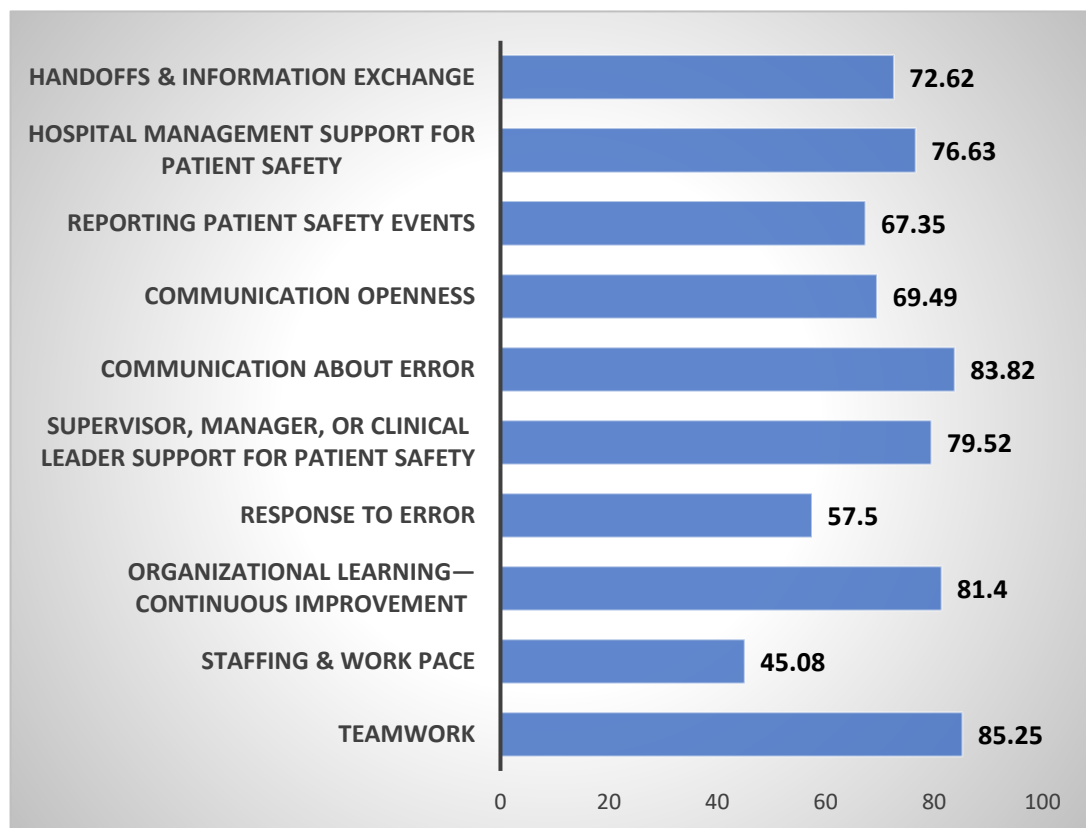


Figure 4.1: Patient safety culture Dimensions

On analyzing the 10 safety culture dimensions among the study participants, it was found that overall composite response was 71.87 %. The dimension teamwork scored the highest percentage positive response of 85.25%, followed by "communication about error" (83.82%) and "organization learning & continuous improvement of patient safety culture" (81.45%). Highest score of teamwork indicates unity and coordination among all units.

On the other hand, staffing had a 45.08 % favorable response rate, which was the lowest percentage (57.5 %). (Fig. 4.1) The lowest staffing percentage denotes insufficient personnel, which has an impact on patient care. Communication openness (69.49%) and reporting patient safety events (67.35%) also have a potential for improvement.

Table 4.2: Composite positive response rate of patient safety culture in all dimensions of HSOPSC among study participants.

Sr.no	Items of Patient safety culture dimensions (Overall)	Frequency	Positive Response (%)
1	Teamwork		85.25
A1	In this unit, we work together as an effective team	284	94.67
A8	During busy times, staff in this unit helps each other.	276	92.31
A9	There is a problem with disrespectful behavior by those working in this unit. (R)	205	68.79
2	Staffing and Work Pace		45.08
A2	In this unit, we have enough staff to handle the workload.	159	53
A3	Staff in this unit work longer hours than is best for patient care. (R)	32	10.74
A5	This unit relies too much on temporary, float, or PRN staff. (R)	130	48.69
A11	The work pace in this unit is so rushed that it negatively affects patient safety. (R)	201	67.91
3	Organizational Learning—Continuous Improvement		81.4
A4	This unit regularly reviews work processes to determine if changes are needed to improve patient safety	254	86.39
A12	In this unit, changes to improve patient safety are evaluated to see how well they worked.	239	82.13
A14	This unit lets the same patient safety problems keep happening. (R)	224	75.93
4	Response to Error		57.5
A6	In this unit, staff feels like their mistakes are held against them. (R)	152	52.60
A7	When an event is reported in this unit, it feels like the person is being written up, not the problem. (R)	129	45.26
A10	When staff make errors, this unit focuses on learning rather than blaming individuals.	205	68.79
A13	In this unit, there is a lack of support for staff involved in patient safety errors. (R)	189	63.64
5	Supervisor, Manager, or Clinical Leader Support for Patient Safety		79.52
B1	My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety	259	86.62

B2	My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts. (R)	210	70.00
B3	My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.	245	81.94
6	Communication About Error		83.82
C1	We are informed about errors that happen in this unit.	241	80.33
C2	When errors happen in this unit, we discuss ways to prevent them from happening again.	261	87.00
C3	In this unit, we are informed about changes that are made based on event reports	249	84.12
7	Communication Openness		69.49
C4	In this unit, staff speaks up if they see something that may negatively affect patient care.	213	72.20
C5	When staff in this unit sees someone with more authority doing something unsafe for patients, they speak up.	210	71.67
C6	When staff in this unit speaks up, those with more authority are open to their patient safety concerns.	201	69.79
C7	In this unit, staff is afraid to ask questions when something do not seem right. (R)	189	64.29
8	Reporting Patient Safety Events		67.35
D1	When a mistake is caught and corrected before reaching the patient, how often is this reported?	196	66.89
D2	When a mistake reaches the patient and could have harmed the patient, but did not, how often is this reported?	198	67.81
9	Hospital Management Support for Patient Safety		76.63
F1	The actions of hospital management show that patient safety is a top priority.	271	90.94
F2	Hospital management provides adequate resources to improve patient safety.	249	83.84
F3	Hospital management seems interested in patient safety only after an adverse event happens. (R)	162	55.10
10	Handoffs and Information Exchange		72.62
F4	When transferring patients from one unit to another, important information is often left out. (R)	182	65.47
F5	During shift changes, important patient care information is often left out. (R)	201	71.02
F6	During shift changes, there is adequate time to exchange all key patient care information.	227	81.36

Note:

- "R" = a negatively worded item
- Item frequency varies as it excludes missing and does not apply responses.
- Codes in each item's Sr. no. section include the section/ number of the question in the questionnaire. For example, A1

The percentages of respondents who responded favorably to the survey items are shown in Table 4.2. The survey question with the highest score for the highest favorable perception was, "In this unit, we work together as an effective team." (94.67%); then "During busy times, staff in this unit helps each other" (92.31%); followed by "The actions of hospital management show that patient safety is a top priority" (90.94%).

The item with the lowest favorable opinion is also shown in the table: "Staff in this unit work longer hours than is ideal for patient care." (10.74%); then "When an event is reported in this unit, it feels like the person is being written up, not the problem" (45.26%); followed by "This unit relies too much on a temporary, float, or PRN staff" (48.69%); In this unit, staff feels like their mistakes are held against them" (52.60%); "In this unit, we have enough staff to handle the workload" (53%).

When participants were asked how frequently patient safety incidents are reported, the majority, or 106 (36.18%), selected the response "most of the time" in response to the question "When a mistake is made but is identified and rectified before hurting the patient." However, when posed a different question about "reporting of event/mistake that might harm the patient but does not," the majority of answers, 113 (38.7%), were for the always alternative.

Table 4.3: Comparison of composite response rate among staff of Intensive care units and other departments

Sr.no	Patient safety culture dimensions	Staff working in different Intensive care unit (n=54)	Staff working in other dept/units (n=144)
		<i>Positive Response %</i>	<i>Positive Response %</i>
1	Teamwork	85.18	85.41
2	Staffing and Work Pace	33.54	46
3	Organizational Learning—Continuous Improvement	85.06	83.52
4	Response to Error	55.43	57.56
5	Supervisor, Manager, or Clinical Leader Support for Patient Safety	74.69	80.09
6	Communication About Error	82.71	87.04
7	Communication Openness	66.37	71.51
8	Reporting Patient Safety Events	70.37	66.66
9	Hospital Management Support for Patient Safety	77.36	75.81
10	Handoffs and Information Exchange	74.84	71.67

Table 4.3 shows that there was no difference in the composite response rate between the staff of Intensive care units (emergency care) and other departments for the majority of patient safety culture aspects except for staffing & work pace. So, there is a need to improve ICU staffing and maintain staff patient ratio in intensive care units to improve patient care.

Table 4.4 -Average composite positive percentage of "patient safety culture" among different Health care providers

Sr.no	Patient safety culture dimensions	Average Composite Positive Response Percentage			
		Doctors (n=50)	Nurses (n=148)	Technicians (n=52)	Others (n=50)
1	Teamwork	76.66	88.50	86.54	82.94
2	Staffing and Work Pace	41.22	45.78	56.80	43.41
3	Organizational Learning—Continuous Improvement	82.99	82.46	82.26	76.12
4	Response to Error	49.42	59.67	58.85	58.08
5	Supervisor, Manager, or Clinical Leader Support for Patient Safety	75.33	80.12	84.62	76.67
6	Communication About Error	83.33	86.91	89.74	68.61
7	Communication Openness	69.60	71.17	66.80	66.89
8	Reporting Patient Safety Events	60.02	72.28	67.31	59.58
9	Hospital Management Support for Patient Safety	71.06	78.52	83.97	68.61
10	Handoffs and Information Exchange	65.12	75.53	76.47	64.94
	Total	67.47	74.09	75.34	66.58

Among the several occupational categories of HCPs, including physicians, nurses, technicians, and others (pharmacist, patient service staff and dieticians), the overall composite mean favorable response rate on "Patient Safety Culture" varied. In the areas of "Communication about mistake," "Organizational learning and continuous development," and "teamwork," doctors had the greatest average positive response rate (83.33 %, 82.99 % , and 76.66 %).

In the following dimensions, nurses had the greatest average positive response rate. – "Teamwork", "Communication about error", and "Organizational learning and continuous improvement" (88.50 %, 86.91 %, 82.46 %). The characteristics of "Communication about mistake," "teamwork," and "Supervisor, Manager, or Clinical Leader Support for Patient Safety" received more favorable responses from technicians (89.74 %, 86.54 %, 84.62 %). Others obtained a higher positive response rate in the dimensions of "teamwork," "Supervisor, Manager, or Clinical Leader Support for

Patient Safety”, and "Organizational learning and continuous improvement" (82.94 %, 76.67 %, 76.12 %). Doctors obtained less scores in the domains of "response to error" and "staffing & work pace" (49.42% and 41.22%) compared to nurses, technicians, and others.

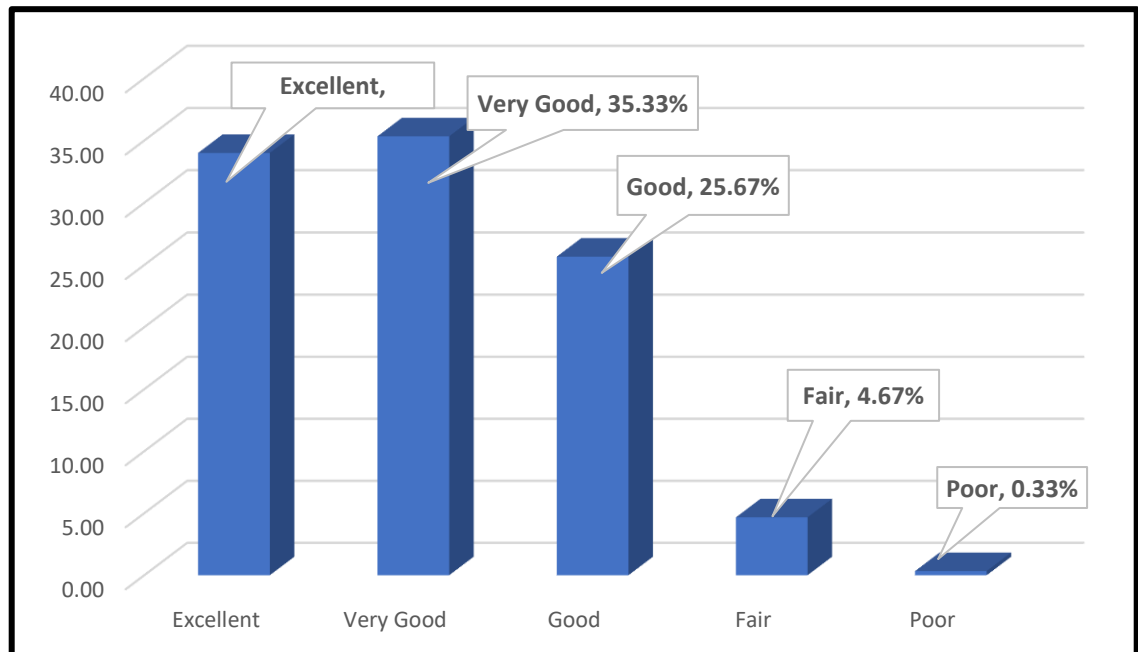


Figure 4.2: Bar diagram demonstrating patient safety grade of work area/units

Patient safety received a rating ranging from "Excellent" to "Poor" overall. Only 4.67 % of the participants who were asked to score the overall patient safety grade in their separate units said the patient safety action was fair. In contrast, the rest said the patient safety action was Excellent (35 %) or Very good (35.33 %). More details can be seen in Figure 4.2.

Table 4.5: Composite positive response rate of number of patient safety events reported by study participants.

Sr.no	Number of events reported in past 12 months	Composite positive response rate (%)
1	No event	222 (74)
2	1 to 2	58 (19.33)
3	3 to 5	19 (6.4)
4	6 to 10	1 (0.33)
5	11 or more	0 (0.00)

Only 26.06 % of respondents reported incidents involving patient safety in the previous year, whereas the majority, or 222 (74 %), either did not see or did not report any incidents. (Table 4.5)

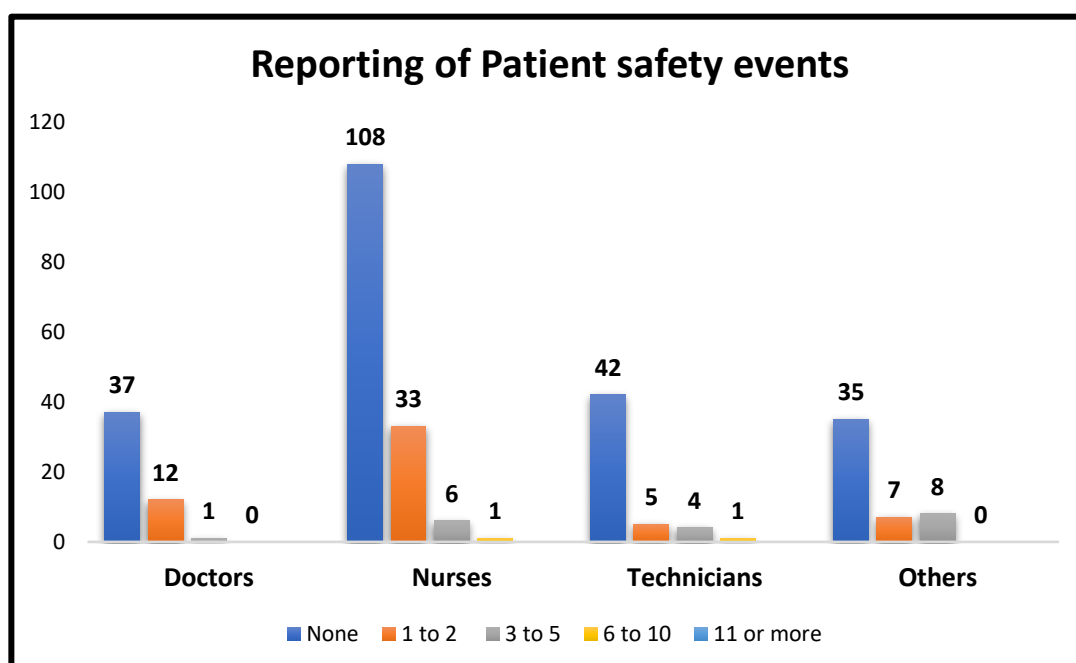


Figure 4.3: Bar diagram showing the number of patient safety events reported by different health care providers.

Figure 4.3 depicts that the majority of the study population reported no events. 1-2 events were primarily reported by nurses, followed by doctors and others. Nurses followed by others and technicians majorly reported 3-5 events.

CHAPTER 5: DISCUSSION

Healthcare businesses increasingly realize how critical it is to change company culture to increase patient safety. The avoidance and prevention of patient injuries or bad occurrences resulting from providing healthcare is referred to as "patient safety." According to the Institute of Medicine, healthcare institutions should foster a culture of safety where adverse events are reported without assigning blame, provide physicians room for growth by encouraging them to learn from their mistakes, and work to stop future errors. ⁽⁸⁾ Given how important patient safety culture is to the provision of healthcare, many hospital accreditation programs, including the "Accreditation Commission for Health Care, the National Accreditation Board for Testing and Calibration for Laboratories, and the International Standard for Organizations," include this as one of the critical components in their checklists. ⁽³⁾

A key step in enhancing patient safety is establishing the "appropriate patient safety culture," which may be determined by many surveys, including the "safety attitude questionnaire (SAQ)" and the "HSOPS questionnaire," both of which have comparable levels of reliability and predictive validity. The demand for evaluation methods that concentrate on the cultural components of patient safety improvement initiatives has increased along with interest in safety culture. ⁽⁷⁾

In the present study, the final response rate of participants was 96.77%, comparatively higher than reported as 84% in Meena KS et al. study ⁽²⁾. Although several instruments are available to evaluate the patient safety culture, HSOPSC is the only one that can evaluate it thoroughly. Although it varied among different cadres of HCPs, the composite score, which incorporates all ten elements of the HSOPSC instrument, revealed a mean positive response percentage of 71.87 %. Comparing this favorable reaction to estimates from the Dhanya M et al. research, it was low (91.07 %). ⁽¹²⁾ However, compared to replies recorded from other Indian contexts, the favorable reactions in the current study are higher. (48% ,58%, and 57.37%) ^(10,3,2).

In all studies, the dimension that had the most favorable reaction was "teamwork within the unit." ^(3,7,10) The majority of studies, however, revealed a low positive response in the dimension of "teamwork across the unit." ^(2,10). The current study also showed a highly favorable response in "teamwork "(85.25 %). The teamwork component was not

split into teamwork between and within the units since version 2.0 was employed in the current study. The highest score in the teamwork dimension shows that all members are working together cohesively. Departmental teamwork is a crucial element in accomplishing organizational goals.

Our study's next highest positive response is for the dimension Communication about error (83.82%). A high positivity score shows that errors are properly communicated between healthcare professionals, lowering errors and enhances patient safety. This result is consistent with the research conducted by Rao MV et al., in which the dimension of Feedback and communication regarding error received the second-highest favorable response (65%) but a lower score than in the current study. ⁽¹⁰⁾

In the present study, Staffing and work pace (45.08 %) had the lowest percentage of positive responses. This finding highlights the need for adequate staff to promote patient safety and improve the culture, both of which may be harmful to patient safety. The requirement for standard staffing is extremely prudent to provide thorough, safe treatment and satisfy patients. Staffing had the lowest proportion of favorable responses of any dimension in the study by Ennas C et al (34.6%), however, the percentage was lower than in the present study. ⁽⁷⁾ In accordance with the findings of the current study, Meena KS et al demonstrated that dimension staffing received the least positive response, 15.06 %, which is much lower than the findings of the current study. ⁽²⁾ Response to errors had the second-lowest percentage of positive responses in the current survey, at 57.5 %. Ennas C et al study revealed that nonpunitive responses to errors resulted in a percentage positive reaction of 45.7 %, which is lower than the current study's findings. ⁽⁷⁾

A positive percentage score of 69.49 % was given to communication openness in our study. Ennas C. et al. also shown somewhat comparable trends to those of the current study, which determined that the dimension of communication openness obtained a favourable response of 62.1 %. ⁽⁷⁾ Alqattan H et al found that the dimension of communication openness had a 44.83 % favourable response, in contrast to this finding. ⁽⁹⁾

The results of the current study showed that 67.35 % of patient safety event reports were favourable, which is quite comparable to the study by Ennas C et al (66.7 %). ⁽⁷⁾

Rajalatchumi A et al. conducted research in contrast to this conclusion, and the findings revealed that the dimension frequency of event reported scored obtained a favorable percentage response of 41.2 percent. ⁽³⁾ As a result, the "communication openness" and "reporting patient safety occurrences" characteristics both have room for improvement.

Most respondents gave the study's overall patient safety factor a very excellent rating (35.33 %). In accordance with the present study, Ennas C et al. found that most respondents rated their overall opinion of safety as very excellent (42.8 %). ⁽⁷⁾

It is necessary to improve and standardize event reporting because, in the current study, a huge percentage of survey respondents (74%) did not report any events in the previous year. This finding may be related to a decrease in the frequency of adverse outcomes or a reluctance on the part of staff to report any events they observed. 47 % of the subjects reported no events, according to research by Rao MV et al. ⁽¹⁰⁾

The majority of the patient safety culture aspects, except "staffing & work pace," showed no variation in response rates between staff from intensive care units and other departments. This may mean that there is a consistent culture of patient safety across the hospital, except the ICUs, where staffing has to be increased owing to the overworked state of the healthcare workers there. The lowest positive response rate is due to insufficient staffing, which negatively impacts patient care. The fact that the units providing emergency care scored higher on some of the dimensions (organization learning and continuous improvement), "reporting patient safety events," and "hospital handoffs & transitions" may be related to the nature of their work and ongoing requirement to provide time-urgent critical care throughout the year. In contrast to this finding, a study by Goyal RC et al. revealed a significant difference in the dimensions of "Feedback and Communication About Error," "Teamwork Across Hospital Units," and "Hospital Handoffs & Transitions" when the response rates of ICU staff members and those from other departments were compared. ⁽⁸⁾

This study showed an average positive response rate among physicians at 67.47 %, the highest among nursing and other technical staff. (75%). Similar results were seen in Rajalatchumi A et al. study. ⁽³⁾ The fact that technicians reacted more favorably might be explained by the nature of their work directly relates to patient safety (all invasive procedures and potential errors that could occur during treatment) and that they are

more closely integrated into other departments' day-to-day operations. The internal structure developed by the organization for nursing staff that makes it simpler to manage staff conflicts and day-to-day monitoring may be responsible for the nursing staff's favorable response, which is similar to this. Additionally, the nursing staff is in charge of the bulk of reporting systems. Additionally, this could have encouraged a more positive response from the nursing personnel.

Even though many studies have been done on HCPs and patient safety, very few of these studies have included responses based on distinct HCP cadres, and even fewer hospital surveys have grouped the responses according to hospital contexts like the emergency room, intensive care unit, and operating rooms. ⁽¹²⁾ The self-administered nature of the HSOPSC instrument eliminates the risk of interviewer bias. It was decided that the replies were extremely dependable because the participants' confidentiality was protected by anonymity, and they were assured that their opinions wouldn't be utilized as a basis for punishment. Compared to the previous studies, this study's response rate (96.77%) was more significant. ^(2,3) This high engagement percentage may result from the organization's continual work to change grassroots architecture.

The study has some shortcomings, including:

- Participants were kept in the dark about the research to help them react honestly. However, it's conceivable that some of our participants were not entirely truthful and that other employees chose not to reply because they felt uncomfortable being honest.
- Because the personnel were chosen at random among the departments, selection bias may have occurred.
- Respondents may become weary of answering HSOPSC questions and lose interest, resulting in them responding hastily. This leads to biased reporting.
- The social desirability biases were introduced through the use of a self-reported questionnaire.

CHAPTER 6: CONCLUSION

Instilling patient safety cultures among all staff members involved in healthcare delivery is of utmost importance since patient safety is a priority for every healthcare facility on moral and legal grounds. To implement efficient interventions and achieve a high level of patient safety, the instrument "Hospital Survey on Patient Safety Culture (HSOPSC) Questionnaire" assists in analyzing this culture in a healthcare facility. The survey, conducted among a group of hospital employees, provides important insight into the issue, and reveals how pervasive a patient safety culture is among them. A thorough study covering all categories of hospital staff, including medical, nursing, paramedical, support services, and administrative staff, who are involved in patient care in the various departments of the hospital, would be necessary to understand the overall safety culture in the organization concerning patient safety. Such surveys would help healthcare organizations address patient safety issues quickly and effectively.

The study's findings showed that although there is a strong sense of teamwork among the units, staffing in ICUs must be improved since healthcare personnel is overworked owing to a staffing shortfall. Therefore, it is important to conduct observation research on the root causes of the healthcare practitioners' claims that they work longer hours than is ideal for patient care.

In our study, almost 52% of the employees responded positively when asked whether they believed their errors were used against them and were responsible for unfavorable outcomes. Systems must ensure that all employees who report harmful incidents are supported, recognized for their participation, and consistently motivated by the knowledge that their reporting has resulted in safer circumstances rather than a punitive response. An appropriate balance between personal accountability and the cost of an unintentional human error should exist. Managers and employees should be made aware of the need to foster a nonpunitive environment for reporting accidents or mistakes, as well as how to do so, through training sessions.

It is necessary to stress the significance of standardized handoff protocols in order to overcome the challenges that arise during the transfer of patients across units or work areas. There is room for improvement in both openness of communication and reporting patient safety incidents. The results of this study point to the need for initiatives

throughout the hospital hierarchy to improve mistake reporting mechanisms within the hospital context through polite and effective interprofessional dialogue, and where reporting errors is rewarded and encouraged.

Enhancing patient safety is essential to improving safety in healthcare. To enhance the system, it is important to address some aspects that HCPs claimed to have adverse reactions to in this study. Holding regular interdisciplinary focused group meetings and staff training sessions, simulation exercises on patient safety culture, and strengthening awareness campaigns on the blame-free, online, and the handwritten error reporting system are a few examples of strategies that can improve outcomes in these weaker dimensions.

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ANNEXURES

- **STUDY TOOL (AHRQ Questionnaire):**

Hospital Survey on Patient Safety (Version 2.0)

Instructions

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10-15 minutes to complete. If a question does not apply to you or your hospital or you don't know the answer, please select "Does Not Apply or Don't Know."

- **"Patient safety"** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery.
- A **"patient safety event"** is defined as any type of healthcare-related error, mistake, or incident, regardless of whether or not it results in patient harm.

Your Staff Position

1. What is your position in this hospital?

Select ONE answer.

Nursing

1. Nursing Aid (ANM)
2. Registered Nurse (GNM,BSc.)

Medical

3. Physician Assistant
4. Resident, Intern
5. Physician, Attending, Hospitalist
6. Dietitian

Other Clinical Position

7. Pharmacist, Pharmacy Technician
8. Physical, Occupational, or Speech Therapist
9. Psychologist
10. Respiratory Therapist
11. Social Worker
12. Technologist, Technician (e.g., ECG, Lab, Radiology)

Supervisor, Manager, Clinical Leader, Senior Leader

13. Supervisor, Manager, Department Manager, Clinical Leader, Administrator, Director
14. Senior Leader, Executive, C-Suite

Support

15. Facilities
16. Food Services
17. Housekeeping, Environmental Services
18. Information Technology, Health Information Services, Clinical Informatics
19. Security
20. Transporter
21. Unit Clerk, Secretary, Receptionist, Office Staff

Other

22. Other, please specify:

Your Unit/Work Area

1. Think of your “unit” as the work area, department, or clinical area of the hospital where you spend most of your work time. What is your primary unit or work area in this hospital?

Select ONE answer.

Multiple Units, No specific unit

1. Many different hospital units, No specific unit

Medical/Surgical Units

2. Combined Medical/Surgical Unit
3. Medical Unit (Non-Surgical)
4. Surgical Unit

Patient Care Units

5. Cardiology
6. Emergency Department, Observation, Short Stay
7. Gastroenterology
8. ICU (all adult types)
9. Labor & Delivery, Obstetrics & Gynecology
10. Oncology, Hematology
11. Pediatrics (including NICU, PICU)
12. Psychiatry, Behavioral Health
13. Pulmonology
14. Physiotherapy & Rehabilitation
15. Dentistry

Surgical Services

16. Anesthesiology
17. Endoscopy, Colonoscopy
18. Pre Op, Operating Room/Suite, PACU/Post Op, Peri Op

Clinical Services

19. Pathology, Lab
20. Pharmacy
21. Radiology, Imaging
22. Respiratory Therapy
23. Social Services, Case Management, Discharge Planning

Administration/Management

24. Administration, Management
25. Financial Services, Billing
26. Human Resources, Training
27. Information Technology, Health Information Management, Clinical Informatics

28. Quality, Risk Management, Patient Safety Support Services
29. Admitting/Registration
30. Food Services, Dietary
31. Housekeeping, Environmental Services, Facilities
32. Security Services
33. Transport

Other

34. Other, please specify:

SECTION A: Your Unit/Work Area

How much do you agree or disagree with the following statements about your unit/work area?

Think about your unit/work area:	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. In this unit, we work together as an effective team.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
2. In this unit, we have enough staff to handle the workload.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
3. Staff in this unit work longer hours than is best for patient care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
4. This unit regularly reviews work processes to determine if changes are needed to improve patient safety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
5. This unit relies too much on temporary, float, or PRN staff.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
6. In this unit, staff feel like their mistakes are held against them.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
7. When an event is reported in this unit, it feels like the person is being written up, not the problem.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
8. During busy times, staff in this unit help each other	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
9. There is a problem with disrespectful behavior by those working in this unit	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
10. When staff make errors, this unit focuses on learning rather than blaming individuals.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
11. The work pace in this unit is so rushed that it negatively affects patient safety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
12. In this unit, changes to improve patient safety are evaluated to see how well they worked	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
13. In this unit, there is a lack of support for staff involved in patient safety errors	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
14. This unit lets the same patient safety problems keep happening	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9

SECTION B: Your Supervisor, Manager, or Clinical Leader

How much do you agree or disagree with the following statements about your immediate supervisor, manager, or clinical leader?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
2. My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
3. My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9

SECTION C: Communication

How often do the following things happen in your unit/work area?

Think about your unit/work area:	Never	Rarely	Some-times	Most of the time	Always	Does Not Apply or Don't Know
1. We are informed about errors that happen in this unit	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
2. When errors happen in this unit, we discuss ways to prevent them from happening again ..	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
3. In this unit, we are informed about changes that are made based on event reports	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
4. In this unit, staff speak up if they see something that may negatively affect patient care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
5. When staff in this unit see someone with more authority doing something unsafe for patients, they speak up	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
6. When staff in this unit speak up, those with more authority are open to their patient safety concerns	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
7. In this unit, staff are afraid to ask questions when something does not seem right	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9

SECTION D: Reporting Patient Safety Events

Think about your unit/work area:	Never	Rarely	Some- times	Most of the time	Always	Does Not Apply or Don't Know
1. When a mistake is <u>caught and corrected</u> <u>before reaching the patient</u> , how often is this reported?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
2. When a mistake reaches the patient and <u>could</u> <u>have harmed the patient, but did not</u> , how often is this reported?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
1. <u>In the past 12 months</u> , how many patient safety events have <u>you</u> reported?						
☐ a. None	☐ b. 1 to 2	☐ c. 3 to 5	☐ d. 6 to 10	☐ e. 11 or more		

SECTION E: Patient Safety Rating

1. How would you rate your unit/work area on patient safety?

Poor Fair Good Very Good Excellent
▼ ▼ ▼ ▼ ▼

SECTION F: Your Hospital

How much do you agree or disagree with the following statements about your hospital?

Think about your hospital:	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. The actions of hospital management show that patient safety is a top priority	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
2. Hospital management provides adequate resources to improve patient safety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
3. Hospital management seems interested in patient safety only after an adverse event happens	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
4. When transferring patients from one unit to another, important information is often left out .	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
5. During shift changes, important patient care information is often left out	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
6. During shift changes, there is adequate time to exchange all key patient care information ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9

Background Questions

1. How long have you worked in this hospital?

- ☐ a. Less than 1 year
- ☐ b. 1 to 5 years
- ☐ c. 6 to 10 years
- ☐ d. 11 or more years

2. In this hospital, how long have you worked in your current unit/work area?

- ☐ a. Less than 1 year
- ☐ b. 1 to 5 years
- ☐ c. 6 to 10 years
- ☐ d. 11 or more years

3. Typically, how many hours per week do you work in this hospital?

- ☐ a. Less than 30 hours per week
- ☐ b. 30 to 40 hours per week
- ☐ c. More than 40 hours per week

4. In your staff position, do you typically have direct interaction or contact with patients?

- ☐ a. YES, I typically have direct interaction or contact with patients
- ☐ b. NO, I typically do NOT have direct interaction or contact with patients

Your Comments

Please feel free to provide any comments about how things are done or could be done in your hospital that might affect patient safety.

Thank you for completing this survey.