

PATIENT SAFETY CULTURE ASSESSMENT IN PRIMARY CARE

INTRODUCTION



Due to an aging population and medical progresses, a considerable part of healthcare delivery continues to shift from secondary to primary and home care¹. At the same time, the demand for home and community services is increasing substantially in order to reduce the number of hospital beds, facilitate earlier hospital discharge, improve quality of care, and decrease associated costs.

Moreover, primary healthcare professionals are encouraged to work together in broad healthcare centers, to collaborate in disease management programs and to consult each other in managing patient care. This reflects the move to a more integrated primary healthcare through collaborative partnerships across multidisciplinary teams.

Despite this awareness, most tools to measure and strengthen patient safety culture have been developed and tested in hospitals. Because of the increase in collaboration within primary healthcare as well as with secondary care, the prevailing safety culture in primary healthcare also becomes an important condition for patient safety in practice.

METHODS

An observational, cross-sectional study design was applied by using the SCOPE-Primary Care Survey².

This study used a convenience sample and administered the survey in a single home care organization with more than 1.500 employees, including nurses, midwives, healthcare assistants, diabetes educators, and nursing supervisors. Data collection occurred between November and December 2016 through the online platform Qualtrics. The electronic survey targeted all healthcare professionals, supervisors, managers, and non-healthcare staff who had direct or indirect interaction with patients. The participants received an invitation by e-mail. Two reminders were sent with an interval of two weeks.

A dimension score above 75% represents a positive attitude towards patient safety and a score less than 50% presents a negative attitude. All analyses were performed using R³.

RESULTS

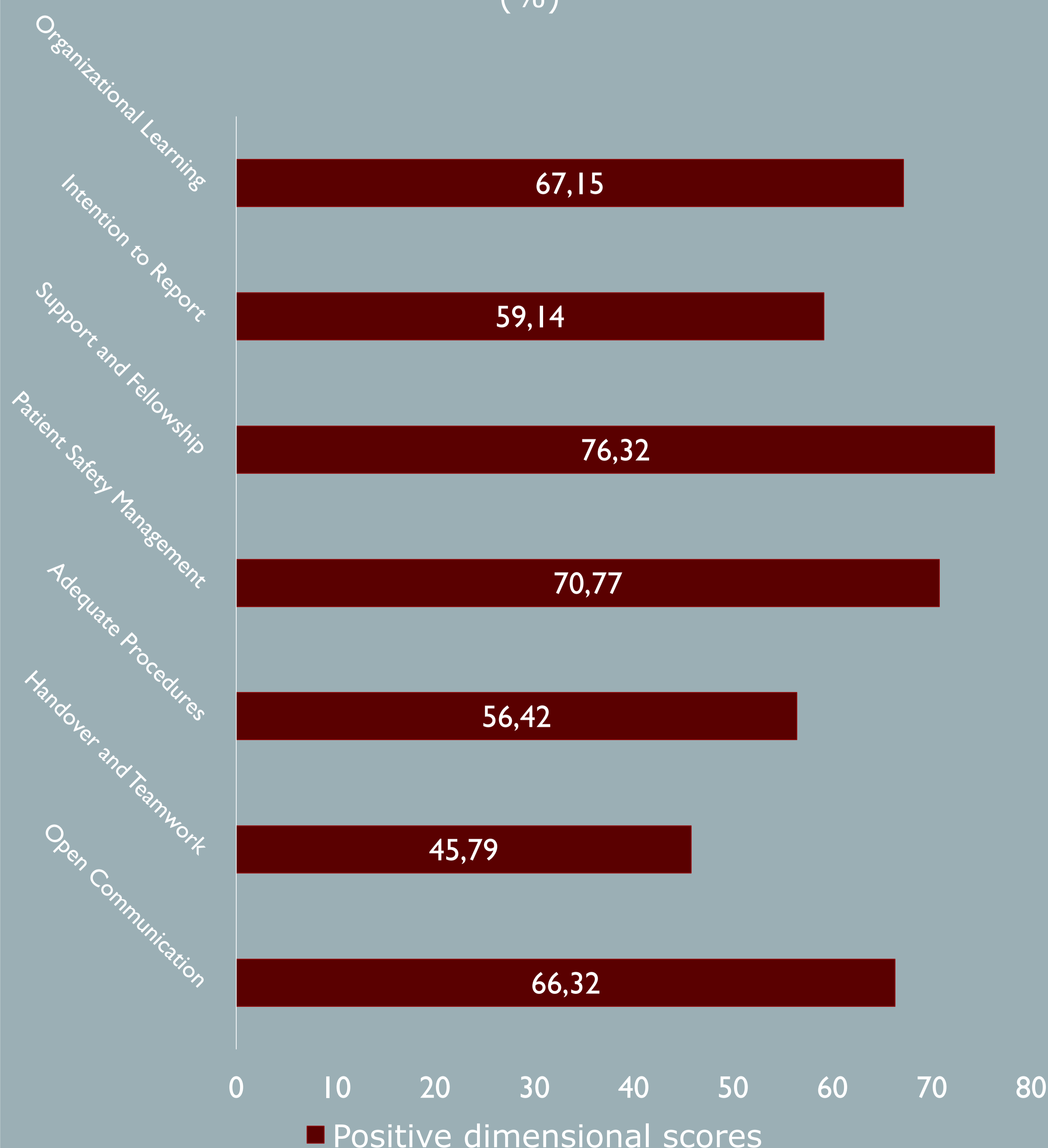
In total, 1.196 employees completed the survey, representing a **response rate of 77%**. Mainly nurses (74.9%) completed the survey, followed by managers (5.0%) and non-healthcare staff (3.0%).

One dimension scored below 50%, namely **Handover and Teamwork (45.8%)**. The highest positive dimensional score was found for **Support and Fellowship (76.3%)**, followed by **Patient Safety Management (70.8%)**, **Organizational Learning (67.2%)**, **Open Communication and Learning from Error (66.3%)**, **Intention to Report (59.1%)**, and finally **Adequate Procedures and Working Conditions (56.4%)**.

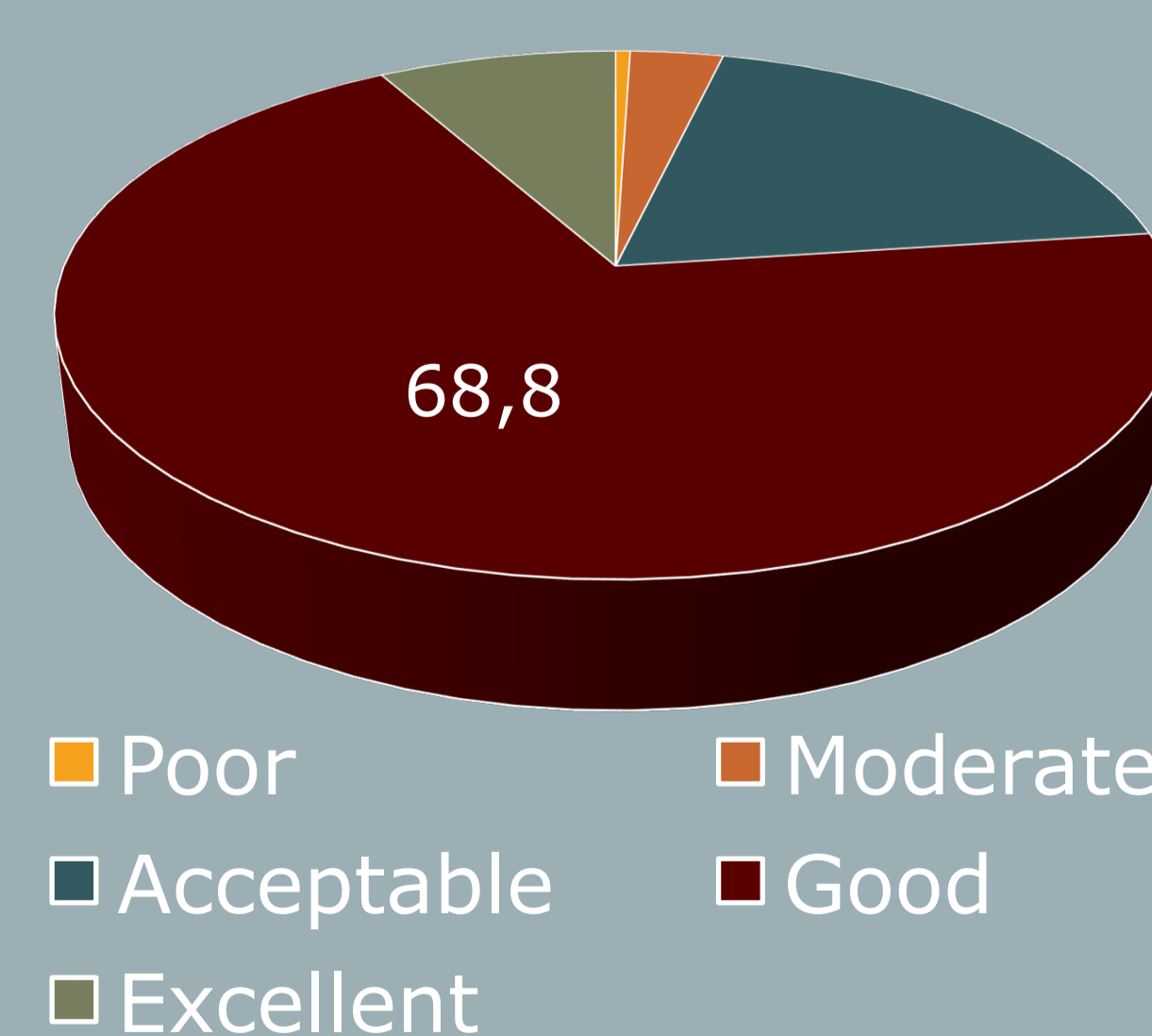
In addition, statistical differences ($P < 0.05$) were found between professions for *Open Communication and Learning from Error* and *Patient Safety Management*. Managers scored significantly higher than healthcare professionals and non-healthcare staff.

Finally, 68.8% of the employees graded patient safety in their organization as **good** and 40.6% **never reported an incident** within the last twelve months.

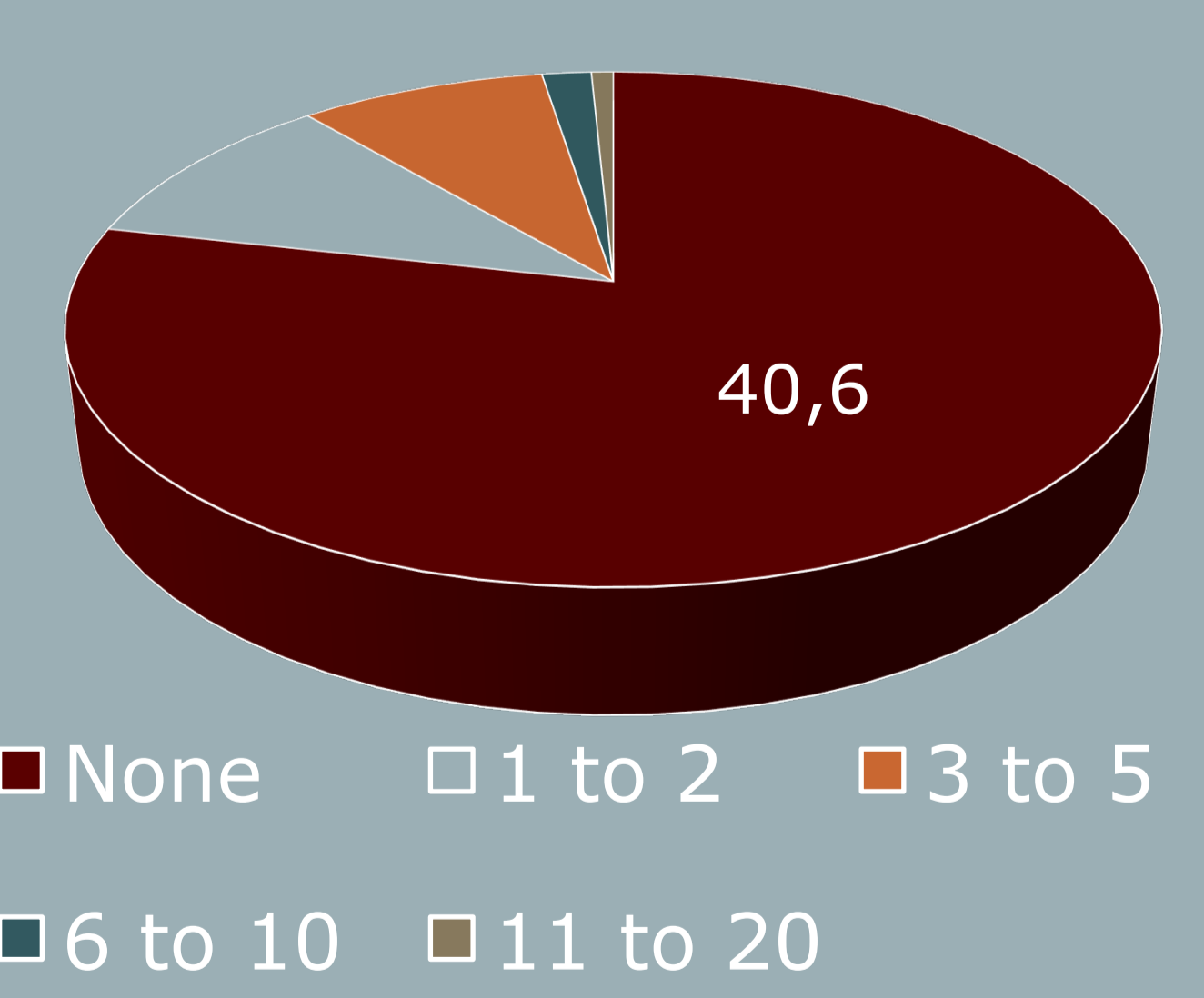
Results on the Patient Safety Culture Assessment (%)



Patient Safety Grade (%)



Reported Events (%)



CONCLUSIONS

The present study indicated **some areas for improvement** concerning patient safety, especially regarding *handover and teamwork*, *adequate procedures and working conditions* and *intention to report events*. **Improvements may be realized through open communication, non-punitive policies with respect to error reporting and staffing improvements**. Additionally, there were some notable differences in positive dimensional scores among professions. This is consistent with other research that reported higher patient safety culture scores from those with managerial responsibilities⁴.