Exploring patient safety culture in a primary, community and continuing care setting in Ireland

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**Objective:**

To examine perceptions of patient safety culture among Primary, Community and Continuing Care (PCCC) Staff.

**Background:**

Following many national inquiries over the last few years there is a high level of public and media interest in all health matters, which places greater demands on health services. Healthcare provision has become more complex and will never be risk-free. Now with multidisciplinary working within primary care teams and integration between PCCC and Acute services, the quality of patient care and safety has never been more important. However, there is very little evidence of research being carried out to explore the patient safety culture in healthcare settings in Ireland. Literature suggests that healthcare leaders should maintain an organisational culture that supports and promotes patient safety, is non-punitive and that a culture of safety is necessary before patient safety practices can be introduced successfully.

**Methods:**

A quantitative approach was applied to the study which took place over a six month period in 2008. A standardised instrument, the Hospital Survey on Patient Safety Culture, developed by the Agency for Healthcare Research and Quality in the United States, was amended and forwarded to a stratified random sample (N=200) of staff across Community, Mental Health and Older People services. Staff groups surveyed included allied health professionals, management/administration, medical/dental, nursing and support services. Perceptions of patient safety strengths and weakness were identified by calculating a composite frequency of the total percentage of positive responses for each of the patient safety culture dimensions (N=12).

**Results:**

Findings within each of the identified patient safety culture dimensions compared favourably to published benchmark scores from the Agency for Healthcare Research and Quality. The teamwork dimension was most positively rated and achieved an 84% composite score. However, opportunities for improvement were suggested in the areas of event reporting (57%), feedback and communication about error (56%), handoffs and transitions (45%), non-punitive response to error (43%) and staffing (42%).

**Conclusions:**

Overall findings suggest that management and staff are actively doing things to improve patient safety. Areas with potential for improvement are in the reporting of events and communication and feedback. This has implications for education with staff across all settings and highlights the role of supervisors/managers in ensuring that a non-punitive work environment is created and maintained in their work areas. The findings from this study have provided a baseline measurement of patient safety culture which can be used to develop a foundation for future patient safety initiative in the study site. This allows for the tracking of change over time with the added benefit of being able to compare findings to those in other similar organisations. This is particularly relevant in the current climate in Irish Healthcare with the recent publication of “Building a Culture of Patient Safety” by the Commission on Patient Safety and Quality Assurance, and the current implementation of the HSE’s Integrated Quality, Safety and Risk Framework.