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Do we communicate openly in healthcare delivery?

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A B S T R A C T

Culture of patient safety is a very important area of research because it reflects the quality of care provided by health institutions. The practice of patient safety begins at the first point of contact between patients and front liners such as doctors, nurses and assistant medical officers (AMOs). The aim of this study was to determine the level of patient safety culture, reported by assistant medical officers in the Ministry of Health hospitals. Hospital Survey on Patient Safety Culture (HSOPSC) questionnaires with minimal modification were distributed to assistant medical officers who had worked for more than 6 months in 140 MOH hospitals. This study took place from November 2012 to February 2013, and the total number of respondents was 2,480. Data was analysed by IBM SPSS software version 20.0. Overall perception of safety practices among the AMOs was 72.3%. The dimensions with the highest positive response rate were 'Organizational Learning - Continuous Improvement' (93.5%), 'Teamwork within Unit' (91.0%) and 'Supervisor/Management Expectation and Promoting Patient Safety' (82.2%). The lowest positive responses were 'Non Punitive Response to Error' (26.7%), 'Communication Openness' (44.2%) and 'Frequency of Events Reported' (44.3%). Blame free culture should be adopted and openness in communication should be encouraged in all hospitals. The practice of blame free culture will encourage reporting of incidents. With better reporting and subsequent investigation, the recurrence of events that may lead to more severe consequences can be prevented. Effective intervention tools should also be developed to increase awareness on the importance of safe patient care.

Introduction

Studies on patient safety have been done in many countries such as The Netherlands (1), Lebanon (2), Sweden (3), China (4), Iran (5) and Taiwan (6). In fact, several authors have analysed the practice of patient safety cultures across countries to allow for improvement (7,8,9). From outpatients to inpatients, direct care to management, safe patient care needs to be upheld to maintain public trust in health care providers.

The issues of patient safety have been discussed extensively, ranging from missing clinical information (10) to wrong site surgery (11). Nieva and Sorra (12) have reported that assessment of safety culture is

important to diagnose the practice level, evaluate intervention and make changes as required. Assessment and redesign on the current system, in terms of concept, tools and implementations should be made according to areas for improvement (2). Attention to missing information is more likely improve the effectiveness of the current system (10). Saint and colleagues (13) have suggested the presence of Patient Safety Officers to assess patients and prevent nosocomial infection in hospitals.

Healthcare delivery is a team based action, therefore good leadership, coordination and communication are the aspects that must be present to safely care for patients (14). Unequivocally, patients and caretakers also play some roles in ensuring safe health care (15). Patients may ensure safety by selecting safe healthcare providers, helping doctors to achieve accurate diagnosis and reporting any error that is taking place (16).

Practice of patient safety is influenced by working hours of staff (17), feedback procedures (18,19), managerial leadership (18), teamwork (20), organizational learning and quality of education (21,22), effective handoff tools (23,24), staffing (25), communication openness (23) and error management (26). According to National Healthcare and Workforce Establishment Statistics 2010, there were 5,672 assistant medical officers (AMOs) in Malaysia, with 99% of them working in public service (27). Furthermore, one study has suggested that medical assistants who are also known as AMOs had the highest patient encounter in primary care (28), a highlight to the importance of safe health care delivery by this group.

Therefore, this study was carried out to find out about the culture of patient safety practiced by assistant medical officers in Malaysia.

This cross sectional study was done from November 2012 until February 2013. Data were collected from assistant medical officers who have worked for at least 6 months in all MOH hospitals. The sample size was determined by using a sample size calculator for prevalence studies version 1.0.01, designed by Naing *et al.* (29). Universal sampling was applied to generate samples from the hospital with the healthcare workforce of 500 and less, while proportionate stratified random sampling was used for hospitals with more than 500 health care staff. Samples for assistant medical officers were then randomly selected from each sampling frame of the identified strata by using SPSS software.

Hospital Survey on Patient Safety Culture (HSOPSC) of the Agency for Healthcare Research and Quality (AHRQ), a tool for assessing the safety culture of hospitals was used with slight modification to collect data from respondents. HSOPSC also has been used in different countries including Lebanon (2), China (4), Taiwan (6), the Netherlands (9), the US (8) and Iran (30).

The HSOPSC questionnaire measures four overall patient safety outcomes:Overall perceptions of safety, Frequency of events reported, Number of events reported and Overall patient safety grade.It contains 42 items which mostly use the 4-point Likert response scale of agreement ("Strongly disagree" to "Strongly agree") or frequency ("Never" to "Always"). The completed questionnaires were sent to the Institute for Health Management by mail and the data were analysed using SPSS version 20.0.
The average percentage of positive responses, defined as the average of the item-level percent positive responses within

the survey dimension, represented positive reaction toward patient safety culture. Prior to the conduct of the study, ethical clearance and approval to conduct this research was obtained from the Medical Research and Ethics Committee (MREC), Ministry of Health Malaysia.

Table.1 Average Positive Response Rate on Patient Safety Dimensions

	Patient Safety	**Average % positive response rate**
Dimension	***Organizational Learning-Continuous improvement***	***93.5***
Item	We are actively doing things to improve patient safety.	97.2
	Mistakes have led to positive changes here.	87.6
	After we make changes to improve patient safety, we evaluate their effectiveness.	95.7
Dimension	***Teamwork within unit***	***91.0***
Item	People support one another in this unit.	95.7
	When a lot of work needs to be done quickly, we work together as a team to get the work done.	94.1
	In this unit, people treat each other with respect.	93.4
	When one area in this unit gets really busy, others help out.	80.6
Dimension	***Supervisor/ management expectation and promoting patient safety***	***82.2***
Item	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.	83.6
	My supervisor/manager seriously considers staff suggestions for improving patient safety.	87.0
	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.	79.1
	My supervisor/manager overlooks patient safety problems that happen over and over.	79.1
Dimension	***Management support for patient safety***	***76.3***
Item	Hospital management provides a work climate that promotes patient safety.	86.1
	The actions of hospital management show that patient safety is a top priority.	90.1
	Hospital management seems interested in patient safety only after an adverse event happens.	52.7
Dimension	***Teamwork across units***	***77.2***
Item	There is good cooperation among hospital units that need to work together.	80.6
	Hospital units work well together to provide the best care for patients.	88.5
	Hospital units do not coordinate well with each other.	69.4
	It is often unpleasant to work with staff from other hospital units.	70.4
Dimension	***Overall perception of patient safety***	***72.3***
Item	Patient safety is never sacrificed to get more work done.	95.6
	Our procedures and systems are good at preventing errors from happening.	87.0
	It is just by chance that more serious mistakes don't happen around here.	47.5
	We have patient safety problems in this unit.	58.9
Dimension	***Handoffs and transitition***	***69.5***
Item	The quality of care is affected when we transfer patient from one unit to another.	60.4
	Important patient care information is often lost during shift changes.	79.2
	Problems often occur in the exchange of information across hospital units.	58.6

	Shift changes are problematic for patients in this hospital.	79.7
Dimension	***Feedback communication about error***	***60.8***
Item	We are given feedback about changes put into place based on event reports.	50.4
	We are informed about errors that happen in this unit.	66.8
	In this unit, we discuss ways to prevent errors from happening again.	65.2
Dimension	***Staffing***	***54.2***
Item	We have enough staff to handle the workload.	26.3
	Staff in this unit works longer hours and this affect patient care.	81.1
	We use more temporary staff and this affects patient care.	64.9
	We work in "crisis mode" trying to do too much, too quickly.	44.3
Dimension	***Communication openness***	***44.2***
Items	Staff will freely speak up if they see something that may negatively affect patient care.	58.1
	Staff feel free to question the decisions or actions of those with more authority.	26.5
	Staff are afraid to ask questions when something does not seem right.	47.9
Dimension	***Frequency of events reported***	***44.3***
Item	When a mistake is made, but is *caught and corrected before affecting the patient*, how often is this reported?	51.3
	When a mistake is made, but has *no potential to harm the patient*, how often is this reported?	39.3
	When a mistake is made that *could harm the patient*, but does not, how often is this reported?	42.3
Dimension	***Non punitive response to error***	***26.7***
Item	Staff feel like their mistakes are held against them.	28.7
	When an event is reported, it feels like the person is being written up, not the problem.	39.4
	Staff worry that mistakes they make are kept in their personnel file.	12.0

The dimensions with the highest positive response rate were 'Organizational Learning- Continuous Improvement' (93.5%), followed by 'Teamwork Within Unit' (91.0%) and 'Supervisor/Management Expectation And Promoting Patient Safety' (82.2%).In contrast, the dimensions with the lowest positive response rate were 'Non Punitive Response to Error' (26.7%), 'Communication Openness' (44.2%) and 'Frequency of Events Reported' (44.3%).

Items with the highest positive response rate included 'We are actively doing things to improve patient safety'(97.2%), 'After we make changes to improve patient safety, we evaluate their effectiveness' (95.7%) and 'People support one another in this unit' (95.7%). Meanwhile, 'Staff worry that mistakes they make are kept in their personnel file' (12.0%), 'We have enough staff to handle the workload' (26.3%), and 'Staff feel free to question the decisions or actions of those with more authority' (26.5%) were the items that recorded the lowest positive response rate.

Communication openness which involves encouragement for reporting and speaking up to errors (4) should be a priority in patient safety. It has been reported that poor communication has led to wrong site surgeries, especially when it involves emergency operation and multiple

procedures on one day (11). In this study, AMOs reported low percentage of positive responses on communication openness. This could be due to the nature of Asian community of the fear of 'losing face' and deemed incompetent, which was also evident in Taiwan (8). Furthermore, any errors may be magnified by media and the public, and the coverage could be unintentionally accusatory due to the lack of medical knowledge from those sides. The stress from meetings with the victims and families or potential lawsuit are damaging to an institution that needs public confidence to operate well (31). In Malaysia, Ministry of Health distributes Medication Safety Newsletter twice a year to the public and private healthcare sectors to publicize about events, potential risks and rules that medical staff should adhere to (32). This information sharing is valuable to identify and resolve common problems in our hospitals or those from other countries.

Culture has huge influence in behaviour and reaction to surrounding activities. Respondents in this study also reported lack of freedom to question the actions from higher authority. It could be because our community, as in Asian community tend to place higher regard to hierarchy which leads us to perceive questioning the superiors as rude. Lee et al (11) has previously stated that level of hierarchy is more prevalent in Asian countries. The lack of freedom to express opinions hinders positive changes from taking place and permits continuity of faulty system. In addition, 'Frequency of Events Reported' was also identified as area for improvement. Lack of reporting might originate from lack of practical usefulness, lack of time, competing priorities (33), and fear of management reaction (8). Staff might perceive event reporting to be an administrative task that swallows up their time which focuses on treating patients. The complexity of retrieving data and information on the error could be tedious thus, discouraged our respondents to report. Colleagues would also try to protect their counterparts who committed errors to maintain good personal interactions and group harmony (8). Besides, the failure to report could happen when errors were immediately corrected by staff, so their colleagues did not want to drag the case further by doing an official report, which was deemed unnecessary at that point.

The failure to report events is dangerous to the healthcare system because any malpractice may go unnoticed and it may severely undermine the severity of defects in healthcare delivery. Variety of event reporting channels and assurance of reporter anonymity may increase adverse event reporting (34). Besides, the inclusion of reports from patients, which later are validated by medical review, should also lead to higher detection rate (15). In Taiwan, in addition to existing voluntary reporting system, 54 standards related to patient safety were added to the new Taiwan hospitals accreditation standards, resulting in pressure for hospitals to achieve better accreditation results (9). Error reporting system must be user friendly, and consumes shorter data entry time, perhaps incorporates uses of drop down menus and check off boxes in selection of answers. The system should also be supportive to the existing environment, especially infrastructures, and not impact the workflow, to avoid rejection by the users. In Malaysia, Ministry of Health has introduced its own medication error reporting system which is voluntary and non punitive. The guideline is also distributed to the public and private healthcare facilities (32).

Blame free culture is an accelerator for patient safety improvement (2,3,4). We found that 'Non punitive response to error' was rated low by the AMOs. Fear of

repercussions, legal action or job loss may lead to underreporting (25). Majority of our respondents reported that they were worried that mistakes they make are kept in their personnel file. Before this, it has been documented that disciplinary actions by employers cause nurses to underreport errors (25). Therefore, it is important to educate all levels of healthcare institution that reporting error is about protecting patients, instead of exposing incompetent medical staff. There should be change of behaviour, starting from upper hierarchy, to accept that reporting error opens the opportunity for improvement, instead of negative personal consequences on reporters. Communication openness should be the focus if we want to be the leader in patient safety movement. In the work process, information is passed from one individual to the next and written or verbal order at any point may lack clarity and quality. Therefore, leaders must possess listening skills and be accepting to suggestions expressed by the team members. As feedback to error, there should be commitment and shared responsibility within the team, followed by root cause analysis as prevention from similar errors in the future.

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