

# Attitude & Practices of Hospital Staff Towards Safety In A Tertiary Care Hospital, Pune – A Compilation of Safety Experiments

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## Abstract

**Introduction** -Safety is a critical component to the quality health care. The culture of safety extends to patients, staff, caregivers, and attendants and to anyone visiting the hospital. As health care organizations endeavor to improve their quality of care, there is growing recognition of the importance of establishing a culture of safety. With growing awareness of accreditations like NABH and JCI, the focus on safety culture is rising. Safety culture plays a vital role and it comes with hospital team effort, at protecting patients and staff from harm and empowered to do the right thing. The study observes attitudes and practices towards safety culture.

**Aim & Objectives** – The study aims to conduct various safety experiments to assess the attitudes and observe the practices towards the safety culture. The study also identifies areas for potential safety improvements.

**Methodology** – The study was an observational one where the response of the staff of the hospital was noted towards a particular pre-planned event leading to breach of safety or deviation from the safety norms. The response of the staff members who have witnessed deviations were noted.

**Results & Conclusion** - The results showed that most of the hospital staff of this hospital feel positively toward patient safety culture in their organization. The training needs and areas of improvement were identified.. Such safety experiments should be conducted from time to time to know error and event reporting

**Key words** – Safety culture, Hospital safety, incident reporting

## Introduction

Safety culture plays a vital role in a hospital and it comes with hospital team effort, at protecting patients and staff from harm and empowered to do the right thing. Essential practices of healthcare employees are often invisible. Also, there is the need for major changes in individual behaviour to shift from the culture of ‘blame’ to an objective response to errors. This means shifting

the blame toward the systems that allow such errors, rather than blaming the individual. Thirdly, healthcare staff’s fear of losing others’ confidence and trust, and thus, fear of damage to personal reputation, need to also be alleviated.<sup>1</sup>

Patient safety, if not assessed, cannot be improved. Changing the culture, or even a few practices and policies, requires health-care professionals and especially the top-level administrators and their employees to share a common vision. A good safety system depends on having a culture that supports and encourages employees to report their errors and near misses.<sup>2</sup>

Measuring the safety culture will help managers understand its impact on the occurrence of errors. It will help to identify the relative contribution of causal factors

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to errors.<sup>3-4</sup> All staff in hospitals should consider the importance of encouraging and supporting the people they supervise when errors are reported.<sup>5,6</sup>

Promoting a culture of reporting errors is applicable to the patient care environment so that staff members learn from each other and help to avoid the occurrence of future errors.<sup>7,8,9</sup> When addressing safety within one particular health care organization, measuring the existing safety culture may help enlighten management regarding issues that impede making progress in improving safety.<sup>10</sup>

Assessment of the safety culture has been carried out in several ways, one of which is the use of observational experiments. Some experiments used have assessed patient-safety features and evaluate the health-professional's perceptions of actions and behaviours in their work environment. The results will help to determine which actions and behaviours, relative to safety requirements and regulatory goals, should be

prioritized for process improvement. Knowledge will help only when put into practice. So there is a dire need to study and observe the practices exhibited by the healthcare staff to create a safety culture.

**Aim & Objectives** – The study aims to conduct various safety experiments to assess the attitudes and observe the practices towards the safety culture. The study also identifies areas for potential safety improvements. This will help to develop a positive attitude towards safety culture.

**Methodology** – The study was an observational one where the response of the staff of the hospital was noted towards a particular pre-planned event leading to breach of safety or deviation from the safety norms. The response of the staff members who have witnessed deviations or breach in safety were noted.

### **Experiments performed to assess attitude and practices towards safety culture**

The following experiments were leading to error in the safety protocol were performed.



#### 1. PATIENT FILE LYING ON THE CHAIR AT OPD WAITING AREA

- Experiment duration: 2 hours. One hour at the OPD waiting area. This experiment resulted in the positivity towards the Patient Safety Culture.
- Ten Housekeeping staff noticed the unknown file and then six of them submitted the file at the nearby reception. Four of them reported about the unknown file at the nearby reception area.
- Seven Doctors had noticed the unknown file and then they informed the nearby reception to pick the file and look for the respective person of that file.
- Few patients, relatives and some staff went unobserved. Some staff noticed but ignored.
- This shows areas of weaknesses and improvement scope



**2. CIGARETTE BUDS AT SECURITY CABIN NEAR ATTENDANCE MACHINE**

- Experiment duration: 1 hour.
- The security staff who were present at the site informed their supervisor and informed Housekeeping staff to clean the area and then started searching for the person who did the incident.
- Each and every staff who was coming at the site for punching their attendance started informing security about the presence of the cigarette buds at the site.



**3. UNKNOWN BAG ON THE PATHWAY NEARBY TO SECURITY CABIN**

- Experiment duration: 1 hour.
- Five people from security noticed the unknown bag and by making sure that the bag does not contain any harmful material in it, stored bag at the security office and was searching for the owner of the bag.
- Ten Housekeeping staff noticed the unknown bag at the site and then informed at security cabin about the bag. Seven family members showed the response towards the unknown bag and informed security person at the cabin about the bag.



**4. DANGLING WIRE AT ATM SITUATED NEAR HOSPITAL ENTRANCE**

- Experiment duration: 1 hour.
- One of the security person noticed the dangling wire and was asking people who were wandering from that area to stay away from that wire.
- Three of the Housekeeping staff shown the response towards that wire by informing security.
- Five of the security staff shown the response by calling the electrician.



**5. CARDBOARDS LYING ON THE STAIRS (2<sup>nd</sup> FLOOR)**

- Experiment duration: 1 hour.
- The two-executive people from Housekeeping department who were passing from this site shown the response towards the cardboards and informed Housekeeping person first to pick them up and was interrogating about the incident.
- Ten Housekeeping staff exhibited the response towards the cardboards by lifting them up.
- Five doctors noticed the cardboards and informed security of that floor.

	<p style="text-align: center;"><b><u>6. LAMP POST WIRE LYING OPEN AT STAFF PARKING AREA</u></b></p> <ul style="list-style-type: none"> <li>▪ Experiment duration: 2 hours.</li> <li>▪ The respective security of that parking area noticed the wire and asking staff to walk away from that wire and then he called electrician to disconnect the wire connection and remove that wire.</li> <li>▪ Each and every staff coming across the respective area shown the response towards it by informing the security about the incident.</li> </ul>
	<p style="text-align: center;"><b><u>7. BROKEN TILE KEPT OUTSIDE THE ICU WAITING AREA NEARBY AT CORRIDOOR</u></b></p> <ul style="list-style-type: none"> <li>▪ Experiment duration: 1 hour.</li> <li>▪ Each and every Housekeeping Staff who were shifting patients on wheelchairs etc., shown the response on the broken tiles by picking them up.</li> <li>▪ Ten consultants and 8 Resident Doctors who came across that area informed security to ask Housekeeping Staff to pick it up.</li> <li>▪ Some of the Patient relatives informed security about the broken tiles.</li> </ul>
	<p style="text-align: center;"><b><u>8. BLOOD STAINED LINEN DUMPED NEAR THE LIFT</u></b></p> <ul style="list-style-type: none"> <li>▪ Experiment duration: 2 hours.</li> <li>▪ At every floor each Housekeeping staff who came over the linen shown the response on that by asking the security at respective floor.</li> <li>▪ At two of the floors the Housekeeping staff started picking it up by wearing the hand gloves.</li> <li>▪ Ten patient relatives coming across the linen shown response by informing the security.</li> <li>▪ Twelve doctors informed the security about the linen.</li> <li>▪ This portrays the presence of Patient Safety Culture within the Hospital Staff.</li> </ul>
	<p style="text-align: center;"><b><u>9. BLOOD STAINED SWABS NEAR BED AT DRESSING ROOM</u></b></p> <ul style="list-style-type: none"> <li>▪ Experiment duration: 1 hour..</li> <li>▪ The Consultants whoever came in that room asked Nursing Staff to pick them up. Each and every Resident Doctor entered the room responded on this incident by asking Nursing Staff to pick the swabs.</li> <li>▪ The other Nursing Staff from other departments who visited that room was asking the respective Nursing Staff of that dressing room that why the blood stained swabs are on the floor.</li> <li>▪ These responses proved the existence of patient Safety Culture within the Hospital Staff.</li> </ul>

**Conclusion**

In general, hospital staff in this hospital feel positively toward patient safety culture within their organization and immediate response was seen to the errors and preplanned events. There were some areas of improvement where staff needs to be more proactive and more alert. Such safety experiments should be conducted

from time to time to know the attitudes and practices of staff during error and event reporting.

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