

A Study on the Knowledge, Attitude and Practice Regarding Patient Safety Goals among the Staff Nurses in a Selected Tertiary Care Hospital

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Abstract: Patient safety has been an increasingly important topic of interest over the last decade, although there are still many fields where further research is needed. Patient safety is a global issue affecting countries at all levels of many patients suffer from preventable harm during the health care in hospitals and each year many people die from medical errors. The primary data will be collected from staff nurses in a selected tertiary care hospital. The research approach adopted in this study is descriptive cross sectional type. A structured questionnaire method will be developed and administered on nurses to assess knowledge, attitude and practice on Patient Safety Goals among the staff nurses. The questionnaire was filled either by interviewing the staff nurses via phone or they filled it themselves. Collected data was analyzed by frequency, percentage, mean, standard deviation and chi-square test. The mean age in the study was 24 years the mean BMI was 19.5 years; there were 10 males and 90 females. Most of the safety practices were being followed. Orientation of the patients towards their safety and of the patient needs a regular reinforcement. In order to make sure that the practices be followed the suggestions of the nurses and those involved in health care at the ground level be brought to the notice of the concerned authorities so that appropriate action be taken

Keywords: Knowledge, Practice, Patient Safety Goals, Staff, Tertiary Care Hospital.

INTRODUCTION

Patient safety has been an increasingly important topic of interest over the last decade, although there are still many fields where further research is needed. Patient safety is a global issue affecting countries at all levels of development .

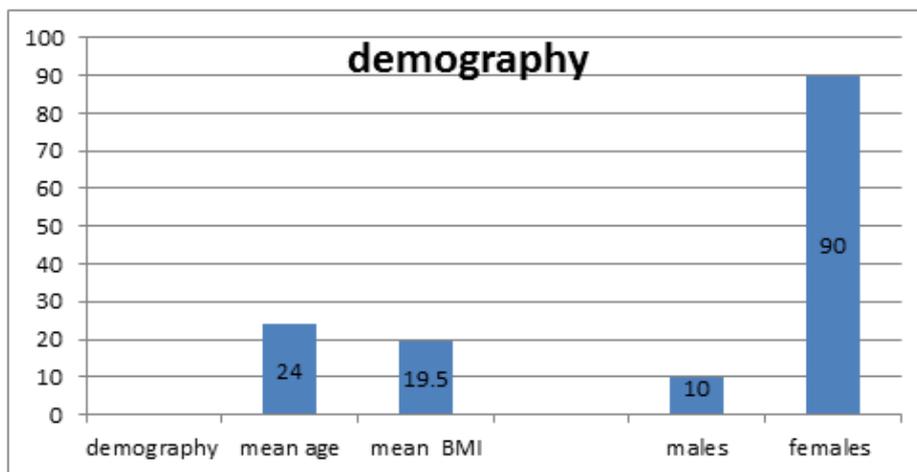
The World Health Organization highlighted the importance of patient safety and related issues, and it is therefore essential to have knowledge of the main contributory factors in order to devise appropriate solutions .Many patients suffer from preventable harm during the health care in hospitals and each year many people die from medical errors.

METHODOLOGY

Father Muller Medical College Hospital is 1250 bed multi- speciality Hospital. The Hospital has doctors in almost all specialities. The primary data will

be collected from staff nurses in a selected tertiary care hospital. The research approach adopted in this study is descriptive cross sectional type. A structured questionnaire method will be developed and administered on nurses to assess knowledge, attitude and practice on Patient Safety Goals among the staff nurses. The questionnaire was filled either by interviewing the staff nurses via phone or they filled it themselves .Collected data was analyzed by frequency, percentage, mean , standard deviation and chi-square test.

RESULTS



| question | Some times | always | rarely | most of the time | never | total |
|---|------------|--------|--------|------------------|-------|-------|
| Hand Wash After Each Patient | 34 | 8 | 35 | 23 | 0 | 100 |
| Use Of Sterilum /Hand Hygiene After Examining Each Patient | 14 | 4 | 2 | 80 | 0 | 100 |
| Capping Syringes After Use | 7 | 8 | 4 | 45 | 36 | 100 |
| Uncapping Used Syringes On Discarding | 4 | 1 | 2 | 92 | 1 | 100 |
| Wearing Sterile Masks On Giving Injections | 5 | 2 | 1 | 10 | 82 | 100 |
| Reporting Of Incidents That Affect Hygiene / Safety Practices | 2 | 4 | 3 | 3 | 90 | 100 |

The mean age in the study was 24 years the mean BMI was 19.5 years; there were 10 males and 90 females. Most of the safety practices were being followed.

DISCUSSION

As per patient survey reports, there seems to be a steep increase in the incidence and prevalence of medical error associated deaths in our country. As many as 98,000 people die in hospitals each year as a result of medical errors that could have been prevented, according to the Institute of Medicine [1].

An epidemiological study of hospital inpatient falls in the United States showed (2004) that 19.1% occurred during ambulation, 10.9% when getting out of bed, 9.3% while sitting down or standing up, and 4.4% while using the bedside commode or toilet. Krauss and colleagues (2007) showed that 79.5% of falls occurred in patient rooms, 11% in patients' bathrooms, and 9.5% in hallways, exam, or treatment rooms, or by the nurse's stations. The physical environment and available nursing supervision seems to have a significant impact on patients' safety during their hospital stays. However,

most hospitals are not explicitly designed to enhance patient safety [2].

JCI (Joint Commission International) Program is designed to create a culture of safety and quality within a health care facility and ensure that it strives to continuously improve patient care process and results for patients .The foundation of quality patient care is a proactive program of patient safety [3]. Meeting these goals helps health care facilities to ensure that a safe health care environment is provided for the patient

The risk of health care associated infections is estimated to be 2-20 times higher in developing countries. Adhering to Patient Safety Goals reduces 5 health care associated infections by promoting hand washing among health care providers. Unsafe practices include reuse of syringes and needles in the absence of sterilization and poor collection and disposal of dirty injection equipments which expose health care workers and the community to the risk of needle stick injuries.

In the present study we found that most of the people used Sterilum for hand sanitization as it saved water and time as they carry it themselves or it was

available bedside. Reporting of adverse events was not done as they either forgot about it as they chose to neglect it. Among the adverse events the most commonly ignored as spillage of the body contents like urine, contents of Ryles tube while removing. The nurses felt that while discarding removal of the caps of needles that were used should be discontinued as it carried a higher risk of injury.

The descriptive study done by Ali Sahin, FatmaAyhan and Serife Kursun[4] to evaluate the attitudes of surgical nurses concerning patient safety in 2007 with the aim to create patient safety awareness by monitoring and recording the issues that threat patient and worker safety. The study included 123 nurses and data collection tools included a questionnaire. This study reveals that working shifts could exceed 12 hours leading to an increase in the risk of making mistakes, inadequate communication and information flow and high work load leading to unfavourable impact on patient safety. The study concluded that inadequate resting, not giving in-service-training, and being unable to establish patient safety concept unfavourably influence both the patient's and worker's safety.

A descriptive correlation study done on Nurse Staffing Models, Nursing Hours, and Patient Safety Outcomes by Hall, Linda , Pink, *et al.* [5] in 2004 with the aim to evaluate the effect of different nurse staffing models on costs and the patient outcomes of patient falls, medication errors, wound infections, and urinary tract infections. The results show that the lower the proportion of professional nursing staff employed on a unit, the higher the number of medication errors and wound infections. The less experienced the nurse, the higher the number of wound infections. The study suggests that a higher proportion of professional nurses in the staff mix (RNs/RPNs) on medical and surgical units in are associated with lower rates of medication errors and wound infections. Higher patient complexity was associated with greater patient use of nursing care resources.

A study by Richardson A. & Storr J [6] in showed that huge potential exists for improvement through nursing empowerment, leadership and the development of tools to strengthen and support nurses' influential role in the quality and safety movement; therefore, the need for investment into well-designed research studies to address these gaps is obvious, required and timely. Jeongeunkim [7] with 886 nurses found that the majority of nurses were not comfortable reporting errors or communicating concerns about safety issues. A significant portion reported concerns about patient safety issues in their working unit

Indre Brasaite using a questionnaire in three multi-disciplinary hospitals in Western Lithuania. Data was collected inform nurses and nurse assistants found that the safety attitudes of respondents were generally

found to be positive. Attitudes related to patient safety issues were positive among health care professionals and opens the door for the open discussion of patient safety and adverse events

CONCLUSION

Orientation of the patients towards their safety and of the patient needs a regular reinforcement In order to make sure that the practices be followed the suggestions of the nurses and those involved in health care at the ground level be brought to the notice of the concerned authorities so that appropriate action be taken

REFERENCES

1. <http://www.patientsafetyfocus.com/patient-safety-current-st.html>
2. http://www.medscape.com/viewarticle/576954_3
3. *Joint Commission International Center for Patient Safety: available from* www.jcipatientsafety.org
4. Şahin A, Ayhan F, Kurşun Ş. Evaluation of surgical nurses' attitudes concerning patient safety. *Journal of Human Sciences.* 2015 Jun 17;12(1):1537-46.
5. Hall LM, Doran D, Pink GH. Nurse staffing models, nursing hours, and patient safety outcomes. *Journal of Nursing Administration.* 2004 Jan 1;34(1):41-5.
6. Richardson A, Storr J. Patient safety: a literative review on the impact of nursing empowerment, leadership and collaboration. *International nursing review.* 2010 Mar 1;57(1):12-21.
7. Kim J, An K, Kim MK, Yoon SH. Nurses' perception of error reporting and patient safety culture in Korea. *Western Journal of Nursing Research.* 2007 Nov 1;29(7):827-44.
8. Brasaite I, Kaunonen M, Suominen T. Healthcare professionals' knowledge, attitudes and skills regarding patient safety: a systematic literature review. *Scandinavian journal of caring sciences.* 2015 Mar 1;29(1):30-50.