

The Discrepancy in Safety Culture Perceptions between Staff Nurses and Nurse Leaders in Medical-Surgical Units

Lisa Harton, PhD, MBA, MPH, RN, FACHE, NEA-BC, CIC
Loyola University of Chicago Marcella Niehoff School of Nursing

Background

- Organization culture remains a significant barrier to safer patient care¹
- Nurses consistently have the least favorable perception (63% favorable) of safety culture and administrators have the most favorable perception (77% favorable)²

Safety Culture^{3,4}

The product of individual and group values, attitudes, perceptions, competencies and patterns of behavior that can determine the commitment to, and the style and proficiency of an organization's health and safety management system

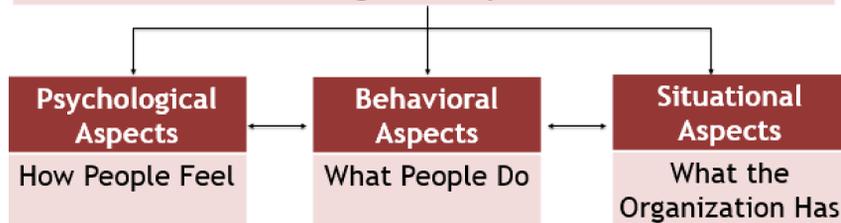


Figure 1. Safety Culture

Purpose

- Understand, explore and describe safety culture as experienced by staff nurses (registered nurses) and nurse leaders within the situational context of medical-surgical units in a hospital.
- Compare and contrast staff nurses' and nurse leaders' safety culture experiences.

Method

- Inductive Qualitative Descriptive

Results

A purposive sample of:

- Staff Nurses (n = 16)
- Nurse Leaders (n = 10)

Staff Nurse Themes	Shared Language Categories	Nurse Leader Themes
Time to "know my patient to keep them safe"	Relationships with Patients	Making sure staff nurses are keeping patients safe
"Using my gut" and nursing interventions	Nursing Interventions	Making sure staff nurses have nursing interventions in place
"Extra eyes on the patient"	Relationships with Colleagues	"I expect staff nurses to stop things or escalate when they feel uncomfortable"
Not always having what is needed to provide safe care	Resources	Making sure staff nurses have what they need to provide safe care
Organization prioritizes patient safety	Organization Prioritizes	Organization prioritizes patient safety
Learning: "Have our Backs"	Learning	Making sure staff nurses are learning and growing



- The language between participant groups was similar but the meaning varied based on unique role experiences
- Most unsafe day:
 - Not enough time
 - Inadequate Staffing
 - Poor relationships with physicians
- Safest Day:
 - Staff nurses: Working together as a team
 - Nurse Leaders: Having a clear plan in place

Implications for Research and Practice

- Organizations must understand and support the staff nurse and nurse leader **making sure**⁵ process to serve as the foundation for safe nursing practice
- Organizations must set expectations and accountability for safety-first behaviors
- Relationships between all members of the healthcare team must be further studied and improved
- Evidence to support a paradigm shift in the role of the staff nurse and nurse leader is warranted

Conclusion

- Staff nurses and nurse leaders experience barriers daily to making sure patients are safe
- Relationships are foundational to safe patient care
- Organizations must understand the psychological, behavioral, and situational aspects influencing a safety culture to realize safer patient care

References

1. Leape LL. Symposium: Patient safety: Collaboration, communication, and physician leadership. *Clinical Orthopaedics and Related Research*. 2015; 473: 1568-1573. doi.org/10.1007/s11999-014-3598-6.
2. Famolaro T, Yount ND, Hare R, et al. Hospital Survey on Patient Safety Culture 2018 Database Report, Appendixes, Parts II and III (Appendixes for AHRQ Publication No.18-0025-EF). (Prepared by Westat, Rockville, MD, under contract No. HHS290201300003C). Rockville, MD: Agency for Healthcare Research and Quality. 2018.
3. Health and Safety Commission Advisory Committee on the Safety of Nuclear Installations. (1993). Organizing for safety: Third report of the ACSNI study group on human factors. Sudbury, UK: HSE Books.
4. Edwards, J., Davey, J., & Armstrong, K. (2013, June). Returning to the roots of culture: A review and re-conceptualization of safety culture. *Safety Science*, 55, 70-80.
5. Schmidt, L. (2010, November/December). Making sure: Registered nurses watching over their patients. *Nursing Research*, 59(6), 400-406.