Errors reporting and Patient Safety Culture in Saudi Hospitals

Ohoud Aldughmi, RN,MSN
Loyola University of Chicago Marcella Niehoff School of Nursing

Background and Significance

- Medical errors are mistakes carried out in organizations that are ineffectively designed to catch these mistakes in time (Bokhari, 2019).
- A study reported that 50–80% of medical errors can be prevented (Ibrahim et al., 2019).
- To prevent medical errors, healthcare organizations should create an environment that encourages providers to report these errors and learn from their mistakes.
- The blaming environment is one of the reasons for not reporting errors in Saudi hospitals.
- The development of a safety culture in healthcare organizations is one of many methods to decrease medical and nursing errors (Ko & Yu, 2017).
- To create a patient safety culture (PSC) environment, healthcare providers' intentions to engage in reporting patient safety events should be explained and predicted.

Purpose

- The purpose of the study is to examine the effects of perceived patient safety culture and psychological safety of nurses on their intention to report errors.

Method

- A quantitative cross-sectional online survey method will be used for this study.

Saudi Patient Safety Initiatives

- As a result of the Kingdom's 2030 Vision, the Saudi healthcare system has proposed many initiatives to improve patient safety.
- The Ministry of Health (MOH) created a body named Saudi Patient Safety Center (SPSC) in 2017.
- This Center aims to create a national strategy to improve patient safety and decrease medical errors.
- The national medical errors reporting project "SATAK was introduced in 2018.
- The goal is to link all Saudi hospitals with one operation to report medical errors in order to measure, analyze, and learn from errors.

Incident Reporting

- A successful incident reporting system assists healthcare organizations in creating a culture of safety (Al-Rayes et al., 2020).
- Several studies have discovered barriers to error reporting among Saudi nurses.
- A lack of motivation and feedback and punitive approach are the reasons for under-reporting errors.

Implications for Research and Practice

- ✓ The study will provide novel and critically important insights into these topics:
- ✓ A relationship between Saudi nurses' intentions to reporting errors and factors affecting incident reporting such as psychological factors.
- ✓ This can provide a safe environment in which nurses feel safe to report errors.
- ✓ The results of the study can serve as a national reference point that encourages improvement efforts and assists hospital leaders in identifying and improving the safety and quality of care.

Conclusion

- Patients should not be hurt by the care that is supposed to help them.
- The healthcare environment is rich with the possibility of errors
- Errors that occurred in a healthcare organization will be viewed as a learning resource

References

AlQudehy, Z., AlSaeed, H., AlZain, N., Lawton, R., & AlQuedehy R. (2018). Barriers to sentinel events reporting in tertiary hospital at Dammam, Saudi Arabia. Open Science Journal, 3(4), 1-9.
Al-Rayes, S. A., Aldar, F. A., Al Nasif, N. S., Alkhadrawi, Z. I., Al-Fayez, A., & Alumran, A. (2020). The use of electronic incident reporting system: Influencing factors. Informatics in Medicine Unlocked, 21, 100477.
Alsulami, S. L., Sardidi, H. O., Almuzaini, R. S., Alsaif, M. A., Almuzaini, H. S., Moukaddem, A. K., & Kharal, M. S. (2019a). Knowledge, attitude and practice on medication error reporting among health practitioners in a tertiary care setting in Saudi Arabia. Saudi Medical Journal, 40(3), 246-251. doi:10.15537/smj.2019.3.23960
Bokhari, R. M. (2019). Improving patient safety and reducing medical errors in Saudi healthcare organizations. Journal of Medical and Pharmaceutical Sciences, (1)3,76-92, DOI: 10.26389/AJSRP.R101218
Hammoudi, B. M., Ismaile, S., & Abu Yahya, O. (2018). Factors associated with medication administration errors and why nurses fail to report them. Scandinavian Journal of Caring Sciences, 32(3), 1038-1046. https://10.1111/scs.12546
Ibrahim, M. A. M., Osman, O. B., & Ahmed, W. A. M. (2019). Assessment of patient safety measures in governmental hospitals in Al-Baha, Saudi Arabia. AIMS Public Health, 6(4), 396.
Ko, Y., & Yu, S. (2017). The relationships among perceived patients' safety culture, intention to report errors, and leader coaching behavior of nurses in Korea: A pilot study. Journal of Patient Safety, 13(3), 175-183
Lee, S. E., Vincent, C., Dahinten, V. S., Scott, L. D., Park, C. G., & Dunn Lopez, K. (2018). Effects of Individual Nurse and Hospital Characteristics on Patient Adverse Events and Quality of Care: A Multilevel Analysis. Journal of Nursing Scholarship, 50(4), 432-440. https://10.1111/jnu.12396