Oncological Patient Safety Culture from the Perspective of the Multidisciplinary Team

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Cultura de Segurança do Paciente Oncológico na Perspectiva da Equipe Multiprofissional

Cultura de Seguridad del Paciente Oncológico desde la Perspectiva del Equipo Multiprofesional

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ABSTRACT

Introduction: The safety culture originates from the organizational culture, being described as the set of perceptions, skills, attitudes and values, both individual and collective, in favor of an organization committed to the management of patient safety. In scenarios such as oncology compounds/High Complexity Oncology Clinics (Unacon), where patients are more vulnerable and the daily routine of the multidisciplinary team is based on various work processes, it is necessary to evaluate the safety culture to detect aspects that need to be improved. **Objective:** Analyze the patient safety culture in an oncology compound from the perspective of the multidisciplinary team. **Method:** Descriptive-exploratory, quantitative, cross-sectional study developed in an oncological compound in Brazil's Southern, with 46 professionals from the multidisciplinary team. Data were collected between July and September 2021, through the application of the Hospital Survey on Patient Safety Culture questionnaire. The guidelines of the Agency for Healthcare Research and Quality were followed to analyze and interpret the data. **Results:** The data obtained showed higher frequency of positivity for "teamwork at the compound" (61.9%) and "expectations and actions of the supervisor/chief to promote the patient safety" (60.9%). **Conclusion:** The results indicate that the safety culture needs to be strengthened at the study site in the 12 dimensions evaluated, with special attention to those with the lowest rate of positivity.

Key words: organizational culture; patient safety; patient care team; Cancer Care Facilities.

RESUMO

Introdução: A cultura de segurança origina-se da cultura organizacional, sendo descrita como o conjunto de percepções, competências, atitudes e valores, tanto individuais quanto coletivas, em prol de uma organização comprometida com a gestão da segurança do paciente. Em cenários como complexos oncológicos/Unidade de Alta Complexidade em Oncologia (Unacon), onde os pacientes estão mais vulneráveis e a rotina diária da equipe multiprofissional é fundamentada por vários processos de trabalho, é necessário que seja avaliada a cultura de segurança em busca de pontos a serem aperfeiçoados. **Objetivo:** Analisar a cultura de segurança do paciente em um complexo oncológico na perspectiva da equipe multiprofissional. **Método:** Estudo descritivo-exploratório, de natureza quantitativa, do tipo transversal, desenvolvido em um complexo oncológico no Sul do Brasil, com 46 profissionais da equipe multiprofissional. Os dados foram coletados entre julho e setembro de 2021, por meio da aplicação do questionário *Hospital Survey on Patient Safety Culture* (HSOPSC). Na análise e interpretação de dados, foram seguidas as orientações da *Agency for Healthcare Research and Quality*. **Resultados:** Os dados obtidos demonstraram maior frequência de positividade para "trabalho em equipe da unidade" (61,9%) e "expectativas e ações do supervisor/chefe para a promoção da segurança do paciente" (60,9%). **Conclusão:** Os resultados indicam que a cultura de segurança precisa ser fortalecida no local do estudo nas 12 dimensões avaliadas, com especial atenção àquelas dimensões com avaliação com menor taxa de positividade.

Palavras-chave: cultura organizacional; segurança do paciente; equipe de assistência ao paciente; Institutos de Câncer.

RESUMEN

Introducción: La cultura de seguridad se origina en la cultura organizacional, describiéndose como el conjunto de percepciones, habilidades, actitudes y valores, tanto individuales como colectivos, a favor de una organización comprometida con la gestión de la seguridad del paciente. En escenarios como los complejos oncológicos/Unidad de Oncología de Alta Complejidad (Unacon), donde los pacientes son más vulnerables y la rutina diaria del equipo multidisciplinario se basa en varios procesos de trabajo, es necesario evaluar la cultura de seguridad en busca de puntos a mejorar. **Objetivo:** Analizar la cultura de seguridad del paciente en un complejo oncológico desde la perspectiva del equipo multidisciplinario. **Método:** Estudio descriptivo-exploratorio de carácter cuantitativo, transversal, desarrollado en un complejo oncológico del Sur de Brasil, con 46 profesionales del equipo multidisciplinario. Los datos se recopilaron entre julio y septiembre de 2021, mediante la aplicación del cuestionario *Hospital Survey on Patient Safety Culture* (HSOPSC). En el análisis e interpretación de los datos, se siguieron las directrices de la *Agency for Healthcare Research and Quality*. **Resultados:** Los datos obtenidos mostraron una mayor frecuencia de positividad para "trabajo en equipo de la unidad" (61,9%) y "expectativas y acciones del supervisor/jefe para la promoción de la seguridad del paciente" (60,9%). **Conclusión:** Los resultados indican que es necesario fortalecer la cultura de seguridad en el sitio de estudio en las 12 dimensiones evaluadas, con especial atención a aquellas dimensiones con menor índice de positividad.

Palabras clave: cultura organizacional; seguridad del paciente; grupo de atención al paciente; Instituciones Oncológicas.

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INTRODUCTION

The patient safety is a world issue with several initiatives being launched to stimulate health institutions to provide safe care with beneficial results and avoiding any risk or adverse event[1].

During the COVID-19 pandemic, this issue escalated to alarming levels with a high burden to the institutions to create new beds, technologies and find skilled professionals[2].

The safety culture is the reduction of health-related unnecessary damages to an acceptable level to the individuals who seek healthcare[3]. For the organization, is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment of the organization with patient safety[4].

Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures and identification of vulnerabilities to adjust the work processes[4,5].

Patient safety is determined by the culture of the multiprofessional team involved in direct and indirect care provided to the patients. The understanding of this concept by health professionals strengthens the nature of the care provided to them[6].

Health institutions provide care to individuals in diverse sickening processes, requiring increasingly complex treatments and technologies that eventually will strengthen the safety culture[7]. It should be in place at every health system, specifically at oncology centers because the health caregivers are at risk of burnout[8].

Directive number 874 dated May 17, 2013[9] describes the complexity of a preventable chronic disease which requires a therapeutic plan addressing full care. The care to the oncological patient needs to be updated on a permanent bases, keeping the focus on the aspects of the care, the medical clinic, social conditions and family, in addition to support to pain, finitude and death[10].

At High Complexity Oncology Units (Unacon) with extensive routines and several processes the multiprofessional team needs to follow, the safety culture has to be monitored for improved performance[8].

The analysis of the patient safety may reveal important topics of the work routine. This approach facilitates the acquisition of information about safety concepts, identifying the weak points for effective planning[11].

The research question is: "How the health multiprofessional team perceives the culture of patient safety at Unacon?". It must be considered within the perspective of the caregivers in an oncologic complex.

The investigation was developed during the COVID-19 pandemic and the results were influenced directly and indirectly by this sanitary crisis since it dismantled the world health system, with fragilized teams due to extenuating turnover, burnout and emotional stress.

METHOD

Exploratory-descriptive cross-sectional quantitative study was developed at a reference public hospital Unacon in the State of Santa Catarina in Brazil's South Region.

The study population consisted in oncology multiprofessional team of physicians, nurses, licensed nurses practitioners, physiotherapists, pharmacists, nutritionists, psychologists, residents and clinical cancerologists. The sample was non-probabilistic by convenience.

The inclusion criteria were attending caregivers when data were collected; professionals who worked for less than six months at Unacon or in vacation or on medical leave were excluded. Seven of the eligible caregivers refused to participate or did not return the collection form, four worked for less than six months and the final sample consisted of 46 participants.

After approval by the Institutional Review Board (IRB) the investigators invited the health professionals to join the study, providing them with the required information and ensuring the anonymity of the responses. The professional who accepted to be enrolled, received two copies of the Informed Consent Form and an envelope with the questionnaire with instructions about how to fill in the data in a secluded room in the presence of the investigators. If the professionals were unable to follow this procedure due to overlapping activities, the questionnaire could be completed otherwise. Upon completion, the questionnaire was handed over to one of the investigators in an envelope at the time and day determined.

Data were collected from July to September 2021 through the application of an instrument titled Hospital Survey on Patient Safety Culture (HSOPSC) elaborated in 2004 by the USA Agency for Healthcare Research and Quality (AHRQ) already in public domain. The version translated and adapted to Portuguese was utilized[11].

The 42-questions HSOPSC address patient safety grouped in 12 dimensions: "teamwork"; "expectations and actions of the supervisor to promote patient safety"; "organizational learning, continuous improvement"; "owner/managing partner/leadership support for patient safety"; "overall perception of the patient safety"; "feedback and error reporting"; "communication openness"; "frequency of events reported"; "teamwork

across units"; " staff training"; "handoffs and transitions" and "non-punitive response to errors"[12].

The Likert-scale was applied to analyze the 12 dimensions, ranging from "fully disagree" to "fully agree". Based in the percentage of positive answers calculated by the combination of the two highest categories of the responses, the evaluation of each dimension was determined, high percent means favorable attitudes towards safety culture[13].

The recommendations of AHRQ were followed to analyze and interpret the data. Positive responses are favorable to patient safety culture and allow to distinguish strong and fragile areas. Strong patient safety areas were those which reached 75% of positive responses ("fully agree" or "agree"), or those with negative responses which accounted for 75% of the responses "fully disagree or "disagree". Similarly, 50% to 75% of the positive responses were attributed to "fragile areas of the patient safety" which need to be improved with 50% or less of positive responses[12].

Data were entered in Microsoft Excel® and later exported to the Statistical Package for the Social Sciences (SPSS), version 20.0 for statistical analysis. The categorial variables were described by frequency and percentage. The quantitative variables were evaluated by the Kolmogorov-Smirnov test. Variables with normal distribution (age) were described by mean and standard-deviation and those with asymmetry (time of work) by the median and interquartile range (percentiles 25 and 75).

The Cronbach's alpha is a reliability coefficient to measure the internal consistency of the questionnaire. The reliability of the dimensions was compared with the results of the original HSOPSC, considering acceptable a Cronbach's alpha ≥0.60.

The study complied with Resolutions 466/2012[14], 510/2016[15] and 580/2018[16] of the National Health Council and was approved on June 2021 by the Institutional Review Board of the hospital where the study was carried out, report number 4,802,897 and CAAE (Submission for Ethical Review) 47759921.0.0000.5359.

RESULTS

Fifty-seven participants of the multiprofessional team were invited. Of these, seven refused to join or did not respond and four were ineligible (work time for less than six months). The response rate was 86.8% (46 of the 53 eligible). The sample consisted of 46 professionals, mostly females with mean age of 32 years-old. The majority of the respondents (73.9%) completed post-graduation and had direct contact with the patients. Most of the professionals worked for less than five years at the hospital (60.9%) and at the current department (58.7%). Nurses predominated, representing 45.6%, 39.1% of which were certified nurses and 6.5%, licensed nurses practitioners. The sociodemographic characteristics are presented in Table 1.

Table 1. Sociodemographic characteristics of the health multiprofessional team of a Unacon at Brazil's Southern, 2021

Characteristics	n=46
Female, n (%)	39 (84.8)
Age, years, mean±standard deviation	32.4±6.9
Education, n (%)	
Complete or Incomplete Elementary School	–
Complete or Incomplete High School	3 (6.5)
Complete or Incomplete University	9 (19.6)
Post-graduation	34 (73.9)
Interaction or direct contact with the patient, n (%)	44 (95.7)
Hospital employment, n (%)	
Less than 1 year	5 (10.9)
1 to 5 years	28 (60.9)
6 to 10 years	10 (21.7)
11 to 15 years	2 (4.3)
16 to 20 years	–
21 years or more	1 (2.2)
Current health-related employment, n (%)	
Less than 1 year	7 (15.2)
1 to 5 years	27 (58.7)
6 to 10 years	8 (17.4)
11 to 15 years	4 (8.7)
16 to 20 years	–
21 years or more	–
Week workload, n (%)	
Less than 20 hours/week	1 (2.2)
20 to 39 hours/week	8 (17.4)
40 to 50 hours/week	31 (67.4)
60 to 79 hours/week	6 (13.0)
Occupation, n (%)	
Physician	7 (15.2)
Nurse	18 (39.1)
Licensed nurse practitioner	3 (6.5)
Physiotherapist	3 (6.5)
Nutritionist	4 (8.7)
Psychologist	2 (4.3)
Pharmacist	3 (6.5)
Resident	6 (13.0)

The internal consistency of the items for each dimension is presented in Table 2: "teamwork", "expectations and actions of the supervisor/chief to promote the safety of the patient", "owner/managing partner/leadership support for patient safety", "frequency of events reported" with value above 0.70. For the other dimensions, there is no good internal consistency.

Table 2. Cronbach's alpha coefficient for the dimensions

Dimensions	Cronbach's α
D1 – Teamwork	0.76
D2 – Expectations and actions of the supervisor/chief to promote the safety of the patient	0.84
D3 – Organizational learning, continuous improvement	0.56
D4 – Feedback and report of errors	0.55
D5 – Communication openness	0.64
D6 – Professionals	0.58
D7 – Non punitive responses to errors	0.42
D8 – Owner/Managing Partner/ Leadership Support for Patient Safety	0.84
D9 – Teamwork across units	0.64
D10 – Handoffs and transitions	0.68
D11 – Overall perception of the patient safety	0.43
D12 – Frequency of events reported	0.90

In view of the 12 patient's safety dimensions, the highest percent of positive responses were: "teamwork across units", with 61.9% of the responses and "expectations and actions of the supervisor/chief to promote the patient's safety", with 60.9% of positive responses as shown in Table 3.

Graph 1 portrays the frequencies of the patient's safety scores attributed by the health professionals of the Unacon where 47% of the participants deemed the safety regular and 44% as very good.

The frequency of the number of events reported by health professionals in the last 12 months is shown in Graph 2, with predominance of no notification (46%); however, ten respondents (22%) reported one to two adverse events, nine (20%) from three to five, two (4%) from six to ten, two (4%) from 11 to 20 and another two (4%), 21 or more.

Table 3. Percent of positive responses according to the dimensions of the safety culture of the sample (n=46)

Dimensions	Total
D1 – Teamwork at the unit	6.9
D2 – Supervisor/manager expectations and actions promoting patient safety	60.9
D3 – Organizational learning, continuous improvement	49.3
D4 – Feedback and communication about errors	38.3
D5 – Communication openness	42.0
D6 – Staffing issues (professionals)	27.2
D7 – Non punitive responses to errors	27.5
D8 – Owner/Managing Partner/ Leadership Support for Patient Safety	45.7
D9 – Teamwork across units	33.2
D10 – Handoffs and transitions	27.2
D11 – Overall perception of the patient safety	40.6
D12 – Frequency of events reported	35.5

DISCUSSION

National studies with health multiprofessional teams revealed the predominance of female nurses because of the intrinsic nature of the care they provide. It is not nurses' sole responsibility to strengthen the patient's safety, the involvement of other professionals is of utmost importance as well[17-19].

The interaction of the multiprofessional team with the patients is expressed by the high percent of 95.7% of caregivers who have direct contact with them, comparable with a study of an average size hospital where 95.22% of the professionals had direct contact with the patient[20]. During treatment, recovery and finitude process of patients with malignant neoplasms, the direct contact creates reliable bonds of trust to solidify the connection patient/family/professional. As care is the major goal of any health institution, the professionals who were not in direct contact with the patients were developing managerial activities to ensure the oncological patient all the attention it needs, as services, materials and medication management for better results.

More than half of the respondents (60.9%) claimed they worked at the institution and Unacon from one to five years and 58.7% affirmed they were assigned to the oncological complex from one to five years. Possibly, this scenario is explained by the high level of rotation during

the COVID-19 pandemic since 2020 which changed deeply the routine of health institutions. The elevated turnover can affect the excellence of the care to the patients and in the other hand, less time of work at the institution can help professionals to adjust to the organizational culture, principles and values[18,21].

The Cronbach's alpha coefficient ranged between 0.43 and 0.90. It is recommended that studies which aim to evaluate the scope of the patient safety through HSOPSC utilize tests to investigate the reliability and validity of the instrument[20].

Within the perspective of the multiprofessional team, the patient safety was rated as satisfactory, similar to 43.1% of the professionals according to a national study at a reference oncological hospital[22]. This result can be explained by overcrowded institutions, poor staffing, obsolete physical structure and equipment shortage which help to maintain the safety of the patients[23].

During the pandemic, this rating is possibly related to the uncertainties caused by the disease and fear of the professionals, revealing physical and personal fragilities which can lead to unsatisfactory care provided to the patients[24].

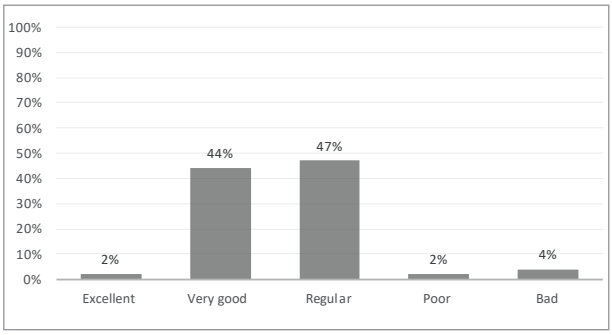
Based on AHRQ guidelines, none of the dimensions of the patient safety could be considered a strong point since positive responses were lower than 75%[12]. The results showed that the 12 dimensions evaluated need to be strengthened. The best dimensions were "teamwork" and "owner/managing partner/leadership support for patient safety", with potential to become strong areas of patient safety at Unacon.

The percent of positive responses for "teamwork" was 61.9% comparable to another study conducted at a private hospital of São Paulo with 63% of positive responses[25]. Shared collaboration, support and respect among health multiprofessional team are the core pillars revealed by the study.

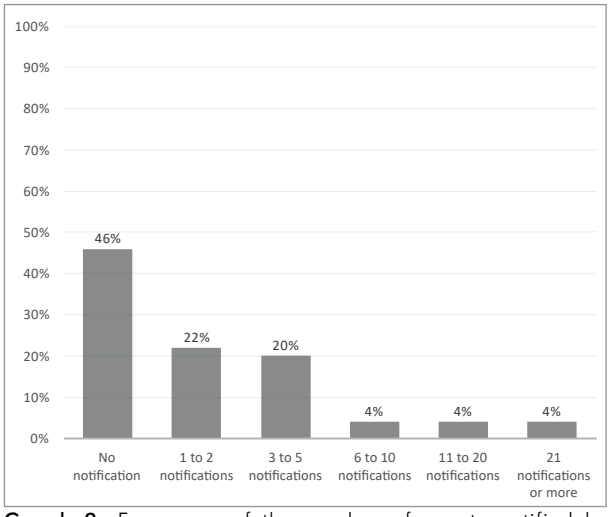
Corroborating the result of the dimension "expectations and actions of the supervisor/chief to promote patient safety" (60.9%), the study mentioned above reached similar results (61%)[25]. This finding reveals that the professionals perceive that their supervisors/chiefs attempt to work to maximize the patient safety, but this dimension needs to be improved. The leaders should find time in their daily routine to discuss the improvements with their team to ensure everyone a safe environment[19].

The most concerning and critical areas with the lowest positive response rates were "professionals", "non-punitive response to errors" and "handoffs and transitions".

Staffing is included in the dimension "professionals" rated as fragile that should be reviewed thoroughly by the managers because understaffed institutions increase the



Graph 1. Evaluation of the patient safety of Unacon of Brazil's South Regions by the health multiprofessional team, 2021



Graph 2. Frequency of the number of events notified by multiprofessional health teams in the last 12 months at Unacon of Brazil's South Region, 2021

risk of adverse events. It is an important indicator of the patient safety because overburdened nurses tend to offer poor care to them. Overload, burnout and pressure from the leaders may potentially account for the low rate of positive responses for this dimension, directly impacting the patient safety[20].

Low positive responses for the dimension "non-punitive response to errors" corroborates the punitive culture, an obstacle to recognize and report errors, omitting facts and damaging the identification of factors that contribute for the occurrence of adverse events. To change this culture, reporting adverse events must not be responded punitively, quite the opposite, it is an opportunity to learn and improve the work processes that need to be revised and restructured to devise strategies to prioritize the patient safety[18,19].

Similar results for the dimension "handoffs and transitions" were found in one of the hospitals evaluated in a national study (28.9%)[18]. The efficacy of the communication is the result of improved teamwork as brief description of patients admission, protocols/checklists of handoffs and transitions with clear and

objective information. The improvement of work processes through facilitating tools is able to promote effective communication and prevent errors for excellence of the care offered and eventually the patient safety[26].

No adverse events in the last 12 months were reported by 46.6% of the respondents, similar to another study[22]. Low level of notifications may not reflect the possible lack of errors or failures but that the safety culture is still not established at the health institutions, instead. The safety culture encourages the reporting of errors allowing their evaluation and implementation of preventive and educational actions[18,26].

The analysis of the patient safety stimulates the health institutions to improve the work processes and pursue the excellence of the care offered to the patients. If fragile areas are detected, actions to strengthen and promote the patient safety can be implemented, however, the data obtained need to be understood under the perspective of the particularities and organization of each institution. The application of instruments as HSOPSC to evaluate the patient safety creates the foundation to plan and execute actions to ensure the quality of the health environment and a satisfactory experience for the patient.

CONCLUSION

The results found are referred to one Unacon at Brazil's South Regions and should not be generalized. The utilization of an instrument translated and validated to Brazil is a strong aspect because it ensured more reliability and safety to its application.

The pandemic at the time the study was conducted is a limitation since the world sanitary condition led to a turnover of the health institutions, mainly nursing, which eventually hindered the eligibility of the respondents in filling out the questionnaire, dismantled the health teams and increased the exposure of the patient to care-related risks.

The analysis of the data obtained favored the identification of the fragilities of the safety dimensions of the patient according to the attending oncologic professionals, mainly in the dimensions of "professionals", "handoffs and transitions", "non-punitive responses to errors", "teamwork across units" and "frequency of events reported", needing urgent improvement interventions because of poor positive responses.

The theme is abstract, it arises from the existing safety culture in another hospital institutions investigated. The present study should be extended to other health environments to stimulate novel discussions in the areas of teaching, research, care and management to favor better absorption by health caregivers and improve the care offered to the patients.

CONTRIBUTIONS

All the authors contributed to the study design, acquisition, analysis and interpretation of the data, wording and critical review. They approved the final version to be published.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

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