PATIENT SAFETY CULTURE IN YANGON CHILDREN HOSPITAL

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M.B., B.S

Dip. Med. Sc. (Hospital Administration)

Master of Hospital Administration (MHA)

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Thesis submitted to

the Postgraduate Academic Board of Studies

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This thesis has been approved by the Board of Examiners

Chief Examiner

Examiner (1) **Examiner (2)**

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ABSTRACT

Patient safety is a serious global public health concern. During health care delivery, unexpected and unwanted events can take place in any setting. To overcome these events and deliver quality of healthcare, patient safety cultures among health workers need to be assess and promoted. For this purpose, the status of patient safety culture was assessed in Yangon Children Hospital. The study was a cross-sectional study with mixed method and was carried out from August to November,2019 to assess the current status of patient safety culture in Yangon Children Hospital. Among healthcare providers, (20) assistant surgeons and (83) nurses participated and responded self-administered questionnaires including background characteristics, twelve dimensions of patient safety culture and two more questions of overall patient safety grade and number of events reported in the past 12 months. In-depth interviews also were carried out to eight participants from all stratum of doctors, sister, staff nurse and trained nurses. Most of the participants had 6months to1year current hospital experience. Most AS and trained nurses had 6months to1year current hospital experience and most of staff nurses and sisters had more than 5years current hospital experience. The most common average working hours per week was 40-49 hours. Half of AS and trained nurses had 6months to1year professional experience. Overall results of patient safety culture in Yangon Children Hospital showed ten dimensions in the area of strength which is 75% or more in positive response to dimensions of patient safety culture; teamwork within unit, organizational learning- continuous improvement, feedback and communication about error, communication openness, events reporting frequency, teamwork across unit, overall perception of patient safety, management support for patient safety, handoffs and transitions, supervisor expectation. Non-punitive response to error was in the area of potential improvement and staffing was in the area of weakness. According to chi square test, there was no significant association between the background characteristics of health care providers of YCH and patient safety culture dimensions. The six themes were found from the findings of in-depth interviews. The consistent findings occurred in both quantitative and qualitative were staffing dimensions. All of the respondents mentioned no enough staff, poor job description and over loaded work. Most of the respondents reported about errors but not all received feedback properly. All of the respondents took handover with verbally or with record books. Most of the respondents follow the guidelines but only few stated they did not follow sometimes during live saving

events. They had awareness of safety precautions during transportation and fall and accidents. Patient safety culture in Yangon Children Hospital was mostly positive culture according to results apart from above non-punitive response to error and staffing dimensions. To maintain good culture, medical and nursing educations on patient safety culture should be continued and supported to the weak area.

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LIST OF ABBREVIATIONS

AHRQ	Agency for Healthcare Research and Quality
AS	Assistant surgeon
CNE	Continuing Nursing Education
CME	Continuing Medical Education
HCP	Healthcare personals
HSOPSC	Hospital Survey on Patient safety culture

ICU	Intensive care unit
OPD	Out-patient department
OT	Operation theatre
SAS	Specialist assistant surgeon
SPSS	Statistical Package for the Social Sciences
UK	United Kingdom
USA	United State of America
WHA	World Health Assembly
WHO	World Health Organization
YCH	Yangon Children Hospital

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CHAPTER (1)
INTRODUCTION

1.1 Background Information

Since the time of Hippocrates patient safety had been existed long before modern-medicine stated as "Do No Harm". However, this was not paid much attention in the past up to early 21st century (Gyani Thomas, 2014). "To err is human: Building a Safer Health System", published in 1999 by the Institute of Medicine (IOM) in the USA alarmed the world to reduce the prevalence and severity of medical errors which become a priority for hospitals all around the world and developing patient safety culture could help healthcare professionals to consider patient safety as a constant concern (Larramendy-Magnin et al., 2019).

In 2002, World Health Assembly (WHA) passed the resolution WHA55.18, which urged countries to pay the greatest possible attention to patient safety and initiated to carry out a series of actions to promote patient safety including development of global norms and standards, promotion of evidenced-based policies, promotion of mechanisms to recognize excellence in patient safety internationally, encouragement of research, provision of assistance to countries in several key areas (WHO, 2004).

Patient safety in health care concerns safety in both patients and health care providers. It is clinical, economical, managerial, and organizational concern in the health-care system. Patient safety culture is a critical issue of quality of health care and emphasizes the reporting of medical errors, adverse events, analysis and prevention of these errors which may lead to adverse health events. Most of them are preventable and occur due to system or organizational defect rather than due to health care providers' performance. Not only misuse of technology but also poor communication between different health care provider (HCP) and client may cause many harms (Reg et al., 2018).

According to the IOM in the USA, ''the biggest challenge moving toward a safer health system is changing the blaming culture to one of individuals for errors in which errors are treated not as personal failures, but as the system failures and prevent harm." Promoting a culture of safety is a fundamental principle of the patient safety

movement. In recent years there has been increasingly understanding within the healthcare industry, more need to create a professional and organizational culture of promoting safer patient care and error free environment. Healthcare systems must shift from the current ‘‘blame and shame’’ culture that prevents acknowledgement of error to learning from experience or errors. A fundamental culture change ensures that innovations introduced to improve patient safety actually achieve their potential. For example, in a punitive culture adverse event reporting systems can’t overcome chronic underreporting problems where acknowledgement of error is not acceptable (WHO,2017).

1.2 Problem statement

Patient safety is a serious global public health concern. There is a 1 in 300 chance of a patient being harmed during health care compared to a 1 in a million chance of a person being harmed while travelling by plane. Industries with a perceived higher risk such as the aviation and nuclear industries have a much better safety record than health care.

Health services treat the patients of older and sicker with significant co-morbidities who require more difficult decisions for health care priorities. Economic pressure on health systems often leads to overloaded health care environments. During health care delivery, unexpected and unwanted events can take place in any setting. (primary, secondary and tertiary care, community care, social and private care, acute and chronic care). In Europe 1 in 10 of every patient is facing the preventable harm or adverse events during hospitalization that may lead to suffer or loss for the patient, their families and health care providers, and taking a high financial toll on health care systems (WHO,2018).

Unsafe medication practices and medication errors are a leading cause of injury but actually these harm are avoidable in health care systems. Globally, annual cost due to medication and its associated errors has been estimated at $42 billion USD. Medication errors occur in weak medication systems and/or human factors. Multiple interventions address the frequency and impact of medication errors. In response to this, WHO has identified “Medication without Harm” as the theme for the third Global Patient Safety Challenge. This will propose the solutions for the obstacles that the world faces today. Aim is to reduce severe avoidable medication-related harm by 50%, globally in the next 5 years and goal is to achieve widespread engagement and

commitment of WHO Member States and professional bodies around the world to reducing the harm associated with medication (WHO, 2017).

1.3 Justification

Modern healthcare systems are mainly concerned with improving the safety of patient care and building of strong organizational safety cultures. The ability of safety cultures is learning openly from safety incidents and reducing the preventable harm to patients. (Al Salem, Bowie and Morrison, 2019) The first step of building organizational safety cultures is to assess the current perceived patient safety culture in hospital. One validated and well-established instrument to measure patient safety culture is the "Hospital Survey on Patient Safety Culture" (HSPSC), developed by the Agency Healthcare Research Quality from the United States and it was used to assess perception of patient safety culture among the study participants. The instrument has been translated into 24 languages and used in 45 countries (AHRQ, 2008).

The resulting data potentially offer the policymakers, healthcare providers, teams and managers a clear view of areas to strengthen the prevailing safety climate and specific challenges. It can also be used for measuring safety climate across time and between organizations on national and international levels (Al Salem, Bowie and Morrison, 2019).

Unsafe medical care is a major contributor to poor patient outcomes globally, low and middle income countries that have limited resources are also facing the challenges of unsafe care. Although there are many prevalence study for unsafe care that emerge across the globe but the data from the Southeast Asia region are poor and especially from the poor resource countries (Harrison, Cohen and Walton, 2015).

Yangon children hospital is 550 bedded teaching hospital and is affiliated to University of medicine (1), Yangon. As a tertiary care center and according to hospital current profile data, average number of out-patient per day is increasing about 2.5 times during last 5 years. In addition to these, percentage of sanctioned bed occupancy become 67% to 90%. Health workforce for YCH is only two third of sanction strength. Alongside limited health workforce, poor resource and increasing workload may effect on patient safety culture. Moreover, there may be inadequate regulatory system for the control of medical errors and mandatory reporting of such errors. It is a common problem in all hospitals, especially in government hospitals.

Although patient safety is a critical issue in health-care delivery, there are very

few studies on this aspect, especially from developing countries such as Myanmar. Considering the dearth of information on this key aspect, this study was planned to carried out patient safety culture among health care providers (doctors & nurses) at a tertiary care public sector hospital, YCH.

CHAPTER (2)

LITERATURE REVIEW

The simplest definition of patient safety is the prevention of errors and adverse effects to patients associated with health care. While health care has become more effective it has also become more complex, with greater use of new technologies, medicines and treatments (WHO, 2017).

The patient safety culture is the extent to which an organization's culture support and promotes patient safety. Organizational culture refers to the beliefs, values, and norms shared by staff throughout the organization that influence their actions and behaviors. Patient safety culture is the extent to which these beliefs, values, and norms support and promote patient safety. Patient safety culture can be measured by determining what is rewarded, supported, expected, and accepted in an organization as it relates to patient safety (AHRQ,2012).

2.1 International studies regarding in patient safety culture

The study of patient safety culture carried out in 13 general hospitals of Saudi Arabian country at 2010 showed 60% respondents graded as very good or excellent in overall patient safety grade, 33% as acceptable and 7% as failing or poor. Organizational learning-continuous improvement, feedback and communication about error and teamwork within units were in the area of strength. Teamwork across unit, non-punitive response to error were in the area of potential for improvement (Alahmadi, 2010).

One study of hospital Patient Safety Culture in Developing Country at 2014 was carried out in four educational hospitals (Imam Khomeini, Mustafa Khomeini, Taleghani and Kowsar hospitals) in Ilam city (Iran). Study showed that 47% of the participants had 1- 5 years of work experience and 71.1% of them worked more than 40 hours per week in hospital. The mean positive answers score of the safety culture in this study was obtained 40% that was much lower than the benchmark (64%). The highest and lowest percentages of the positive answer were attributed to teamwork within units (70%) and non-punitive response to error (11%), respectively. In order to increase the patient safety culture in the hospitals, the number of professional staff

should be increased and a practical plan about the patient safety culture and hospital

management should support the staff to report errors without fear of the punishment (Nourmoradi et al., 2015).

AL Lawati et al., conducted the assessment of patient safety culture in primary health care in Muscat, Oman. The response rate is 94% and the staff had a strong sense of teamwork within the units (85%), they reported organization learning for continuous improvement (84%) and teamwork across the units (82%). However, the four dimensions which received the lowest scores were related to communication problems between the staff (23%), non-punitive response to errors (27%), frequency of event reporting (40%), and errors occurring when transferring patients to higher levels of health care during handoffs and transitions (46%) (AL Lawati et al., 2019).

The safety attitudes study conducted in five Norwegian nursing homes about psychometric properties at 2019. Among them (62.2%) responded to the questionnaire and the confirmatory factor analysis showed that the total model of the six factors Teamwork climate, Safety climate, Job satisfaction, Perceptions of management, Working conditions, and Stress recognition had acceptable goodness-of-fit values in the nursing home setting (Bondevik et al., 2019).

A survey study of patient safety culture in a Switzerland university hospital emergency department showed positive assessments for the categories, non-punitive response to errors (78.7%), teamwork within units (70.1%), supervisor/ manager expectations and actions promoting patient safety (67.9%) and compared to other hospitals, also “staffing”. The lowest average percent positive responses were found in the categories frequencies of reported event (37.8%), teamwork across units 46.88% and handoffs and transitions (47.4%). Overall perception of patient safety was higher by physicians (78%) than by nurses (60%). Older responders graded communication openness as more positive than younger ones (p=0.037). The data also showed that employees with a lower professional degree stayed longer in the emergency department (p=0.033). Interestingly, this group also reported more adverse events (p=0.0001) compared to HCP with a higher professional degree. Physicians thought they would do more for patient safety than do nurses (p=0.001) and they also rated the communication openness (p=0.0001) and the team work across units (p=0.013) to be better than their nursing colleagues (Ricklin, Hess and Hautz, 2019).

2.2 Asian country studies regarding in patient safety culture studies

The characteristic of patient safety culture carried out in Japan, Taiwan and the

United states at 2010 showed event reporting during past 12 months was the highest in Japan and lowest in Taiwan. In the US, staffing was high but continuous improvement was rated in low (Fujita et al., 2013).

A study of factors affecting patient safety culture in a tertiary care hospital in Sri Lanka at 2013 showed strong positive response in teamwork within organization. Correlation between overall patient safety and other variables were significant. Their patient safety culture was in reactive stage with strong blame culture (Amarapathy et al., 2013).

A patient safety climate survey carried out in six hospitals of China between July and October 2011 concerning nine composites: institutional commitment to safety, unit management support for safety, organizational learning, safety system, adequacy of safety arrangements, error reporting, communication and peer support, teamwork and staffing. All composites were positively and significantly associated with the two perceived safety. These are staff perception of the safety ($B=0.81$, $p<0.001$), and overall perceived safety ($B=0.80$, $p<0.001$) (Zhu et al., 2014).

A study done in Malaysian hospitals and health clinics for safety culture perceptions of pharmacists at 2015 with a multicenter assessment using the Safety Attitudes Questionnaire. Response rate was 83.6%. Stress recognition (73.0 ± 20.4) and working condition (54.8 ± 17.4) received the highest and lowest mean scores, respectively. Pharmacists exhibited positive attitudes towards: stress recognition (58.1%), job satisfaction (46.2%), teamwork climate (38.5%), safety climate (33.3%), perception of management (29.9%) and working condition (15.4%). With the exception of stress recognition, those who worked in health clinics scored higher than those in hospitals ($p<0.05$) and higher scores (overall score as well as score for each domain except for stress recognition) correlated negatively with reported number of medication errors. Conversely, those working in hospital (versus health clinic) were 8.9 times more likely ($p<0.01$) to report a medication error (OR 8.9, CI 3.08 to 25.7). As stress recognition increased, the number of medication errors reported increased ($p=0.023$). Years of work experience ($p=0.017$) influenced the number of medication errors reported. For every additional year of work experience, pharmacists were 0.87 times less likely to report a medication error (OR 0.87, CI 0.78 to 0.98) (Samsuri, Pei Lin and Fahrni, 2015).

In 2015 Korean study of patient participation and its relationships with nurses'

patient-centered care competency, teamwork, and safety climate showed response rate was 74.1%, the mean score for patient participation was 2.76 ± 0.46 of 4.0. The mean scores for PCC, teamwork, and safety climate were 3.61 ± 0.46, 3.64 ± 0.41, and 3.35 ± 0.57 of 5.0, respectively. Nurses who experienced high patient participation in patient safety activities (≥ 3.0) had higher scores for PCC, teamwork, and safety climate. Multiple logistic regression analysis revealed that PCC (OR ¼ 2.31, 95% CI ¼ 1.14e4.70) and safety climate (OR ¼ 2.51, 95% CI ¼ 1.09e5.78) scores were the significant factors associated with patient participation (Hwang, Kim and Chin, 2019).

In Myanmar, patient safety culture was conducted in West Yangon General Hospital, 2017. Overall results on the patient safety culture positive responses more than 75% in nine dimensions such as teamwork within units, feedback about error, communication openness, organizational learning, teamwork across hospital units, supervisor expectations, overall perceptions of patient safety, management support and hospital handoffs & transitions. And, there was with the positive responses less than 75% in another three dimensions such as staffing, non-punitive response to errors and events reporting frequency. An association was observed between least working hours per week and increased number of positive answers (Cho-Cho-Lwin,2017).

Conceptual Framework

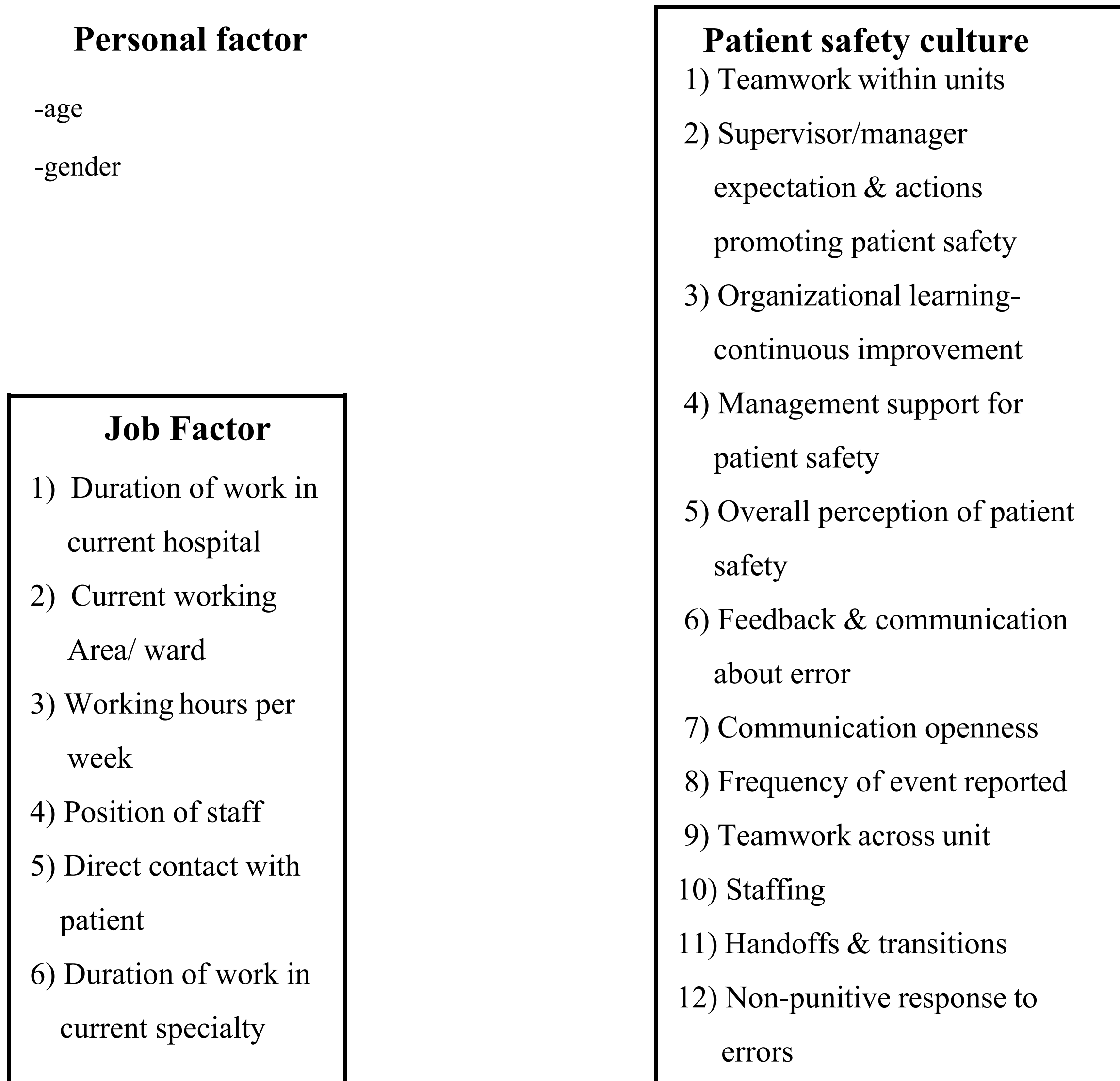

Figure (2.1) Conceptual Model for patient safety culture

CHAPTER (3)

OBJECTIVES

3.1 General Objective

To assess the patient safety culture in Yangon Children Hospital

3.2 Specific Objectives

1. To assess the perception of patient safety culture among assistant surgeons and nurses
2. To describe the relations between background characteristic of study participants and their perceived patient safety culture

3.3 Research Question

How do the healthcare providers perceive patient safety culture in Yangon Children Hospital?

CHAPTER (4)
RESEARCH METHODOLOGY

4.1 Study design

Hospital based cross sectional study design with both quantitative and qualitative methods was conducted.

4.2 Study period

The study was carried out from August to November, 2019.

4.3 Study area

The study was conducted in Yangon Children Hospital.

4.4 Study population

The study population was AS and nurses who had more than 6months service in public hospital.

4.5 Sample size determination

Sample size was calculated by using the formula for sample size calculation in finite populations as follow, (Eberly, 2018)

$$n = \frac{m}{1 + \frac{m-1}{N}} \qquad m = \frac{z^2\, p\, q}{d^2}$$

Where n = minimum required sample size

p = proportion of positive answers of participants (p= 0.79) (Cho-Cho-Lwin,2017)

q = 1-p = 1- 0.79 = 0.21

z = 1.96 at 95%CI (reliability coefficient)

d = precision (margin of error) = 0.07

$m = (1.96)^2 (0.79) (0.21)/ (0.07)^2 = 130$

n =130/1+(130-1)/266=87.54

N = total number of study population

Non response rate 10% = 9

Minimum required sample size = 88+9 = 97

4.6 Sampling procedure

In Yangon Children hospital, there are (23) specialist AS, (31) civil assistant surgeons, (18) sisters, (58) staff nurses and (136) trained nurses. AS and nurses with more than 6months hospital experience were invited to participate the research.

For the quantitative data, stratified random sampling was done proportionately of SAS (9), AS (11), sister (7), staff nurse (21) and trained nurse (50) was done.

For the qualitative data, two SAS, two AS, one sister, one staff nurse and two trained nurses were invited for in-depth interviews.

4.7 Data collection method and tools

Quantitative data: Structured self-administered questionnaires of AHRQ Hospital Survey on Patient Safety Culture User's Guide was used after translation to Myanmar (AHRQ,2004). It contains two portions, one is background information of respondents and the other is hospital survey on patient safety culture which emphasizes patient safety, error and event reporting. There are 42 items grouped into 12 composite measures of the followings.

1. Teamwork within units (4 items)
2. Supervisor/manager expectations and actions promoting patient safety (4 items)
3. Organizational Learning—Continuous improvement (3 items)
4. Management support for patient safety (3 items)
5. Overall Perceptions of Patient Safety (4 items)
6. Feedback and communication about error (3 items)
7. Communication Openness (3 items)
8. Frequency of Events Reported (3 items)
9. Teamwork across units (4 items)
10. Staffing (4 items)
11. Handoffs and transitions (4 items)
12. Non punitive response to error (3 items)

These composites are measured by using five points Likert scale of agreement, (strongly agree, agree, neither agree or disagree, disagree, strongly disagree) for 9 composites and (never, rarely, sometimes, most of the time, always) for the rest of 3 composites. The survey also includes two questions asking about providing an overall grade on patient safety for their work area/unit and indicating the number of events they reported over the past 12 months.

Qualitative data: In-depth interviews to doctors and nurses were done using interview guideline. Voice recording were done after getting permissions. Note taking was also done in every case.

Pretest was done at Yangon Eye Specialist Hospital before the study was conducted.

4.8 Data management and analysis

4.8.1 Quantitative data

Collected data was checked for completeness, errors and consistencies. Data entry by Epi-data and data analysis was carried out by using SPSS software version 16.0. Among 42 questions, 24 questions are positively worded and 18 questions are negatively worded. The score for positively worded items were strongly agree 5 and strongly disagree 1. Scores were reversed for negatively worded items. The highest score 4 and 5 were regarded as positive response answers and the lowest score (1-3) were considered as negative response answers. In the study, each dimension was mentioned as an average of different items in that dimension.

For descriptive statistics, frequency distribution and percentage of each variable was calculated. Background characteristics and patient safety culture dimensions were described by using frequency distribution tables and graphs. Association between socio-demographic characteristics, dimensions of patient safety culture was tested by Fisher's exact test.

4.8.2 Qualitative data

Recordings of the interviews were transcribed into text (transcripts) which include non-verbal expression of the respondents. Themes were identified and then analyzed manually by thematic analysis.

4.9 Ethical consideration

The study was conducted according to the guidelines issued by University of Public Health Institutional Review Board (UPH-IRB) and approval certification number was UPH-IRB(2019/MHA/12). The selection of the participants and the procedure were thoroughly explained to the participants. Gaining new knowledge from this study and the freedom to withdraw were explained. Written informed consents were obtained from the respondents. Privacy and confidentiality of the collected information were strictly safeguarded.

CHAPTER (5)

FINDINGS

Yangon Children Hospital is 550 bedded teaching hospital and is affiliated to University of medicine (1), Yangon. As a tertiary care center, average number of out-patient per day is 543 and average number of inpatient per day is 497. Percentage of bed occupancy (sanctioned bed) is 90%.

5.1 Background characteristics of participants

Table (5.1) Distribution of current hospital experience in each profession

Rank	Hospital experience							
	<1 year		1-3 year		3-5 years		>5 years	
	N	(%)	N	(%)	N	(%)	N	(%)
AS (n=20)	9	(45.0)	4	(20.0)	5	(25.0)	2	(10.0)
Sisters (n=7)	1	(14.3)	0	(0.0)	0	(0.0)	6	(85.7)
Staff Nurses (n=23)	2	(8.7)	2	(8.7)	4	(17.4)	15	(65.2)
Trained Nurses (n=53)	26	(49.1)	17	(32.1)	8	(15.1)	2	(3.8)

In the study, 103 participants were responded to patient safety culture questionnaire. Among them, most of the assistant surgeons and trained nurses had hospital experiences between 6 months and one year. Sisters and staff nurses had hospital experiences more than 5 years.

Table (5.2) Distribution of average working hours per week in each profession

Rank	Average working hours per week							
	<40 hours		40-49 hours		50-59 hours		>60 hours	
	N	(%)	N	(%)	N	(%)	N	(%)
AS (n=20)	3	(15.0)	5	(25.0)	10	(50.0)	2	(10.0)
Sisters (n=7)	5	(71.4)	1	(14.3)	1	(14.3)	0	(0.0)
Staff Nurses (n=23)	3	(13.0)	11	(47.8)	6	(26.1)	3	(13.0)
Trained Nurses (n=53)	10	(18.9)	21	(39.6)	8	(15.1)	14	(26.4)

Among the respondents, assistant surgeon worked mostly 50-59 hours per week, most sisters worked less than 40 hours per week and majority of staff nurse and trained nurses worked 40-49 hours per week as an average.

Table (5.3) Distribution of professional experience in each profession

Rank	Profession experience							
	<1 year		1-3 year		3-5 years		>5 years	
	N	%	N	%	N	%	N	%
AS (n=20)	11	(55.0)	7	(35.0)	1	(5.0)	1	(5.0)
Sisters (n=7)	0	(0.0)	2	(28.6)	2	(28.6)	3	(42.9)
Staff Nurses (n=23)	0	(0.0)	0	(0.0)	0	(0.0)	23	(100.0)
Trained Nurses (n=53)	27	(50.9)	16	(30.2)	8	(15.1)	2	(3.8)

All of the respondent staff nurses had more than 5 years in professional experience and also nearly half of the sisters. Most of assistant surgeons and trained nurses had less than 1 year of professional experience.

Table (5.4) Distribution of working area in each profession

Rank	Professional experience													
	Medical unit		Surgical unit		OT Unit		ICU & Isolation		OPD, Emergency, Day Care		Specialty Unit		Others	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
AS (n=20)	3	(15.0)	2	(10.0)	0	(0.0)	3	(15.0)	5	(25.0)	5	(25.0)	2	(10.0)
Sisters (n=7)	0	(0.0)	1	(14.3)	0	(0.0)	1	(14.3)	0	(0.0)	4	(57.1)	1	(14.3)
Staff Nurses (n=23)	3	(13.0)	0	(0.0)	1	(4.3)	1	(4.3)	1	(4.3)	14	(60.9)	3	(13.0)
Trained Nurses (n=53)	4	(7.5)	6	(11.3)	9	(17.0)	6	(11.3)	5	(9.4)	22	(41.5)	1	(1.9)
Total (n=103)	10	(9.7)	9	(8.7)	10	(9.7)	11	(10.7)	11	(10.7)	45	(43.6)	7	(6.8)

The main participants were currently working at the specialty units (orthopaediatric unit, haemato-oncology unit, nutrition-renal unit and neuro unit).

5.2 Results of patient safety culture dimensions

Table (5.5) Results on patient safety dimension in all respondent (n=103)

Dimensions of patient safety culture	**Positive answer**		**Negative answer**	
	N	**%**	**N**	**%**
Teamwork within units	102	99.0	1	1.0
Supervisor expectation & actions promoting patient safety	78	75.7	23	24.3
Organizational learning-continuous improvement	102	99.0	1	1.0
Management support for patient safety	78	75.7	25	24.3
Overall perceptions of patient safety	90	87.4	13	12.6
Feedback & communication about error	95	92.2	8	7.8
Communication openness	97	94.2	6	5.8
Events reporting frequency	92	89.3	11	10.7
Teamwork across units	92	89.3	11	10.7
Staffing	29	28.2	74	71.8
Handoffs and transitions	81	78.6	22	21.4
Non-punitive response to error	58	56.3	45	43.7
Total Average Score	83	80.4	20	19.6

Overall results on patient safety show highest percent positive answers in two areas. One is teamwork within units and the other is organizational learning and continuous improvement. The highest percent negative answer is staffing. Total average score was 80.4% for positive answers. For the responses of the questions in each dimension was described in annex (6).

Figure (5.1) Positive responses on overall patient safety dimension according to the rank

Positive responses on patient safety culture of all ranks were more than 75%. The highest positive responses were occurred among sisters and the lowest positive responses were occurred among trained nurses.

Figure (5.2) Results on patient safety dimension in assistant surgeon (n= 20)

Assistant surgeon positively answered 100% in dimension of teamwork within units, organizational learning-continuous improvement and overall perceptions of patient safety but negatively answered in staffing dimension.

Figure (5.3) Results on patient safety dimension in sisters (n=7)

Although sisters of YCH positively answered most of the dimensions of patient safety culture, they strongly answered in staffing dimension as 100% negative.

Figure (5.4) Results on patient safety dimension in Staff nurses (n= 23)

In the dimension of teamwork within units, teamwork across units and organizational learning-continuous improvement, staff nurses responded 100% positive. The highest percentage of negative answer by staff nurses was staffing dimension.

Table (5.5) Results on patient safety dimension in trained nurses (n=53)

Among the participants, trained nurses answered positively in dimension of teamwork within units and organizational learning-continuous improvement. They also answered as the most negative in staffing dimension.

Table (5.6) Results on patient safety culture dimensions in less than 1year hospital experience group (n=36)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	36	100.0	0	0.0
Organizational learning-continuous improvement	36	100.0	0	0.0
Feedback & communication about error	35	97.2	1	2.8
Communication openness	34	94.4	2	5.6
Events reporting frequency	34	94.4	2	5.6
Supervisor expectation & actions promoting patient safety	33	91.7	3	8.3
Overall perceptions of patient safety	32	88.9	4	11.1
Teamwork across units	31	86.1	5	13.9
Management support for patient safety	30	83.3	6	16.7
Handoffs and transitions	28	77.8	8	22.2
Non-punitive response to error	22	61.1	14	38.9
Staffing	10	27.8	26	72.2

Among participants who have experience less than 1year hospital service answered highest percentage of positive answer in teamwork within units and organizational learning-continuous improvement. The weakest dimension they answered was staffing.

Table (5.7) Results on patient safety culture dimensions in 1-3years hospital experience group (n= 21)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	20	95.2	1	4.8
Organizational learning-continuous improvement	21	100.0	0	0.0
Feedback & communication about error	20	95.2	1	4.8
Communication openness	21	100.0	0	0.0
Events reporting frequency	18	85.7	3	14.3
Supervisor expectation & actions promoting patient safety	11	52.4	10	47.6
Overall perceptions of patient safety	16	76.2	5	23.8
Teamwork across units	18	85.7	3	14.3
Management support for patient safety	16	76.2	5	23.8
Handoffs and transitions	15	71.4	6	28.6
Non-punitive response to error	6	28.6	15	71.4
Staffing	4	19.0	17	81.0

Differ from other results, participants of 1-3 years of hospital services answered 100% in communication openness. The other highest percentage of positive answer is organizational learning-continuous improvement. The lowest percentage of positive answer is staffing dimensions.

Table (5.8) Results on patient safety culture dimensions in 3-5years hospital experience group (n=13)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	13	100.0	0	0.0
Organizational learning-continuous improvement	12	92.3	1	7.7
Feedback & communication about error	11	84.6	2	15.4
Communication openness	10	76.9	3	23.1
Events reporting frequency	11	84.6	2	15.4
Supervisor expectation & actions promoting patient safety	9	69.2	4	30.8
Overall perceptions of patient safety	12	92.3	1	7.7
Teamwork across units	10	76.9	3	23.1
Management support for patient safety	8	61.5	5	38.5
Handoffs and transitions	11	84.6	2	15.4
Non-punitive response to error	10	76.90	3	23.1
Staffing	5	38.5	8	61.5

In the dimension of teamwork within units, all respondents of (3-5) years hospital experience group showed positive answer. However most of respondents answered less positively and got the lowest number of positive answers in the dimension of staffing.

Table (5.9) Results on patient safety culture dimensions in more than 5 years hospital experience group (n= 33)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	33	100.0	0	0.0
Organizational learning-continuous improvement	33	100.0	0	0.0
Feedback & communication about error	29	87.9	4	12.1
Communication openness	32	97.0	1	3.0
Events reporting frequency	29	87.9	4	12.1
Supervisor expectation & actions promoting patient safety	25	75.8	8	24.2
Overall perceptions of patient safety	30	90.9	3	9.1
Teamwork across units	33	100.0	0	0.0
Management support for patient safety	24	72.7	9	27.3
Handoffs and transitions	27	81.8	6	18.2
Non-punitive response to error	20	60.6	13	39.4
Staffing	10	30.3	23	69.7

In more than 5years hospital experience group, there was the highest positive answers in the dimension of teamwork within units, teamwork across units and organizational learning-continuous improvement. The lowest positive answer was observed in the dimension of staffing.

Table (5.10) Results on patient safety culture dimensions in working hours (less than & equal to 40 hours per week (n= 21)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	21	100.0	0	0.0
Organizational learning-continuous improvement	21	100.0	0	0.0
Feedback & communication about error	21	100.0	0	0.0
Communication openness	21	100.0	0	0.0
Events reporting frequency	19	90.5	2	9.5
Supervisor expectation & actions promoting patient safety	19	90.5	2	9.5
Overall perceptions of patient safety	20	95.2	1	4.8
Teamwork across units	21	100.0	0	0.0
Management support for patient safety	19	90.5	2	9.5
Handoffs and transitions	18	85.7	3	14.3
Non-punitive response to error	14	66.7	7	33.3
Staffing	4	19.0	17	81.0

Participants, whose average working hours less than or equal to 40 hours per week, showed positive answers in full range in five dimensions of patient safety culture. These are teamwork within units, teamwork within units, organizational learning-continuous improvement, feedback & communication about error and Communication openness. The least positive answer was also observed in the dimension of staffing.

Table (5.11) Results on patient safety culture dimensions in working hours (41-50 hours) per week (n=38)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	37	97.4	1	2.6
Organizational learning-continuous improvement	38	100.0	0	0.0
Feedback & communication about error	34	89.5	4	10.5
Communication openness	35	92.1	3	7.9
Events reporting frequency	34	89.5	4	10.5
Supervisor expectation & actions promoting patient safety	27	71.1	11	28.9
Overall perceptions of patient safety	34	89.5	4	10.5
Teamwork across units	34	89.5	4	10.5
Management support for patient safety	26	68.4	12	31.6
Handoffs and transitions	25	65.8	13	34.2
Non-punitive response to error	16	42.1	22	57.9
Staffing	12	31.6	26	68.4

Participants with 41-50 average working hours per week had positive responses totally in the dimension of organizational learning-continuous improvement. The lowest positive answer was observed in the dimension of staffing.

Table (5.12) Results on patient safety culture dimensions in working hours (51-60 hours) per week (n=25)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	25	100.0	0	0.0
Organizational learning-continuous improvement	24	96.0	1	4.0
Feedback & communication about error	22	88.0	3	12.0
Communication openness	22	88.0	3	12.0
Events reporting frequency	22	88.0	3	12.0
Supervisor expectation & actions promoting patient safety	16	64.0	9	36.0
Overall perceptions of patient safety	18	72.0	7	28.0
Teamwork across units	20	80.0	5	20.0
Management support for patient safety	16	64.0	9	36.0
Handoffs and transitions	22	88.0	3	12.0
Non-punitive response to error	17	68.0	8	32.0
Staffing	9	36.0	16	64.0

In the dimension of teamwork within units, all respondents with 51-60 average working hours per week group answered positively. However most of respondents answered less positively answer in the dimension of staffing.

Table (5.13) Results on patient safety culture dimensions in working hours (more than 60 hours) per week (n= 19)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	19	100.0	0	0.0
Organizational learning-continuous improvement	19	100.0	0	0.0
Feedback & communication about error	18	94.7	1	5.3
Communication openness	19	100.0	0	0.0
Events reporting frequency	17	89.5	2	10.5
Supervisor expectation & actions promoting patient safety	16	84.2	3	15.8
Overall perceptions of patient safety	18	94.7	1	5.3
Teamwork across units	17	89.5	2	10.5
Management support for patient safety	17	89.5	2	10.5
Handoffs and transitions	16	84.2	3	15.8
Non-punitive response to error	11	57.9	8	42.1
Staffing	4	21.1	15	78.9

Participants with more than 60 average working hours per week had positive responses totally in the dimension of teamwork within units, organizational learning-continuous improvement and communication openness. The lowest positive answer was observed in the dimension of staffing.

Table (5.14) Results on patient safety culture dimensions in less than 1 year of professional experience (n= 40)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	**%**	**N**	**%**
Teamwork within units	40	100.0	0	0.0
Organizational learning-continuous improvement	40	100.0	0	0.0
Feedback & communication about error	39	97.5	1	2.5
Communication openness	38	95.0	2	5.0
Events reporting frequency	37	92.5	3	7.5
Supervisor expectation & actions promoting patient safety	34	85.0	6	15.0
Overall perceptions of patient safety	35	87.5	5	12.5
Teamwork across units	35	87.5	5	12.5
Management support for patient safety	32	80.0	8	20.0
Handoffs and transitions	31	77.5	9	22.5
Non-punitive response to error	25	62.5	15	37.5
Staffing	14	35.0	26	65.0

Less than 1 year of professional experience respondents group had highest positive answers in two dimensions, teamwork within units and organizational learning-continuous improvement but they gave lowest positive answers in dimension of staffing.

Table (5.15) Results on patient safety culture dimensions in (1-3) years of profession experience (n=27)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	26	96.3	1	3.7
Organizational learning-continuous improvement	27	100.0	0	0.0
Feedback & communication about error	25	92.6	2	7.4
Communication openness	27	100.0	0	0.0
Events reporting frequency	24	88.9	3	11.1
Supervisor expectation & actions promoting patient safety	18	66.7	9	33.3
Overall perceptions of patient safety	23	85.2	4	14.8
Teamwork across units	24	88.9	3	11.1
Management support for patient safety	20	74.1	7	25.9
Handoffs and transitions	22	81.5	5	18.5
Non-punitive response to error	13	48.1	14	51.9
Staffing	6	22.2	21	77.8

Dimensions of patient safety culture in organizational learning-continuous improvement and communication openness were the highest positive answers among participants with 1-3 years of profession experience and the lowest positive answer is staffing.

Table (5.16) Results on patient safety culture dimensions in (3-5) years of profession experience (n=15)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	15	100.0	0	0.0
Organizational learning-continuous improvement	14	93.3	1	6.7
Feedback & communication about error	13	86.7	2	13.3
Communication openness	11	73.3	4	26.7
Events reporting frequency	11	73.3	4	26.7
Supervisor expectation & actions promoting patient safety	7	46.7	8	53.3
Overall perceptions of patient safety	13	86.7	2	13.3
Teamwork across units	12	80.0	3	20.0
Management support for patient safety	10	66.7	5	33.3
Handoffs and transitions	11	73.3	4	26.7
Non-punitive response to error	9	60.0	6	40.0
Staffing	6	40.0	9	60.0

Participants with 3-5 years of profession experience mentioned 100% positive in teamwork within units and most of them mentioned lowest positive answer as staffing.

Table (5.17) Results on patient safety culture dimensions in more than 5 years of profession experience (n= 21)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	21	100.0	0	0.0
Organizational learning-continuous improvement	21	100.0	0	0.0
Feedback & communication about error	18	90.5	3	14.3
Communication openness	21	100.0	0	0.0
Events reporting frequency	20	95.2	1	4.8
Supervisor expectation & actions promoting patient safety	19	90.5	2	9.5
Overall perceptions of patient safety	19	90.5	2	9.5
Teamwork across units	21	100.0	0	0.0
Management support for patient safety	16	76.2	5	23.8
Handoffs and transitions	17	81.0	4	19.0
Non-punitive response to error	11	52.4	10	47.6
Staffing	3	14.3	18	85.7

In the dimensions such as teamwork within units, organizational learning and communication openness, all positive answers were obtained among the respondents with more than 5 years of profession experience. The lowest positive answers were observed in the dimension of staffing.

Table (5.18) Results on patient safety culture dimensions in medical unit (n=10)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	9	90.0	1	10.0
Organizational learning-continuous improvement	10	100.0	0	0.0
Feedback & communication about error	8	80.0	2	20.0
Communication openness	9	90.0	1	10.0
Events reporting frequency	8	80.0	2	20.0
Supervisor expectation & actions promoting patient safety	7	70.0	3	30.0
Overall perceptions of patient safety	8	80.0	2	20.0
Teamwork across units	9	90.0	1	10.0
Management support for patient safety	4	40.0	6	60.0
Handoffs and transitions	7	70.0	3	30.0
Non-punitive response to error	4	40.0	6	60.0
Staffing	5	50.0	5	50.0

The participants from medical unit answered organizational learning-continuous improvement dimension was the highest positive answer and management support for patient safety and non-punitive response to error were the lowest positive answers.

Table (5.19) Results on patient safety culture dimensions in surgical unit (n= 9)

Dimensions of patient safety culture	**Positive answer**		**Negative answer**	
	N	**%**	**N**	**%**
Teamwork within units	9	100.0	0	0.0
Organizational learning-continuous improvement	9	100.0	0	0.0
Feedback & communication about error	9	100.0	0	0.0
Communication openness	9	100.0	0	0.0
Events reporting frequency	8	88.9	1	11.1
Supervisor expectation & actions promoting patient safety	8	88.9	1	11.1
Overall perceptions of patient safety	9	100.0	0	0.0
Teamwork across units	9	100.0	0	0.0
Management support for patient safety	8	88.9	1	11.1
Handoffs and transitions	7	77.8	2	22.2
Non-punitive response to error	6	66.7	3	33.3
Staffing	1	11.1	8	88.9

Half of the dimensions of patient safety culture such as teamwork within units, teamwork across units, organizational learning-continuous improvement, overall perceptions of patient safety, feedback & communication about error and communication openness were 100% positive answers and the lowest positive answer was staffing dimension.

Table (5.20) Results on patient safety culture dimensions in operation theatre (n=10)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	10	100.0	0	0.0
Organizational learning-continuous improvement	10	100.0	0	0.0
Feedback & communication about error	9	90.0	1	10.0
Communication openness	10	100.0	0	0.0
Events reporting frequency	9	90.0	1	10.0
Supervisor expectation & actions promoting patient safety	9	90.0	1	10.0
Overall perceptions of patient safety	10	100.0	0	0.0
Teamwork across units	9	90.0	1	10.0
Management support for patient safety	9	90.0	1	10.0
Handoffs and transitions	7	70.0	3	30.0
Non-punitive response to error	6	60.0	4	40.0
Staffing	2	20.0	8	80.0

All respondents from operation theatre mentioned teamwork within units, organizational learning-continuous improvement, overall perceptions of patient safety and communication openness were the highest positive answers and staffing dimension as the lowest positive answer.

Table (5.21) Results on patient safety culture dimensions in ICU & Isolation unit (n=11)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	11	100.0	0	0.0
Organizational learning-continuous improvement	10	90.9	1	9.1
Feedback & communication about error	9	81.8	2	18.2
Communication openness	11	100.0	0	0.0
Events reporting frequency	9	81.8	2	18.2
Supervisor expectation & actions promoting patient safety	8	72.7	3	27.3
Overall perceptions of patient safety	10	90.9	1	9.1
Teamwork across units	10	90.9	1	9.1
Management support for patient safety	8	72.7	3	27.3
Handoffs and transitions	9	81.8	2	18.2
Non-punitive response to error	8	72.7	3	27.3
Staffing	4	36.4	7	63.6

Patient safety culture dimensions of teamwork within units and communication openness were the highest positive answers among ICU & Isolation unit participants group. Staffing dimension was the lowest positive answer.

Table (5.22) Results on patient safety culture dimensions in OPD, Emergency & Day care unit(n=11)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	11	100.0	0	0.0
Organizational learning-continuous improvement	11	100.0	0	0.0
Feedback & communication about error	11	100.0	0	0.0
Communication openness	11	100.0	0	0.0
Events reporting frequency	11	100.0	0	0.0
Supervisor expectation & actions promoting patient safety	9	81.8	2	18.2
Overall perceptions of patient safety	11	100.0	0	0.0
Teamwork across units	9	81.8	2	18.2
Management support for patient safety	10	90.9	1	9.1
Handoffs and transitions	10	90.9	1	9.1
Non-punitive response to error	8	72.7	3	27.3
Staffing	3	27.3	8	72.7

Teamwork within units, organizational learning-continuous improvement, overall perceptions of patient safety, feedback & communication about error, communication openness and events reporting frequency were the highest positive answers among the participants of OPD, Emergency & Day care units. The lowest positive answer was staffing dimension.

Table (5.23) Results on patient safety culture dimensions in specialty units (n=45)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	45	100.0	0	0.0
Organizational learning-continuous improvement	45	100.0	0	0.0
Feedback & communication about error	42	93.3	3	6.7
Communication openness	41	91.1	4	8.9
Events reporting frequency	40	88.9	5	11.1
Supervisor expectation & actions promoting patient safety	30	66.7	15	33.3
Overall perceptions of patient safety	36	80.0	9	20.0
Teamwork across units	40	88.9	5	11.1
Management support for patient safety	33	73.3	12	26.7
Handoffs and transitions	36	80.0	9	20.0
Non-punitive response to error	21	46.7	24	53.3
Staffing	12	26.7	33	73.3

The respondents from specialty units (ortho, neonate, haemato-onco, nutrition & renal) answered the dimensions of patient safety culture of teamwork within units and organizational learning-continuous improvement as highest positive answers and staffing as least positive answer.

Table (5.24) Results on patient safety culture dimensions in other unit (n=7)

Dimensions of patient safety culture	Positive answer		Negative answer	
	N	%	N	%
Teamwork within units	7	100.0	0	0.0
Organizational learning-continuous improvement	7	100.0	0	0.0
Feedback & communication about error	7	100.0	0	0.0
Communication openness	6	85.7	1	14.3
Events reporting frequency	7	100.0	0	0.0
Supervisor expectation & actions promoting patient safety	7	100.0	0	0.0
Overall perceptions of patient safety	6	85.7	1	14.3
Teamwork across units	6	85.7	1	14.3
Management support for patient safety	6	85.7	1	14.3
Handoffs and transitions	5	71.4	2	28.6
Non-punitive response to error	5	71.4	2	28.6
Staffing	2	28.6	5	71.4

In other units (PR, Office, Blood Bank) group, there were the highest positive answers in the dimension of teamwork within units, supervisor expectation & actions promoting patient safety, organizational learning-continuous improvement, feedback & communication about error and events reporting frequency. The lowest positive answers were observed in the dimension of staffing.

Figure (5.5) Results of overall grade on patient safety of hospital (n=102)

The overall grading given by the participants were mostly acceptable and very good.

Figure (5.6) Number of event reported by the participants in the past 12 months (n=103)

There was no participant who reported 11-20 events past 12 months and most of the participants reported no events.

5.3 Relation between background characteristics and patient safety culture dimensions

Table (5.25) Relationship between background characteristics and Patient safety culture

Variables	Patient safety culture		Chi square (Fisher Exact)	*P* value
	Positive n(%)	Negative n(%)		
Profession				
AS	19 (95.0)	1 (5.0)	0.488	1.000
Sister nurse	7 (100.0)	0 (0.0)		
Staff nurse	22 (95.7)	1 (4.3)		
T/N nurse	50 (95.1)	3 (5.7)		
Current hospital experience				
<1 year	39 (97.5)	1 (2.5)	2.818	0.369
1-3 years	26 (96.3)	1 (3.7)		
3-5 years	13 (86.7)	2 (13.3)		
>5 years	20 (95.2)	1 (4.8)		
Working hours per week				

< 40 hours	20 (95.2)	1 (4.8)		
40-49 hours	35 (92.1)	3 (7.9)	2.018	0.551
50-59 hours	25 (100.0)	0 (0.0)		
>60 hours	18 (94.7)	1 (5.3)		
Professional experience				
<1 year	39 (97.5)	1 (2.5)		
1-3 years	26 (96.3)	1 (3.7)	2.248	0.465
3-5 years	2 (13.3)	13 (86.7)		
>5 years	20 (95.2)	1 (4.8)		

Table (5.25) Relationship between background characteristics and Patient safety Culture (continued)

Variables	Patient safety culture		Chi square (Fisher Exact)	*P* value
	Positive n(%)	Negative n(%)		
Working area in each profession				
Medical unit	9 (90.0)	1 (10.0)		
Surgical unit	9 (100.0)	0 (0.0)		
OT	9 (90.0)	1 (10.0)		
ICU & Isolation	11 (100.0)	0 (0.0)	3.405	0.757
OPD, Emergency, Day care	11 (100.0)	0 (0.0)		
Specialty unit	42 (93.3)	3 (56.7)		
Others	7 (100.0)	0 (0.0)		

Positive patient safety culture results were occurred sisters group in the profession, less than 1year service in YCH, 50-59 hours of average working hours, less than 1 year of professional experience and surgical, ICU, isolation, OPD, Emergency, day care and other units (office, blood bank, PR). But there were no significantly association between background characteristics and patient safety culture.

5.4 Qualitative findings on patient safety culture in Yangon Children Hospital

Eight IDIs were conducted for qualitative assessment on patient safety culture among participants of Yangon Children Hospital. IDIs were performed to two specialists AS, two AS, one sister, one staff nurse and two trained nurses according to the qualitative guideline questions.

Table (5.26) Characteristics of respondents of in-depth interview

No	Ranking	Age	Sex	Education	Current hospital service
1	SAS	33	female	M.Med.Sc(Paed)	3year 8 month
2	SAS	38	male	M.Med.Sc(Paed)	3year 3month
3	AS	25	male	M.B.,B.S	6 month
4	AS	27	male	M.B.,B.S	7 month
5	Sister	50	female	B.N.Sc (Bridge)	9year
6	Staff nurse	46	female	Nursing diploma	7years
7	Trained nurse	34	female	Nursing diploma	3 years
8	Trained nurse	24	female	Nursing diploma	3 years

Among the respondents of in-depth interview, the youngest one was 24 years old and the oldest one was 50years old. Maximum current hospital service was 9 years

and minimum current hospital service was 6months.

A total of six themes were identified from in-depth interviews:

1. Staffing
2. Feedback and communications about error
3. Handoffs and transition
4. Provider safety
5. Patient safety during Transportation
6. Fall and Accidents

1.Staffing

Six out of eight participants mentioned about not enough staff from general workers to doctors. They carry loads of burden with unclear job description.

‘ဝန်ထမ်းအထွေထွေအားကတော့လဲ သန့်ရှင်းရေးသမားဆိုရင် သန့်ရှင်းရေးကော၊ Ward ထဲကခိုင်း တဲ့ အလုပ်ကော၊ လူနာပို့တာရောအစုံပလုံလုပ်ရတယ်။ Job description မရှိပဲ အစုံလုပ်ရတဲ့ သဘောရှိတော့ သူတို့(၁)(၂)ယောက်ပဲရှိတယ်။ ဆရာဝန်အထွေအားတော့လုံလောက်တယ်ထင်ပါတယ်။ အလုပ်သမားကလဲ သူတို့၊ Indent ဆေးထုတ်သယ်ဖို့လဲ သူတို့ပဲ ဆိုတော့။ ညဆိုလဲ (၁)ယောက်ပဲ ရှိတယ်။ICUကို လူနာပို့တာမျိုးဆို ကိုယ်တွေပါရောပြီး Trolleyတွန်းရတာမျိုးရှိ တယ်။”

(၃၃နှစ်ကလေးအထူးကုဆရာဝန်)

“General workers do everything in the ward such as cleaning, transportations of patients, tasks ordered by the staffs, etc without specific job description for them. There is only 1 to 2 workers in the ward but I think there is enough doctors. They do also general works of the ward and help the staff in indenting medicine transportations. There is only 1 worker at night. So we also help the patient transport to ICU with trolley.”

(33 years old SAS)

"အဓိကကတော့ frontlineမှာ လုပ်နေရတဲ့လူတွေပို လိုပါတယ်။ wardထဲဆိုလဲ ASက ၄ယောက်ပဲရှိတယ်။ ဒါကလဲ ခွဲထားပေးနိုင်သလောက်ပဲပေါ့လေ။ ဒါထက်မပြေးမပြေး ပိုရရင်တော့

အဆင် ပွဲတော်ပေါ့ပါလေ။OTနေ့ဆို AS (၂)ယောက်က OTထဲဝင်တယ်။ Wardထဲမှာ (၂)ယောက်ပဲ ကျန်တယ်။ အဲ့ထဲက (၁)ယောက်က chart showတွေ၊ တခြားchangesတွေလုပ်၊ ကျန်တာ အကုန်လုံးကို နောက် (၁)ယောက်က လုပ်ရတယ်။ ဒါက surgical ward ပေါ့နော်။ အခြား ward တွေလဲ ဒီလိုပဲ အခက်အခဲ ရှိတယ်။ (၁)ယောက်ထဲ လုပ်ရတော့ အနဲအများကျန်ခဲ့တာတွေ ရှိတယ်။”

(၂၇နှစ် လက်ထောက် ဆရာဝန်)

“Frontline persons are mainly required. There are four AS in the ward. That’s all they can appoint. I’d prefer more AS. Two AS are assigned at OT and two AS are assigned in the ward at OT day. One AS from the ward do chart shows and other changes. Another AS do all other works in surgical ward. Some obstacles also present in other wards. Doing things by only one makes more or less missing things.”

(27 years old AS)

2. Feedback and communications about error

Nearly all participants in IDI said error were happened and reported to seniors. One of participant expressed her feeling due to unacceptance of her remind by the senior. Some who had done error are warned and some are taken action by the in-charge.

“နောက်တစ်ခုက များသောအားဖြင့် doseပေါ့ တွက်တာ မှားတာမျိုးလေး တွေ့ရ တယ်။ အဲ့လိုတစ်ခါရှိဖူးတယ်။ ပြန်မိရင်တော့ ထုချေလွှာရေးရတယ်။ ဌာနမှူးနဲ့ တွေ့ရတယ်။အဲ့လိုမျိုးမှာတွေ တော့ ရှိတယ်။ ပြန်ပြန်စစ်တော့ မိမိသွားပြီး လက်လွန်ခဲ့လေ့နဲ့ မဖြစ်ခင် သိသွားတယ်။ (USG ရိုက်တာလိုမျိုး၊changes မလုပ်မိတာမျိုး)။ သိသွားရင်fine တပ်တာမျိုးရှိ တယ်။”

(၃၃နှစ်ကလေးအထူးကုဆရာဝန်)

“Usually another mistake is error in calculation of dose. I experienced one time which was found out and he or she was warned by head of the unit. Recheck again & again make more catchment of error doing before.(example , doing changes, USG). If errors was found out, you must pay FINE ”

(33 years old SAS)

“Error အမှားအယွင်း ကလုပ်တာများပါတယ်။ ရှိခဲ့တယ်။လုပ်ခဲ့တယ်ဆိုရင်လဲ reporting လုပ်ပါတယ်။ အဆင့်ဆင့် reportလုပ်ကြတယ်။နောက်ဆုံးကတော့ ward in-charge

နဲ့ professor ထိပါ။ အလုပ်လုပ်နေရင်းလဲ ဖြစ်ခဲ့ဖူးတဲ့ အမှားအယွင်းတွေ လွန်ခဲ့တဲ့ ၄နှစ်၊၅နှစ် လောက်ကဖြစ်ခဲ့ ဖူးတာတွေ ဘာတွေအခြေခြေ ပြန်ပြောပြန်သတိပေးတယ်။အမှားထပ် မဖြစ်စေဖို့ ပါ။”

(၃၈နှစ်ကလေးအထူးကုဆရာဝန်)

“There is scarce of error in hospital. If we had done error, we reported the senior up to ward in-charge and professor. We warned our college and juniors not to do same error although it was occurred last 4-5 years ago.”

(38 years old SAS)

“Haemangioma thigh မှာလေ။ General PG ဆိုတဲ့ အခါကြတော့ မသိဘူး။ ကိုယ်က remind လုပ်တယ်လေ။ ဆရာနော် FFP (fresh frozen plasma) ကလေး body weight နဲ့ဆို မများနေဘူးလားဆရာ။ ဆရာတို့ကသွင်းဆို ကျွန်မတို့ကလဲ သွင်းပေးလိုက်တယ်။ဒါပေမဲ့ ကလေးက Overload ဖြစ်သွားတယ်။ ကိုယ်က ward ဆရာမလေ သူက ဆရာဝန်လေနော်။ များတယ်ဆိုတာ ကိုယ် remind လုပ်တယ်လေ (၂)ခါ(၃)ခါ ကိုယ်ပြောတယ်။ ဒါပေမဲ့ သူတို့က လက်မခံတဲ့အတွက် ကိုယ့်ဘက်က တာဝန်ကင်းပြီလေ။ ဒါပေမဲ့ ကလေးက ဆုံးရှုံးလိုက်ရတယ်။ ex သွားတယ်လေ”

(၃၄နှစ် သူနာပြုဆရာမ)

“One night a case of haemangioma thigh, general post graduate student didn’t know the correct amount of FFP(fresh frozen plasma). I reminded him this was more enough for the child with that weight. But he ordered me to carry on the infusion and I’d done it. I’m only a nurse and he is a doctor. I reminded him 2 to 3 times but he didn’t accept. The child become overloaded and expired.”

(34 years old trained nurse)

3.Handoffs and transition

Most of the participants gave the handover case by case, especially ill case and the one to do special procedure. They always use to give over by verbally and note books also. They also used to take handover before changing ward which is a good habit for patient safety culture.

“တစ်ward နဲ့ တစ်ward ပြောင်းသွားရင် roaster ထွက်ပြီးနောက်ရက်ကြရင် ward ရဲ့ sisterကိုwish သွားလုပ်ရပါတယ်။ ပြီးအစဉ်လိုက် wish လုပ်ပါတယ်။ ပြီးရင် ကိုယ်သိတဲ့အမှတ

ယတောကျ မသိလဲပဲward over ယူရပါတယ်။ day duty အတွက် အရင်ယူရပါတယ်။ night ကတော့ ဝင်ဝင်ချင်း ခြင်းချင်းမခြားတော့ တဖွဲဖွဲမ ယူပါတယ်။”

(၂၄နှစ်သူနာပြုဆရာမ)

"After releasing the duty roaster, we wish the sister of the new ward and other seniors. Then we takes ward duty over for the morning shift and for night shift later."

(24 years old trained nurse)

"ward အကူးအပြောင်းမှာ handoverအနေနဲ့ ward ရဲ့ culture ပဲပေါ့နော်။ procedure ဘာတွေလုပ်လဲ။ ဒါပဲhandover လုပ်တာများပါတယ်။ handover ယူတာDuty Rosterကြီး ထွက်တဲ့ ပေါ်မူတည်ပါတယ်။ စောစောထွက်လို့အချိန်ရရင် ကြားထဲမှာ ကွဲယူဖို့ အချိန်ပိုရတယ်။ ခုဆိုရင် ၂၈ဖြစ်နေပြီ။ Roster မထွက်သေးဘူး။ ကပျမထွက်ရင်နဲ့နဲ့တော့ကသီပါတယ်။"

(၂၇နှစ် လက်ထောက် ဆရာဝန်)

"During the period of ward change, mostly we take handover such as ward culture and procedure. Handover taken was depend on the release of duty roaster. If the order release early, we get more times to take handover. Today is 28 and had not released yet. Too late make us less convenience."

(27 years old AS)

4. Provider safety

Most of the participants described the provider safety and followed the protocol and procedure of their hospital. Only few mentioned they didn't follow the safety procedure during life-saving times.

"သူတို့ကို investigation လုပ်တော့မယ်ဆိုရင် ကိုယ့်ဘက်က safe ဖြစ်အောင်ဆို အရင်ဆုံး Glove ဝတ်ပါတယ်။ လူနာက BCR(hepatitis B, hepatitis C, Retro test) ဘာမနျူးမသိနိုင်တော့ ကျွန်မတို့ Glove အမြဲဝတ်ပါတယ်။ လူနာကိုင်ပြီး investigation အကုန်ယူပြီးရင် handwashing သေချာလုပ်ပါတယ်။"

(၃၄နှစ် သူနာပြုဆရာမ)

"Before doing investigations we wear glove for personal protection. We can't guess who have infection so we always wear glove. After doing investigations, we do handwashing properly."

(34years old trained nurse)

“ဆရာမတွေ safetyအတွက်က day duty ပဲဖြစ်ဖြစ်၊ night duty ပဲဖြစ်ဖြစ် လူနာစောင့်ကို ကန့်သတ်ထားတာပေါ့။ တတ်နိုင်သမျှ လုံခြုံရေးပေါ့။ ညဘက်ဆို အလုပ်သမားကို လူနာ မရှိတဲ့ နေရာကို သော့ခတ်ခိုင်းထားတယ်။”

(၅၀နှစ် သူနာပြုဆရာမကြီး)

“For the safety of nurses whatever day or night duty, we limited patient attendants and locked the area where there is no patient at night.”

(50 years old sister)

“Urgent တွေဆိုရင် မသုံးဖြစ်ဘူး။ အရေးပေါ် အရေးပေါ်လုပ်မယ်ဟာ့ ဆိုရင် Suction စုပ်မယ်ဟာ့ဆိုရင် လက်အိတ်ကမဝတ်ဖြစ်ဘူး။ mask ကမတပ်ဖြစ်ဘူး။ တပ်ဖြစ်အောင်တော့ ကြိုးစားပါတယ်။အရေးကြီးတယ်။ အသက်လုပ်မဲ့အခါမျိုးဆိုတခါတရံပွင့်ကိုင်မိတယ်။ gloveမဝတ်ပဲနဲ့ ပေါ့။”

(၄၆နှစ်အထက်တန်းသူနာပြု)

“During urgent & emergency condition, we had not worn gloves and mask mostly. We tried to wear these things but we usually do with bare hands at the time of life saving.”

(46 years old staff nurse)

5. Patient safety during Transportation

Two of eight participant describe Patient safety during Transportation.

“Transportation ပိုင်းတွေပေါ့။ ဒီအဆောက်မှာက ဓါတ်လှေကားပြနာပဲ။ သာမန်လူနာတွေအတွက်က ကိစ္စမရှိပေမဲ့ disable ဖြစ်နေတဲ့ ကလေးတွေအတွက် အဆင်မပြေဘူး။ တခါတခါ ကျ chest tube ကြီးတွေနဲ့ ဆင်းလာကြတယ်။chest tube နဲ့လူနာဆိုတာ တတ်နိုင်ရင် mobilize မဖြစ်တာ အကောင်းဆုံးပဲ။ အဲလိုဆင်းလာ၊bottleက အပေါ်မြောက်၊ ဒါလူနာအတွက် safety မဖြစ် ဘူး။ အန္တရာယ်ရှိတယ်။ “

(၂၇နှစ် လက်ထောက် ဆရာဝန်)

“In transportation, the problem is elevator. It’s not serious for patient but for the disable. Sometimes they went down with chest tubes which is bottle up and it’s dangerous and not safety for patient.”

(27 years old AS)

“ICUကနေ တခြားတခုခုပို့မယ်။ အဲလိုtransportationတွေမှာသွားမယ်ဆိုရင် Emergency boxကိုသယ်ရမယ်။ box ထဲမှာလဲ Bag &Mask ပါရမယ်။လူနာရဲ့အတွက် ပါရမယ်။

မသွားခင် သေချာ စစ်ပြီး ယူသွားရမယ့်ကိုလဲ အမြဲအသင့် ဖြစ်အောင် သုံးပြီးတိုင်း ပြန်ဖြည့်ရတယ်။'

(၃၈နှစ်ကလေးအထူးကုဆရာဝန်)

"During transportation eg ICU MO(medical officer) must bring the emergency box. It must contain bag & mask. Before going transportation, must check thoroughly and we always fill up after use."

(38 years old SAS)

6.Fall and Accidents

One of the participant mentioned about fall and accident of patients which is one of the international patient safety goals.

"prednisolone သောက်နေရတဲ့အတွက် အရိုးတွေ မကြံ့ခိုင်တော့ ကလေးတွေ ပြေးတာ လွှားတာက အစလိုက်ပြုစုနေရတယ်။တချို့ကြတော့ တအားဆော့တယ်။ ဆော့တဲ့ကလေး တွေမှာ အရိုးမကြံ့ခိုင်တော့၊ အများဆုံးက အရိုးကျိုးမှာ ကြောက်တယ် ကျွန်မတို့က အတတ်နိုင်ဆုံး၊ ဆရာမတွေဆိုရင်လဲ အချိန်ပိုင်းအလိုက် ကလေးတွေ ထိခိုက်ဒဏ်ရာမရအောင် လုပ်ပေးတယ်။"

(၅၀နှစ် သူနာပြုဆရာမကြီး)

"We care the patient who took the drug prednisolone so we tell not to run to prevent fall and not to get fracture. Some are so playful and we mostly afraid of getting fracture. So we, duty nurses always care the patient as much as we can."

(50 years old sister)

Table (5.27) Summary of themes for patient safety culture

Themes	Subthemes	
1.Staffing	Not enough staff	No job description Overloaded work
2.Feedback and communication about error	Reporting of errors	Accept and take action Accept and find out ways not to do again same error Not accept the suggestions of others
	Feedback	Received Not received
3.Handoffs and transitions	Handover after duty period	Verbally Written with note book
	Handover when	Case by case

	changing wards/units	
4.Provider safety	During procedure	Follow the guideline/procedure
	Working environment	Safety of providers
5.Patient safety during transportation	Transportation within hospital	Available of trolley, wheel chair, lift
	Transfer to other hospital	Available of emergency care, drugs
6.Fall and accident	Awareness of fall and accidents in the hospital	Admin also clinical personal

CHAPTER (6)
DISCUSSION

6.1 Background characteristics

In this study, 103 participants of health staffs from Yangon Children Hospital were responded to patient safety culture self-administered questionnaire. About half of assistant surgeons and trained nurses had current hospital experiences between 6 months and one year. Sisters and staff nurses had current hospital experiences more than 5 years. Assistant surgeon and trained nurses were less experience among participants because AS were shifted mostly two to three years after posting in tertiary hospital. Similar finding that AS had less than 1year current hospital experiences found in a study conducted by Cho-Cho-Lwin (2017) but nurses had more than 5 years hospital experiences. Another study done at Saudi Arabia to health professionals including nurses, lab technician, manager and medical staff showed 1-5 years of common current hospital experiences (Alahmadi, 2010).

Among the respondents, most of assistant surgeon worked 50-59 hours per week, sisters worked less than 40 hours per week but most of the participants worked 40-49 hours per week as an average in the study. The respondents worked (33.6h/week) or more was found in a survey study which is done at emergency department in Switzerland (Ricklin, Hess and Hautz, 2019).

All of the respondent staff nurses had more than 5 years in professional experience and most of the sisters also. More than half of assistant surgeons and trained nurses had less than 1 year in professional experience. Different finding found in a study done at turkey to 265 nurses. Their result showed participants among nurses had 1-5 years of professional experience (Ege, 2019).

6.2 Results of patient safety culture in all respondents

According to the Agency of Health Research and Quality (AHRQ), any composite that achieves 75% and above can be considered as an area of strength, that have average positive responses between 50% and 75% as area for potential improvement and that have average positive response below 50% as area of weakness in the safety culture.

Ten dimensions of patient safety culture results of all respondents in YCH were in area of strength. They were teamwork within unit, supervisor expectation & actions promoting patient safety, organizational learning-continuous improvement, management support for patient safety, overall perceptions of patient safety, feedback & communication about error, communication openness, events reporting frequency, teamwork across units and handoffs and transitions. Remaining two were staffing and non-punitive response to error. The findings which is the lowest positive responses, staffing and non-punitive response to error were found as similar to a study conducted in 13 general hospitals at Saudi Arabia (Alahmadi, 2010).

In the study, teamwork within unit and organizational learning-continuous improvement were nearly 100% positive responses. This reveal staffs are supporting each other and working together as a team and mistakes lead to positive changes to build strong patient safety culture. Similar finding that teamwork within unit and organizational learning-continuous improvement were highest positive responses was found in the study of Saudi Arabia (Alahmadi, 2017; Liu et al., 2014; Ricklin, Hess and Hautz, 2019). In in-depth interview, almost respondents did not mention too much about teamwork although teamwork within units were highly positive response in quantitative questionnaire.

The two dimensions; communication openness and feedback and communications about error were second high positive responses of participant in the study. In current study, most of the respondents in in-depth interview said majority felt free to question to seniors if they had doubt and most of the seniors replied

respectfully. Feedback and communication about error in a Jordan study showed second most highest positive responses but lower than current study (Suliman et al., 2017).

In the study, overall perceptions of patient safety, events reporting frequency and teamwork across units were also in the area of strength. These dimensions indicate hospital units are well cooperated each other and obeyed and followed their respective protocol of each unit. Good perception of patient safety may be the results of training program in CME, CNE about patient safety which is the most popular nowadays in Myanmar. Similar findings of overall perceptions of patient safety and teamwork across units were found in the study conducted in West Yangon General Hospital but events reporting frequency was lesser than current study which was different (Cho-Cho-Lwin, 2017). In in-depth interview, one of the respondent said they did not do personal protection while life-saving periods. It pointed out to check the practice of health workers although perception was good.

On the margin of area of strength and area for potential improvement, there were three dimensions. These were supervisor expectation & actions promoting patient safety, management support for patient safety and handoff and transitions. To improve this area, supervisors should praise the staffs who follow the safety protocols and should also take into account their suggestions. Another way to improve was providing a work climate which showed patient safety was the top priority. Handoffs should be effective because gaps of handover lead to tons of problems. These findings, supervisor expectation & actions promoting patient safety, management support for patient safety were found similar to a study of tertiary hospital in Sri Lanka (Amarapathy et al., 2013). In in-depth interview, all of the respondents expressed their handover process accurately during day and night duty change and ward change.

The dimension non-punitive response to error was the second lowest positive response and staffing was the lowest. There was controversial because management support for patient safety and supervisor expectations dimensions had high score but low positive response in non-punitive response in error. There may be blaming culture and take action for error upon the staff. There was no doubt that staffing was becoming the lowest positive response because considerable shortage of staffs and no enough staff to handle the workload and increasing demand of consumers during this decade. This was consistent to the studies done in Saudi Arabia and Sri Lanka

(Alahmadi, 2017; Amarapathy et al., 2013). In in-depth interview, all of the respondents mentioned no enough staff to give quality care and safer care which is consistent to quantitative results. Nearly all participants answered that there was error which may or may not be harmful to the patients but some added that there was taking action which may be warning letter or may be the money 'fine'. This may lead to reduce reporting which become less awareness for positive effects of reported errors. In a study of UK, participants accept reporting was important for organizational learning but remain problematic due to existing barriers and cause less delivering of actionable learning (Sujan, 2015).

In the study, common overall grade on patient safety of hospital was acceptable and very good. Only small percentage was accounted for poor and excellent on patient safety grade. No one thought as failing. Grading finding was consistent to a study conducted in Japan and Taiwan. More than half of the participants reported no adverse event in the past 12 months. Among participants, nearly one third of respondents reported 1-2 events and 3-5 events. Healthcare workers of the Asian countries were more likely to avoid the reporting of adverse events because they did not want to lose face. This finding was same in a study, but Japanese health workers were reported more than Taiwanese though they were being Asian countries (Fujita et al., 2013).

6.3 Results on patient safety culture according to profession, current hospital experiences, working hours per week and working units

Less positive culture was found in staffing and non-punitive response to error in all professionals. Among the participants, sisters responded positive in eight dimensions with full strength 100% but they strongly responded negative in staffing. Public hospitals are now facing with shortage of general workers, less retention of health workers, both doctors and nurses. So they worked with the strength they had in order to overcome the obstacles such as increasing workload and increasing demands from patients. Teamwork within unit, organizational learning-continuous improvement and overall perception of patient safety were the highest positive response mentioned by AS and trained nurses and these are the main core dimension for the patient safety culture. The perception on patient safety culture by AS and nurses were positive in nature though their experiences were less than 1 year and this may be a step to climb the ladder of patient safety.

In the study, one different thing is the result of communication openness by the participants of 1-3years hospital experience was 100% positive response. According to the operational definition, communication openness means staff can speak freely if they see something that make worse to the patient and can ask without hesitation. Although they had less experience, their perception was very high positive. This indicates the shift of blame culture to an objective response to error in newer generations. Building trust among healthcare workers, providers and consumers is needed to achieve patient safety and foster the outcome which are learnt from errors (Liu et al., 2014).

Fewer working hours (less than and equal to 40 hours per week) had the more positive responses in teamwork within unit, organizational learning-continuous improvement, feedback & communication about error, communication openness and teamwork across units. A study conducted in China found out that those who worked more than 60 hours a week had poor response fewer than those working less than 60 hours (Liu et al., 2014). Participants with fewer working hours replied more positive in both study although cut off point was not the same.

Similar to other findings, the highest positive responses were teamwork within unit and organizational learning-continuous improvement for nearly all groups of professional experiences. According to working area, the respondents working in surgical unit, OPD, Emergency and Day care units responded in 6 dimensions as highest positive responses (100%) and another 4 dimensions were more than 75%. The respondents working in medical unit responded less positive to the dimensions of management support for patient safety and non-punitive response to error. These may be due to the needs of providing a work climate that promote patient safety is a top priority. Another need was to encourage the staff for openness of communications and start to shift blame culture toward the system that allow error and from which change to more safety culture (Ahmad Al-Nawafleh, 2016).

6.4 Relation between background characteristics and patient safety culture

No significant association between background characteristics and patient safety culture, and background characteristics with patient safety grading.

6.5 Strength and Limitation of the study

The strength of this study in qualitative approach is that qualitative questions were asked till the data became saturated. Likewise, for quantitative findings, the

questionnaire used in this study was developed by the Agency for healthcare research and quality (AHRQ) which is widely used internationally.

On the other hand, there are some limitations in this study. It was only cross-sectional study so the results were snapshot of perception and could not find out causal relation. It was conducted in one tertiary specialist hospital so it may need to expand and increase sample size. The study described the perceived behavior of the participants only and had not contained checking the records of patient safety such as reporting of adverse events, changes after the lesson learn from error.

CHAPTER (7)
CONCLUSIONS

Modern healthcare systems are mainly concern with improving patient safety culture. To establish the patient safety culture, the first step to do is assessing the current situation. So the study was carried out in YCH by using standard tools and questionnaires designed by AHRQ which is widely used around the world. By doing so, strengths and weaknesses of the hospital can be recognized and can manage to improve patient safety culture.

According to the results, total positive responses were (80.4%) and total negative responses were (19.6%). Areas of strength were teamwork within unit, organizational learning-continuous improvement, communication openness and feedback and communications about error, supervisor expectation and actions promoting patient safety, management support for patient safety, overall perception of patient safety, events reporting frequency, teamwork across unit, handoffs and transitions. Non-punitive response to error was in the area of potential improvement and staffing stand in the area of weakness. Positive responses of doctors were (81.2%) and that of sisters were (86.9%). Positive responses of staff nurses were (84.6%) and that of trained nurses were (79.6%). The patient safety grading mostly showed

acceptable and very good. Majority (66%) of the participants had reported no event in the past 12 months. Although communication openness was highly positive response, event reporting was low that may be due to presence of blame culture and obstacles.

In in-depth interviews, the participants answered no enough staff, over workload, feedback and communication error. They did not emphasize about teamwork within or across units although these dimensions were high positive response.

Overall patient safety cultures of YCH were not totally positive in patient safety culture and to maintain and promote the positive culture, dimension in the area of weakness and in the area of potential improvement should be supported.

CHAPTER (8)
RECOMMENDATIONS

To improve patient safety culture, the following recommendations were drawn based on the findings of the study.

1. Emphasizing the patient safety and developing patient safety culture by all employees, patients and their families.
2. Continuing education or training program should be available for improving patient safety and healthcare organization.
3. To improve skills and competencies of health workforce, patient safety curriculum guide for both medical and nursing students should be developed.
4. Encourage and support non-punitive culture and shifting the blame culture to open environment where blame is seen as impediment to improve patient safety.
5. Staffing dimension is in the area of weakness for patient safety culture and so responsible authorities should do proper recruitment.
6. Further study is needed on patient safety culture in other hospitals both specialty and general.

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ANNEXES

ANNEX (1) Operational Definition of Variables

No	Variable	Operational definition	Measurement scale
1	Patient safety culture	The product of individual and group beliefs, values, attitudes, perceptions, competencies and pattern of behavior that determine the organization's commitment to quality and patient safety	Nominal
2	Communication Openness	Staff freely speak up if they see something that may negatively affect a patient and feel free to question those with more authority	Nominal
3	Feedback and Communication About Error	Staff are informed about errors that happen, are given feedback about changes implemented, and discuss ways to prevent errors.	Nominal
4	Frequency of Events Reported	Mistakes of the following types are reported: (1) mistakes caught and corrected before affecting the patient, (2) mistakes with no potential to harm the patient, and (3) mistakes that could harm the patient but do not.	Nominal
5	Handoffs and Transitions	Important patient care information is transferred across hospital units and during shift changes.	Nominal

No	Variable	Operational definition	Measurement scale
6	Management Support for Patient Safety	Hospital management provides a work climate that promotes patient safety and shows that patient safety is a top priority.	Nominal
7	Non punitive Response to Error	Staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.	Nominal
8	Organizational Learning-Continuous Improvement	Mistakes have led to positive changes and changes are evaluated for effectiveness.	Nominal
9	Overall Perceptions of Patient Safety	Procedures and systems are good at preventing errors and there is a lack of patient safety problems.	Nominal
10	Staffing	There are enough staff to handle the workload and work hours are appropriate to provide the best care for patients	Nominal
11	Supervisor/Manager Expectations and Actions Promoting Patient Safety	Supervisors/managers consider staff suggestions for improving patient safety, praise staff for following patient safety procedures, and do not overlook patient safety problems.	Nominal
12	Teamwork Across Units	Hospital units cooperate and coordinate with one another to provide the best care for patients.	Nominal
13	Teamwork Within Units	Staff support each other, treat each other with respect, and work together as a team.	Nominal

ANNEX (2) Informed consent (Myanmar and English)

<u>သုတသေနလုပျငနျးတှငျ ပါဝငျဆောငျရှကျရနျ သဘောတူညီခကြျတောငျးခံခွငျး</u>

ဤသဘောတူညီခကြျမှာ ရနျကုနျကလေးဆေးရုံကွီး၏ ဆေးကုသမှုလုပျငနျးမြားတှငျ လူနာမြား ဘေးအန်တရာယျကငျးလုံခွံမှုအစဉျအလာအား ဆနျးစဈခွငျးဖွဈပါ၍ ရနျကုနျကလေး ဆေးရုံကွီးတှငျ တာဝနျထမျးဆောငျနသေော ဆရာဝနျမြားနှငျ့ သူနာပွုမြားအား သုတသေန ပွုလုပျခွငျးလုပျငနျးတှငျ ပါဝငျဆောငျရှကျပေးပါရနျ ဖိတျခေါျခွငျးဖွဈပါတယျ။

အဓိက သုတသေီအမညျ - ဒေါကျတာသန်တာ

ဌာန - ပွညျသူ့ကနျြးမာရေးတက်ကသိုလျ၊ရနျကုနျ

သုတသေနခေါငျးစဉျ - ရနျကုနျကလေးဆေးရုံကွီး၏ဆေးကုသမှု လုပျငနျးမြားတှငျ လူနာမြား ဘေးအန်တရာယျ ကငျးလုံခွံမှု အစဉျအလာအား ဆနျးစဈခွငျး။

အပိုငျး(က) သုတသေနနှငျ့ သကျဆိုငျသောအခကြျမြား

၁။ မိတျဆကျနိဒါနျး

ကြနျုမ ဒေါကျတာသန်တာသညျ ဆေးရုံအုပျခုပျြမှု ပညာမဟာဘွဲ့သငျတနျး ပွညျသူ့ကနျြးမာရေးတက်ကသိုလျ၊ ရနျကုနျမှ သငျတနျးသူတဈဦးဖွဈပါသညျ။ ကြနျုမအနဖွေငျ့ ရနျကုနျကလေးဆေးရုံကွီးမှ ဆရာဝနျနှငျ့သူနာပွုမြား၏ ဆေးကုသမှုလုပျငနျးမြားတှငျ လူနာမြား ဘေးအန်တရာယျ ကငျးလုံခွံမှု အစဉျအလာဆိုငျရာ သဘောထားအမွငျအား သုတသေနတဈခုဆောငျရှကျလိုပါသညျ။ သုတသေနအကွောငျးကိုရငျးပွပွီး သငျ့အား ပါဝငျရနျ ဖိတျခေါျလိုပါသညျ။သငျ့အနနေဖွငျ့ မရငျးလငျးသညျမြားရှိပါက မေးမွနျးနိုငျပါသညျ။

၂။ ရညျရှယျခကြျ

ဤသုတသေန၏ရညျရှယျခကြျမှာ ရနျကုနျကလေးဆေးရုံကွီး၏ ဆေးကုသမှု

လုပ်ငန်းများတွင် လူနာအား ဘေးအန္တရာယ်ကင်းလုံခြုံမှု အစဉ်အလာအား ဆန်းစစ်လိုခြင်းဖြစ်ပါသည်။

၃။ သုတသေနဆောင်ရွက်ပုံအမျိုးအစား

ဤသုတသေနသည် သင်္ချာကိုယ်တိုင် မေးခွန်းများကိုဖတ်၍ ဖြေဆိုရမည်ဖြစ်ပြီး မိနစ်(၃၀)ခန့် ကြာမြင့်မည်ဖြစ်ပါသည်။

၄။ ပါဝင်သူ မည်သူသူများရွေးချယ်ခြင်း

သင့်အား ဤသုတသေနတွင် ပါဝင်ရန် ဖိတ်ခေါ်ခြင်းမှာဆေးကုသမှုလုပ်ငန်းများတွင် လူနာများဘေးအန္တရာယ်ကင်း လုံခြုံမှုအစဉ်အလာနှင့်ပတ်သက်သော သင်၏သဘောထား အမြင်များသည် ပွင့်ပွင့်ရေးလုပ်ဆောင်မှုများအပေါ် အထောက်အကူပြုနိုင်မည်ဟု ယူဆ၍ ဖြစ်ပါသည်။

၅။ မိမိဆန္ဒအလျောက်ပါဝင်ခြင်း

ဤသုတသေနတွင် သင်ပါဝင်ကူညီခြင်းသည် သင်၏သဘောဆန္ဒ အလျောက်သာ ဖြစ်ပါသည်။ ပါဝင်ခြင်း၊ မပါဝင်ခြင်းမှာ သင်၏ ဆန္ဒအတိုင်းရွေးချယ်မှုသာဖြစ်ပါသည်။

၆။ လုပ်ဆောင်ပုံ

ဤသုတသေနတွင် ပါဝင်ရန် သင်ဘောတူညီပါက သင်ကိုယ်တိုင်မေးခွန်းများကို ဖတ်၍ ဖြေဆိုရမည်ဖြစ်ပြီး မိနစ် ၃၀ခန့်ကြာမြင့်မည်ဖြစ်ပါသည်။ သင်သည် သီးသန့် နေရာတစ်ခုမှာဖြေဆိုရမှာဖြစ်ပြီး သင်၏လူမှုရေးအခြေအနေအလက်များ၊ လုပ်ငန်းခွင်ဆိုင်ရာ အခြေအနေအလက်များနှင့် ဆေးကုသမှုလုပ်ငန်းများတွင် လူနာများဘေးအန္တရာယ်ကင်းလုံခြုံမှု အစဉ်အလာနှင့်ပတ်သက်သော သဘောထားအမြင်နှင့်အချက်အလက်များကို လေ့လာသိရှိ လိုပါသည်။ မေးခွန်းများဖြေဆိုရာတွင် စိတ်အနှောက်အယှက်ဖြစ်၍ မဖြေဆိုလိုသော မေးခွန်းများရှိပါက သင့်ဆန္ဒအလျောက် မဖြေဆိုပဲနေခွင့်ရှိပါသည်။

၇။ အကျိုးကျေးဇူးများ

ဤသုတသေနတွင် ပါဝင်သောကြောင့်သင့်အတွက်

တိုက်ရိုက်အကျိုးကြားဖြစ်မည် မဟုတ်ပါ။သို့သော် သင်ပါဝင်မှုသည် ဆေးကုသမှုလုပ်ငန်းများနှင့် လူနာများ၏ဘေးအန္တရာယ် ကင်းလုံခြုံမှု အစီအစဉ်များပိုမိုထိရောက်စေရန် ပံ့ပိုးကူညီပေးနိုင်သည် အပြင် တွင် အထောက်အကူဖြစ်စေပါသည်။

၈။ အချက်အလက်များ သိမ်းဆည်းထားရှိခြင်း

ဤသုတေသနမှ ကောက်ယူရရှိသည့် အချက်အလက်များကို လုံခြုံစွာထားရှိမည် ဖြစ်ပါသည်။ သင့်ထံမှ သိရှိရသည့်အချက်အလက်များကို သုတေသနအဖွဲ့မှ တပါးအခြား မည်သူမှ မသိစေရပါ။

၉။ သုတေသနရလဒ်များကို ဖြန့်ဝေခြင်း

ဤသုတေသန၏ တွေ့ရှိချက်များကို စိတ်ဝင်စားသူများမှ သိရှိနိုင်စေရန် ရလဒ်များကို သာ ဖြန့်ဝေမည် ဖြစ်ပါသည်။

၁၀။ ဆက်သွယ်ရမည့်ပုဂ္ဂိုလ်

အကြောင်းတစ်စုံတစ်ရာမေးမြန်းလိုလျှင် ဒေါက်တာသန့်တာ၊ ဖုန်း-၀၉ ၅၁၉၆၈၈၄ ကို ဆက်သွယ်နိုင်ပါသည်။ ဤသုတေသနကို လူပုဂ္ဂိုလ်များအပေါ် သုတေသနပြုမှုဆိုင်ရာ ကျင့်ဝတ်ကော်မတီမှ ခွင့်ပြုချက်ရရှိပြီးဖြစ်ပါသည်။

အပိုင်း (ခ)သုတေသနတွင် ပါဝင်ရန်သဘောတူညီမှု ပုံစံ

ကျွန်ုပ်သည် ဆေးကုသမှုလုပ်ငန်းများတွင် လူနာများဘေးအန္တရာယ်ကျရောက်မှု နှင့်ပတ်သက်သော သဘောထားအမြင်အား လေ့လာသော သုတေသနတွင် ပါဝင်ရန် ဖိတ်ခေါ်ခြင်းခံရပါသည်။ ဤသုတေသနတွင် ပါဝင်သောကြောင့် ကျွန်ုပ်အတွက် တိုက်ရိုက် အကျိုးကျေးဇူးမရရှိပါ။ကျွန်ုပ်သည် ကိုယ်တိုင်မေးခွန်းများကို ဖတ်၍ ဖြေဆိုရမည်ဖြစ်ပြီး မိနစ်(၃၀)ခန့် ကြာမြင့်မည်ဖြစ်ကြောင်းနှင့် လူမှုရေးအခြေအနေများ၊ လုပ်ငန်းခွင်နှင့် ဆိုင်သော အခြေအနေများနှင့် မိမိတို့ ဆေးကုသမှုလုပ်ငန်းများတွင် လူနာများ ဘေးအန္တရာယ်ကျရောက်မှုနှင့် ပတ်သက်သော သဘောထားအမြင်အား မေးမြန်းမှာ ဖြစ်ကြောင်းသိရှိရပါသည်။ ဤသုတေသနတွင် ကျွန်ုပ်သည် အထက်ဖော်ပြချက် များကို ဖတ်ရှုပြီးဖြစ်ပါသည်။ မရှင်းလင်းသည့်မေးခွန်းများကိုလည်း မေးမြန်းနိုင်၍ ၎င်းတို့ကို ကျွန်ုပ်သည် ကျေနပ်စွာဖြေဆိုပေးပါသည်။ ကျွန်ုပ်ဆန္ဒအလျောက် ဤသုတေသနတွင် ပါဝင်ရန် သဘောတူပါသည်။

သုတေသနတွင်ပါဝင်သူအမည် -...................................

သုတေသနတွင်ပါဝင်သူလက်မှတ် -...................................

ရက်စွဲ - ....

အပိုင်း (ဂ) အသေးစိတ်မေးမြန်းခြင်းအတွက် မိတ်ဆက်စကားပြောရန်

ကျွန်မ ဒေါက်တာသန်တာ၊ ဆေးရုံအုပ်ချုပ်မှုပညာမဟာဘွဲ့သင်တန်း ပြည့်သူကျန်းမာ ရေးတက္ကသိုလ်၊ ရန်ကုန်မှ သင်တန်းသူတစ်ဦးဖြစ်ပါသည်။ ရန်ကုန်ကလေးဆေးရုံကြီး၏ ဆေးကုသမှုလုပ်ငန်းများတွင် လူနာများ ဘေးအန္တရာယ်ကင်းလုံခြုံမှု အစဉ်အလာဆိုင်ရာ အခြေအနေများကို စာတမ်းပြုစုလိုပါသည်။ ----------------------------- မဖြေကြားပေးသော အဖြေများ အကဲဖြတ်ချက်များမှာ အလွန်အသုံးဝင်မှာဖြစ်ပါတယ်။ အချိန်ပေးပြီး ဖြေကြား ပေးသည့်အတွက် ကျေးဇူးတင်ပါတယ်။ မိမိစိတ်ထဲရှိသည့်အတိုင်း ထင်မြင်ချက်များကို လွတ်လပ်စွာ ဆွေးနွေးပေးစေလိုပါတယ်။ ဆွေးနွေးချက်များကို အသံသွင်း ခွင့်ပြုပါရန် လေးစားစွာ တောင်းခံအပ်ပါသည်။ ကျွန်မတို့ မကြားလိုက်ရတဲ့ လွတ်သွားသော အကြောင်းအရာများကို ပြန်ဖွင့်ပြီး နားထောင်လို၍ ဖြစ်ပါတယ်။ ဆွေးနွေးချက်များကို စာတမ်းပြုစုမည့် ကိစ္စများတွင်သာ အသုံးပြုမှာဖြစ်ပါတယ်။

ဆွေးနွေးရန်မေးခွန်းများ

(၁) ရန်ကုန်ကလေးဆေးရုံကြီး၏ ဆေးကုသမှုလုပ်ငန်းများတွင် လူနာများ ဘေးအန္တရာယ်ကင်းလုံခြုံမှု အစဉ်အလာ (Patient Safety Culture) အနေနှင့် လုပ်ဆောင် နေမှုများရှိပါသလား။

(၂) မိမိကိုယ်တိုင် (သို့) အခြားသူများရဲ့ ဘေးအန္တရာယ်ကင်း လုံခြုံမှုနှင့် ပတ်သက်သော အတွေ့အကြုံ ရှိကဖျော်ပြပေးပါ။

(၃) ဆေးကုသမှု လုပ်ငန်းများတွင် လူနာများ ဘေးအန္တရာယ်ကင်း လုံခြုံမှုအစဉ်အလာ (Patient Safety Culture) ဆိုင်ရာလုပ်ငန်းများ လုပ်ဆောင်ရာတွင် အခက်အခဲများ ရှိပါ သလား။ အားနည်းချက် နှင့်အားသာချက်များကို ဖော်ပြပေးပါ။

(၄) ဆေးကုသမှု လုပ်ငန်းများတွင် လူနာများ ဘေးအန္တရာယ်ကင်း လုံခြုံမှုအစဉ်အလာ

(Patient Safety Culture) လုပ်ဆောင်ရာတွင် ပိုမိုတိုးတက်စေရန် အကြံပြုချက်များ ရှိပါကပြောပေးပါ။

အပိုင်း (ဃ) အသေးစိတ်မေးမြန်းခြင်းတွင် ပါဝင်ရန်သဘောတူညီမှု ပုံစံ

ကျွန်ုပ်သည် ဆေးကုသမှု လုပ်ငန်းများတွင် လူနာများ ဘေးအန္တရာယ်ကင်း လုံခြုံမှုနှင့် ပတ်သက်သော သဘောထားအမြင်အား လေ့လာသော သုတေသနတွင် ပါဝင်ရန် ဖိတ်ခေါ်ခြင်းခံရပါသည်။ ဤသုတေသနတွင် ပါဝင်သောကြောင့် ကျွန်ုပ်အတွက် တိုက်ရိုက် အကျိုးကျေးဇူးမရှိပါ။ ဤသုတေသန တွင် ကျွန်ုပ်သည် ဖော်ပြချက်များကို ဖတ်ရှုပြီးဖြစ်ပါသည်။ မရှင်းလင်းသည့်မေးခွန်းများကိုလည်း မေးမြန်းနိုင်၍ ၎င်းတို့ကို ကျွန်ုပ်သည်ကျေနပ်စွာဖြေဆိုပေးပါသည်။ ကျွန်ုပ်ဆန္ဒအလျောက် ဤသုတေသန တွင် ပါဝင်ရန် သဘောတူပါသည်။

သုတေသနတွင်ပါဝင်သူအမည် -..................................

သုတေသနတွင်ပါဝင်သူလက်မှတ် -..................................

ရက်စွဲ - ....

Informed consent form

Institutional Review Board

University of Public Health, Yangon

Name of Investigator – Dr Thanda

Title of research - “Patient safety culture in Yangon Children Hospital, 2019”

Part (A) Informed consent form for self-administered questionnaires

1. Introduction

I am Dr Thanda, a doctor and a candidate of Master of Hospital Administration attending at University of Public Health, Yangon. I am doing research on “Patient safety culture in Yangon Children Hospital, 2019”

2. Purpose of the research

This study is to assess “Patient safety culture in Yangon Children Hospital, 2019”.

3. Type of Research Intervention

This research will involve your participation in self-administered questionnaires about thirty minutes.

4. Participant Selection

You are being invited to take part in this research because we feel that you will interest in “Patient safety culture in Yangon Children Hospital”.

5. Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether participate or not.

6. Procedure

I would like to invite you to take part in this research project. If you accept, you have to answer in self-administered questionnaires about thirty minutes. The questionnaires will include information about your background information and patient safety culture in your hospital. You do not have to answer any question or take part in the discussion if you feel the issue(s) are too personal or if talking about them

makes you uncomfortable.

7. Benefits

Participation in this study will not benefit the participant directly but your participation is likely to help us find out more about how to solve the problem of patient safety in our health care organization.

8. Confidentiality

I will not be sharing information about your participation in this study to anyone outside. The information that I collect from this research project will be kept private.

9. Sharing the Results

The knowledge that I get from research will be only to the persons who have the responsibility for this study. I will then publish the results to be read only by the interested people.

10. Who to contact

If there are any queries before, during and after the study you can directly contact the investigator Dr Thanda, Phone – 095196884 or via email thanda.td77@ gmail.com. This proposal had been reviewed and approved by the Institutional Review Board, University of Public Health, Yangon which is a committee whose task is to make sure that research participants are protected from harm. If you wish to find out more about the committee, contact the secretary of the committee at University of Public Health, Yangon, No. 246, Myo-ma Kyaung Street, Latha Township, Yangon, 11311. Office phone +95 1395213, +95 1395214 extension: 23/25.

Part (B) Consent form

I have been invited to participate in research about "Patient safety culture in Yangon Children Hospital". I know that I will have to answer the self-administered questionnaires which will take about thirty minutes. I am aware that there may be no benefit to me personally. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked to my satisfaction. I consent voluntarily to be a participant in this study.

Name of participant -----------------------------------

Signature of participant -----------------------------------

Date -----------------------------------

Part (C) Informed consent form for in-depth interview

1. Introduction

I am Dr Thanda, a doctor and a candidate of Master of Hospital Administration attending at University of Public Health, Yangon. I am doing research on "Patient safety culture in Yangon Children Hospital, 2019"

2. Purpose of the research

This study is to assess "Patient safety culture in Yangon Children Hospital, 2019".

3. Type of Research Intervention

This research will involve your participation for in-depth interview about fifteen minutes.

4. Participant Selection

You are being invited to take part in this research because we feel that you will interest in "Patient safety culture in Yangon Children Hospital".

5. Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether participate or not.

6. Procedure

I would like to invite you to take part in this research project. If you accept, you have to answer for in depth interview about fifteen minutes. It will be taken at a place which is comfortable for you. The questionnaires will include patient safety culture**.** You do not have to answer any question or take part in the discussion if you feel the issue(s) are too personal or if talking about them makes you uncomfortable.

7. Benefits

Participation in this study will not benefit the participant directly but your participation is likely to help us find out more about how to solve the problem of patient safety in our health care organization.

8. Confidentiality

I will not be sharing information about your participation in this study to anyone outside. The information that I collect from this research project will be kept private.

9. Sharing the Results

The knowledge that I get from research will be only to the persons who have the responsibility for this study. I will then publish the results to be read only by the interested people.

10. Who to contact

If there are any queries before, during and after the study you can directly contact the investigator Dr Thanda, Phone – 095196884 or via email thanda.td77@ gmail.com. This proposal had been reviewed and approved by the Institutional Review Board, University of Public Health, Yangon which is a committee whose task is to make sure that research participants are protected from harm. If you wish to find out more about the committee, contact the secretary of the committee at University of Public Health, Yangon, No. 246, Myo-ma Kyaung Street, Latha Township, Yangon, 11311. Office phone +95 1395213, +95 1395214 extension: 23/25.

ANNEX (3) Data Collection Form (Myanmar and English)

ရန်ကုန်ကလေးဆေးရုံကြီး၏ဆေးကုသမှုလုပ်ငန်းများတွင်
လူနာများဘေးအန္တရာယ်ကင်းလုံခြုံမှုအစဉ်အလာဆိုင်ရာမေးခွန်းလွှာ

စတင်ချိန်..............ပြီးဆုံးချိန်............
အမှတ်စဉ်..................

လူနာများဘေးအန္တရာယ်ကင်းလုံခြုံမှု ဆိုသည်မှာ ဆေးကုသမှုနှင့်ဆက်စပ်၍ လူနာများတွင် အန္တရာယ်မကျရောက်စေရန် ဆေးကုသမှုလုပ်ငန်းစဉ်တွင် ဖြစ်ပေါ်တတ်သော အမှားများ၊ ကာကွယ်၍ရသော နောက်ဆက်တွဲဆိုးကျိုးများကို ကာကွယ်ခြင်းကို ဆိုလိုပါသည်။

လူနာများအန္တရာယ်မကျရောက်ခြင်း ဆိုသည်မှာ မှားယွင်း ဆောင်ရွက်မှုများသည် လူနာများ အတွက် ထိခိုက်မှုတစ်စုံတစ်ရာမရှိခြင်းကို ဆိုလိုပါသည်။

အပိုင်း (က)လုပ်ငန်းခွင်အတွေ့အကြုံဆိုင်ရာမေးခွန်းများ

၁။ အသက် ______________________

၂။ ကျား/မ ______________________

၃။ ရန်ကုန်ကလေးဆေးရုံကြီးတွင်တာဝန်ထမ်းဆောင်ခဲ့သည်မှာအချိန်ကာလမည်မျှ ရှိပြီနည်း။

---------------------(ပြည့်ပြီး လ/နှစ်)

၄။ ယခုလက်ရှိဌာန/အဆောင်တွင် တစ်ပတ်လျှင်နာရီမည်မျှကြာအောင် အလုပ်လုပ်

ရသနည်း။

--------------------(နာရီ)

၅။ ယခုလက်ရှိရာထူးတွင် တာဝန်ထမ်းဆောင်နေသည်မှာ အချိန်ကာလ မည်မျှရှိ ပြီနည်း။

------------------(ပြည့်ပြီး လ/နှစ်)

၆။ ယခုမညျသညျ့ရာထူးတှငျ တာဝနျထမျးဆောငျနပေါသနညျး။

၇။ ယခုမညျသညျ့ဌာန/အဆောငျတှငျ တာဝနျကခြေသေနညျး။

၈။ သငျယခုဆောငျရှကျနသေောရာထူးနရောအရ လူနာမငြ်းအား တိုကျရိုကျကိုငျတှယျ ကုသမှုမငြ်း ပေးရပါသလား။

အပိုငျး (ခ) ဆေးကုသမှုနငျ့ဆကျစပျ၍ လူနာမငြ်းတှငျ ဖွစျပျေါတတျသော အမှားမငြ်း၊ ကာကှယျ၍ရသော နောကျဆကျတှဲဆိုးကိုးမြ်ားကို ကာကှယျခွငျးနငျ့ ပတျသကျ၍ ယုံကွညျမှုနငျ့ အပွုအမူဆိုငျရာ မေးခှနျးမငြ်း

၁	ဌာနတှငျးစုပေါငျးဆောငျရှကျခွငျး	လုံးဝသဘောတူပါသညျ	သဘောတူပါသညျ	မသိပါ	သဘောမတူပါ	လုံးဝသဘောမတူပါ

(၁)	ဌာနအတွင်းဝန်ထမ်းများအချင်းချင်း အပြန်အလှန်ကူညီလေ့ ရှိသည်။					
(၂)	အလုပ်များ အလျင်အမြန် ပြီးမြောက်အောင်ဆောင်ရွက် ရန် လိုအပ်သောအခါများတွင် မိမိတို့အားလုံး စုပေါင်းဆောင်ရွက် လေ့ရှိသည်။					
(၃)	လက်ရှိလုပ်ကိုင်နေသော ဌာနတွင် တစ်ဦးနှင့်တစ်ဦး လေးစား စွာဆက်ဆံလေ့ရှိသည်။					
(၄)	ဌာန/အဆောင်အတွင်း တစ်နေရာတွင် အလုပ်များနေပါက ထိုအဆောင်အတွင်းရှိ အခြား နေရာများမှဝန်ထမ်း များက ကူညီလေ့ ရှိသည်။					
၂	ဆေးကုသမှု လုပ်ငန်းများတွင် လူနာများ၏ ထိခိုက်မှု အန္တ ရာယ်ကာကွယ်ခြင်းတွင် အထက်လူကြီးများ၏ မပြတ်မနား ချက် နှင့် တိုးတက်အောင်ဆောင်ရွက်ခြင်း					
(၁)	လူနာများအားကုသမှုပေးရာတွင် ဘေးအန္တရာယ်ကင်းစေရန် အတွက် ဆောင်ရွက်ထားရှိသော ညွှန်ကြားချက်များအတိုင်း လိုက်နာဆောင်ရွက်ပါက မိမိအထက်လူကြီးမှ ချီးကျူးလေ့ ရှိသည်။					
(၂)	ဆေးကုသမှုလုပ်ငန်းစဉ်တွင်လူန ာများ၏ဘေးအန္တရာယ် ကင်း ရှင်းမှုအတွက် မိမိတို့၏အကြံပြုချက်များအား အထက်လူကြီး မှ လက်ခံစဉ်းစားပေးလေ့ ရှိသည်။					

		လုံးဝသဘောတူပါသ	သဘောတူပါ

		ညျ	ညျ
(၃)	အလုပ္အကိုင္ရွာေဖြသူမ်ားအတြက္ လမ္းညႊန္ခ်က္။ ရွိခဲ့ေသာ ကုမၸဏီ/အစိုးရ အသစ္ခ်ိတ္ဆက္ေပးျခင္း။ အလုပ္ပ်က္သြားသည့္အခါမ်ိဳးတြင္လူနာမ်ား၏ ဘ၀အေနအထားသစ္ အလုပ္ အကိုင္တစ္ခုခု ရရွိေရးအတြက္ ႀကိဳးပမ္းပါသည္။ လိုက္ေလ်ာညီေထြမႈ မရွိသည့္အခါမ်ိဳးတြင္ အထက္လူႀကီးမ ထံသို႔ တင္ျပ လုပ္ေဆာင္ႏိုင္ေစရန္ ကူညီေပးလိုပါသည္။		
(၄)	ဆက္သြယ္ေရးလုပ္ေဆာင္ရာတြင္ အဆင့္မ်ားကို မိမိတို႔ရဲ႕ လူနာမ်ားအား သတင္းေပး ပါ၀င္ေဆြးေႏြးခြင့္ ေပးရန္လိုသည္။		
၃	အဖြဲ႕အစည္းအလိုက္ လက္ေတြ႕ပိုင္း စည္းကမ္းမ်ား ကိုင္တြယ္မႈဆိုင္ရာ		
(၁)	မိမိတို႔၏ ဆက္သြယ္မႈဆိုင္ရာတြင္ လူနာမ်ား၏ ဘ၀အေျခအေန လုံၿခံဳမႈအတြက္ အထူးဂ႐ုစိုက္ပါ ေဆာင္ရြက္ေပးရမည္။		
(၂)	လူနာမ်ား၏ ဘ၀အေျခအေနကို ထိခိုက္ေစေသာ မွားယြင္း ေဆာင္ရြက္မႈမ်ားမွ သတိထားရမည္ ျဖစ္ၿပီး ႀကိဳတင္ ကာကြယ္ႏိုင္မည့္ နည္းလမ္းမ်ားကို ရွာေဖြေပးပါသည္။		
(၃)	ျပႆနာမ်ားႏွင့္ ဘ၀အေျခအေနလုံၿခံဳမႈ မ်ား၏ ေဆာင္ရြက္ထားရွိမႈအေပၚသက္ေရာက္မႈမ်ားအား ျပန္လည္ သုံးသပ္ေဆာင္ရြက္ရမည္။		
၄	လူနာမ်ားအားကာကြယ္ရာတြင္ ဘ၀အေျခအေနလုံၿခံဳမႈအတြက္ အုပ္ခ်ဳပ္ မႈပိုင္းမွ ေထာက္ပံ့မႈမ်ား		
(၁)	ဆရာ၀န္အုပ္ခ်ဳပ္မႈပိုင္းမွ လူနာမ်ား၏ ဘ၀အေျခအေနလုံၿခံဳမႈအတြက္ အေကာင္းဆုံး ေဆာင္ရြက္ႏိုင္ရန္ ဆရာ၀န္အတြင္း လူနာအေန ရာယူမႈျဖစ္ႏိုင္ေသာ ေနရာမ်ားကိုရွာေဖြၿပီး လိုအပ္ေသာဆရာ၀န္ သုံးပစၥည္းကိရိယာမ်ားကို အျပည့္အစုံ ေထာက္ပံ့ေပးပါသည္။		
(၂)	ဆက္သြယ္မ လုပ္ငန္းစဥ္တြင္ လူနာမ်ား၏ ဘ၀အေျခအေနလုံၿခံဳမႈ အတြက္ ဆရာ၀န္အုပ္ခ်ဳပ္မႈပိုင္းမွ အဓိက ဦးစားေပး၍ ပံ့ပိုး ေဆာင္ရြက္ေပးပါသည္။		

		လုံး၀သေဘာ ေတူပါသည္	သေဘာ တူပါသ	မသိ ပါ	သေဘာ မတူ	လုံး၀သ ေဘာမတူ

			ညျ		တူပါ	တူပါ
(၃)	လူနာများ ထိခိုကျမှုအန်တရာယျကွဲ ပွီးမသာ လူနာများ၏ ဘဴး ကျေးလုံခွံမှုကို အဓိကထားဆဴေချရှကျ ရန္ဴ ဆဴးရုံအုပျခုပြျမ ပိုျးမ စိတျဝင်ျစားလဴ့ရှိသညျ။					
၅	လူနာများဆဴးကုသရာ တှငျ ဘဴးကျေးလုံခွံမှုအတှကျ ခွံငုံ သိမွငျနားလညျခွငျး					
(၁)	လူနာများ ဆဴးကုသမှုပဴးခွငျး၌ လုပျငန်းပိုမိုပွီးမွဴာကျစေ ရန္ဴအတှကျ ဘဴးအန်တရာယျကျေးစ ရေန္ဴ ခမြတျထားသဴာ ညှန္ဴကွားခကြျများကို လမြှဲ၍ ဆဴာငျရှကျခွငျး မှိုးမှရိပါ။					
(၂)	လူနာများဘဴးအန်တရာ ယျကျေးစရေန္ဴ ဆဴာငျရှကျထား ရှိသဴာ ညှန္ဴကွားခကြျများသညျ ပွညျ့စုံကဴာငျ းမှန္ဴ ပါသညျ။					
(၃)	ယခုအခွအေနတေှငျ လူနာများ ဘဴးအန်တရာယျ ကရြောကျ စနေိုငျသဴာ အမှားအယှငျးများ					

	မဖွစျပားရခွငျးမာ ကုသိုလျ ကံကဓေါငျး၍ ဖွစျသညျ။					
(၄)	လကျရှိဌာနတှငျ လူနာမြား၏ ဘေးကငျးလုံခွုံမှုကို ထိခိုကျစေ နိုငျသဓော အကွဓောငျးအရာမြားရှိသညျ။					
၆	မားယှငျးခကြျနငျ့ပတျသကျ၍ ပွနျလညျသုံးသပျဆှေးနှေးခွငျး	အမွဲတမျး	မြးသဓေါအားဖွငျ့	တစျခါတရံ	ရှားရှားပါးပါး	ဘယျသဓောအခါမ
(၁)	လူနာမြား၏ ဘေးကငျးလုံခွုံမှုကို ထိခိုကျစသေဓော မားယှငျး ဆဓောငျရှကျမ သတငျးပို့ တငျပွခကြျမြားအတှကျ မညျသို့ ပွငျပွငျ ဆဓောငျရှကျရမညျကို ပွနျလညျ သိရှိပါသညျ။					
(၂)	လူနာမြား၏ ဘေးကငျးလုံခွုံမှုကို ထိခိုကျစသေဓော မားယှငျး ဆဓောငျရှကျမှုမြားရှိလာပါက အထကျလူကွီးသို့ သတငျးပို့ပါ သညျ။					

		အမွဲတမျး	မြးသဓေါအားဖွငျ့	တစျခါတရံ
(၃)	လူနာမြား၏ဘေးကငျးလုံခွုံမှု ကိုထိခိုကျစသေဓောမားယှငျးဆဓောငျ			

	ရှကျမှုမငြး ထပျမံမပွလုပျမိစရေနျ ဆတောငျရှကျရမညျ့ နညျးလမျး မငြးကို ညိနှိုငျးဆုံးနေးကွပါသညျ။			
၇	ဆကျဆံပွတောဆိုမှုပုငျလငျးခွငျး			
(၁)	လူနာမငြး၏ ဘငေးကငျးလုံခွုံမှုကို ထိခိုကျစသေတော မားယှငျး ဆတောငျရှကျမှုမငြးကို တှဖ့ရှိခဲ့လငြျ မိမိတို့ အခငြျးခငြျး သတိပငေး တားမွစျရမညျ။			
(၂)	လူနာမငြး၏ ဘငေးကငျးလုံခွုံမှုအတှကျ ဆတောငျရှကျ ထားရ သတော ညှနျကွားခကြျမငြးနငျ့ ပတျသကျ၍ မရငျးလငျးသညျ့ အခကြျမငြး ကို မိမိ၏အထကျလူကွီးအားလှတျလပျစှာမေး မွနျးနိုငျသညျ။			
(၃)	မိမိတို့ ဝနျထမျးမငြးမ မရငျးလငျးသတော ညှနျကွားခကြျမငြးကို ပွနျလညျမေးမွနျးရနျကွတောကျရှုံသညျ။			
၈	အကွတောငျးကွားရသညျ့ အရေးကွီးဖွစျရပျမငြး ဆိုငျရာ			
(၁)	လူနာမငြး၏ဘငေးကငျးလုံခွုံမှု ကို ထိခိုကျစသေတော မားယှငျး ဆတောငျရှကျမှုမငြးအား မကျူးလှနျခငျ အခိျနြမီ ပွပွငျဆတောငျ ရှကျနိုငျခဲ့သညျ့ ဖွစျစဉျမငြး ကွံ့တှဖ့ခဲ့လငြျ အထကျလူကွီး ထံသို့ (အမွဲတမျး၊မငြးသတောအားဖွငျ့၊တခါတရံ၊ရားရားပါးပါး) သတငျးပို့ အကွတောငျးကွားသငျပါသညျ။ (သို့)အကွတောငျး မကွားသငျပါ။ ဥပမာ(၁)-လူနာအား သှေးမားသှငျးမိမလိုဖွစျပွီးမ အခိျနြမီပွနျ လညျ ပွပွငျနိုငျခဲ့ခွငျး။ ဥပမာ(၂)-လူနာအား သှေးအုပျစုမားရငေးပွီးနတောကျ အခိျနြမီ ပွနျလညျပွငျနိုငျခဲ့ခွငျး။			

		အမွဲတမျး	မငြးသတောအား ဖွငျ့	တခါတရံ	ရားရငးပါးပါး	ဘယျသတော အခါမ
(၂)	လူနာအား ဘငေးအန်တရာယျရှိရနျ အလားအလာမရှိသတော အမား မငြးအားပွလုပျမိသတော ဖွစျစဉျမငြးကွံ့တှဖ့ခဲ့လငြျ အထကျ လူကွီး ထံသို့(အမွဲတမျး၊မငြးသတောအားဖွငျ့၊ တခါတရံ၊ ရားရား					

	ပါးပါး)သတငျးပို့ အကွောငျး ကွားသငျ့ပါသညျ။ (သို့)အကွောငျး မကွားသငျ့ပါ။ ဥပမာ(၁) - လူနာအားမားယှငျး၍ BP Chart ,I/O Chart တငျမိခွငျး။ - သှေးအဖွတေ့ူမဢြးအား Chart မား၍ တှဲမိခွငျး။ ဥပမာ(၂)-အဖွမေဢြးကိုစဗျနိုငျးသ ညျထကျပို၍ရေးပေးခွငျး။ -လူနာအားမားယှငျး၍ သှေးအဖွတေ့ူမဢြး အားပေး မိခွငျး။					
(၃)	လူနာအား ဘေးအနႅတရာယျရိနိုငျပွီး အနႅတရာယျမကရြောကျ ခဲ့သော အမားမဢြးအား ပွုလုပျမိသော ဖွဈစဉျမဢြး ကွုံတှေ့ခဲ့လငျြအထကျလူကွီးထံ သို့ (အမွဲတမျး၊ မဢြးသော အားဖွငျ့၊ တခါတရံ၊ရားရားပါးပါး) သတငျးပို့ အကွောငျး ကွားသငျ့သညျ။(သို့) အကွောငျးမကွား သငျ့ပါ။ ဥပမာ(၁)-လူနာမဢြးအား ဆေးမားထိုးခွငျး၊ သှေးမား သှငျး ခွငျး။ ဥပမာ(၂)-လူနာမဢြးအတှကျ သှေးမားပေးခွငျး၊ သှေးအဖွမေားပေးခွငျး။					
၄	ဌာနအခငြျးခငြျးပူးပေါငျးဆောငျ ရှကျခွငျး	လုံးဝသ ဘောတူပါ သညျ	သဘေ ာတူပါ သညျ	မ သိ ပါ	သ ဘေ ာမ တူပါ	လုံးဝသ ဘောမ တူပါ

(၁)	ဆေးရုံအတွင်းရှိ ဌာန/အဆောင်အခြေအနေ များ အလုပ်ပမာဏ အတွက် တက်လုပ်ဆောင်ရန် လိုအပ်လာသောအခါ ကောင်းမွန်သော ပူးပေါင်းဆောင်ရွက်မှုရှိသည်။					
(၂)	အကောင်းဆုံးသော လူနာစောင့်ရှောက်မှုပေးရန် အတွက် ဆေးရုံတွင် ဌာန/အဆောင်အခြေအနေများသည် အလုပ်ကို အတူတကွပူးပေါင်းလုပ်ဆောင်သည်။					

		လုံးဝသဘောတူပါသည်	သဘောတူပါသည်	မသိပါ	သဘောမတူပါ	လုံးဝသဘောမတူပါ
(၃)	ဆေးရုံရှိဌာန/အဆောင်အခြေအနေများသည်ပူးပေါင်း ဆောင်ရွက်ရာတွင် စိတ်ပါဝင်စားမှုမရှိပါ။					
(၄)	အခြားဌာန/အဆောင်မှ ဝန်ထမ်းများနှင့်အတူ အလုပ်လုပ် ရာတွင် အဆင်မပြေမှုများ မကြာခဏ တွေ့ကြုံရပါသည်။					
၁၀	ဝန်ထမ်းအင်အားအခြေအနေ					
(၁)	မိမိတို့ဌာနတွင်လုံလောက်သော ဝန်ထမ်းအင်အား ရှိသည်။					
(၂)	မိမိတို့ဌာနတွင် ဝန်ထမ်းများအလုပ်ချိန် (နာရီ) ကြာရှည်စွာ လုပ်ဆောင်နေရသည့် လူနာများ ကုသနေရသည့်အတွက်					

	အကဓာျပးဆုံးဖွစျသည္။					
(၃)	နဖ့စား/အဌားဝန္ထမ္းမ်ား ပိုၡ်ခန္ထားခွငျးသည္ လူနာ မ်ားကို အကဓာျပးဆုံးကုသမှုပဒေးနိုငျသ ည္။					
(၄)	လူအမ်ား အုပျစုလိုကျဖွစျပၚျသဓာ အရငေးပၚျ အခွအေနေ မ်ားတှငျ ကုသရငေးလုပျငန္းမ်ားကို အလငြျအမွန္ ပွီးအဓာျ အထူးကွိုးစား ဆဓာငျရှကျ ရသည္။					
၁၁	တာဝန္ခ်ိန္ကူးပွဓာငျးခွငျးန ငျ့ဒ ၫနကူးပွဓာငျးခွငျးမ်ား					
(၁)	အဆဓာငျတစျခုမတစျခုအကူး အပွဓာငျးမ်ား၌ လူနာမ်ား အတှကျဘေးအန်တရာယျ ကွံ့တှ့ေရသည္ ဖွစျစဥ္မ်ား ရ သည္။					
(၂)	လူနာအတှကျလိုအပျသဓာ ကုသမှုညှန္ကွားခကြျမ်ားကို ဆဓာငျရှကျရမည့္ အခ်ိန္အလိုကျ ဆဓာငျရှကျနိုငျရန္ အတှကျ တာဝန္ကူး ပွဓာငျးခ်ိန္မ်ား၌ ဝန္ထမ္း အခငြျးခငြျးအသိပဒေး ပွဓာကွားရန္ (Overပဒေးခွငျး) တာဝန္လှဲပွဓာငျးစာအုပျ၌ ရငေးသားရန္ပကြျ ကှကျခွငျးမ်ား မကွာခဏရှိသည္။					

		လုံးဝသဘဓာတူပါသ ည္	သဘဓ

(၃)	လူနာ၏အမည် R/N၊ ရောဂါရာဇဝင်၊ စစ်ဆေးတွေ့ရှိမှုများကို မှန်ကန်ရှင်းလင်း ပြည့်စုံစွာရေးသားခြင်းမရှိ၍ လူနာဆောင်/ဌာန အခြားခြား ပူးပေါင်းကုသမှုများတွင် ရောဂါအမည် မှားခြင်း၊ ဆေးကုသမှုမှားခြင်း၊ သွေးအုပ်စုမှားခြင်း၊ပြဿနာများ မကြာခဏ ပေါ်ပေါက်လေ့ရှိသည်။		
(၄)	ဤဆေးရုံ၌ လူနာများဘေးကင်းလုံခြုံမှုကို ထိခိုက်နိုင်သော ပြဿနာများသည် တာဝန်ကူးပြောင်း ချိန်များတွင် ဖြစ်ပေါ် လေ့ရှိသည်။		
	မှားယွင်းစွာဆောင်ရွက်မှုများအတွက်အရေးယူဆောင်ရွက်ခြင်းဆိုင်ရာ		
(၁)	လူနာများ၏ ဘေးကင်းလုံခြုံမှုကို ထိခိုက်စေသော မိမိတို့၏ မှားယွင်း ဆောင်ရွက်မှုများကို အခြားဝန်ထမ်းများမှ အပြစ်တင်မည်ဆိုး ဖြစ်နေကြသည် ဟုခံစားရသည်။		
(၂)	မိမိတို့၏ မှားယွင်းဆောင်ရွက်မှုများကို အထက်လူကြီးသို့ တင်ပြအစီရင်ခံခြင်းသည် အကြောင်းကြားရုံ သက်သက်သာဖြစ်ပြီး ပြဿနာ တစ်ခုအား တင်ပြသည်ဟုမယူဆပါ။		
(၃)	မိမိတို့၏မှားယွင်းဆောင်ရွက်မှုများကိုအမှုထမ်းသက် စာအုပ်တွင် ရေးသွင်းမည်ကိုစိုးရိမ်ပါသည်။		
၁၃	လူနာများ၏ဘေးကင်းလုံခြုံမှု အဆင့်	လုံးဝမကောင်းပါ	အသ းပါ
(၁)	ကျေးဇူးပြု၍ ရန်ကုန်ကလေးဆေးရုံကြီးတွင် သင်ယခု အလုပ်လုပ်နေ သောယူနစ်တွင်ရှိသည့် လူနာများ၏ ဘေးကင်းလုံခြုံမှုအဆင့်ကို ဖော်ပြပေးပါ။		

၁၄	လူနာများ၏ ဘေးကင်းလုံခြုံမှုကို ထိခိုက်စေသော မှားယွင်းဆောင်ရွက်မှုသတင်းပို့မှုအကြိမ်အရေအတွက်	လုံးဝမပို့ဘူး ပါ	တစ်ကြိမ်/နှစ်ကြိမ်ပို့ပါ သည်
(၁)	လွန်ခဲ့သော(၁၂)လအတွင်း လူနာများ၏ ဘေးကင်း လုံခြုံမှုကို		

	ထိခိုက်စေသောမှားယွင်းသောဆေးပေးမှုများကိုသတိပေးပို့ခဲ့ပါသည်။		

Interview guidelines for In-depth interview

အသက် (ပြည့်ပြီးအသက်) - ____________ နှစ်

ကျား/မ - ____________

ရာထူး - __________________________

ပညာအရည်အချင်း - ___________________________

အစိုးရ ဝန်ထမ်းလုပ်သက် - ________________ နှစ်

လက်ရှိဆေးရုံတွင်တာဝန်ထမ်းဆောင်နေသော လုပ်သက် - _________________ နှစ်

(၁) ရန်ကုန်ကလေးဆေးရုံကြီး၏ ဆေးကုသမှုလုပ်ငန်းများတွင် လူနာများ ဘေးအန္တရာယ် ကင်း လုံခြုံမှု အစဉ်အလာ (Patient Safety Culture) အနေနဲ့ လုပ်ဆောင်နေမှု များ ရှိပါသလား။

(၂) မိမိကိုယ်တိုင် (သို့) အခြားသူများရဲ့ ဘေးအန္တရာယ်ကင်း လုံခြုံမှုနှင့် ပတ်သက်သော

အတွေ့အကြုံ ရှိက ပြောပြပေးပါ။

(၃) ဆေးကုသမှု လုပ်ငန်းများတွင် လူနာများ ဘေးအန္တရာယ်ကင်း လုံခြုံမှုအစဉ်အလာ (Patient Safety Culture) ဆိုင်ရာလုပ်ငန်းများ လုပ်ဆောင်ရာတွင် အခက်အခဲများ ရှိပါသလား။ အားနည်းချက် နှင့်အားသာချက်များကို ဖြေပေးပါ။

(၄) ဆေးကုသမှု လုပ်ငန်းများတွင် လူနာများ ဘေးအန္တရာယ်ကင်း လုံခြုံမှုအစဉ်အလာ (Patient Safety Culture) လုပ်ဆောင်ရာတွင် ပိုမိုတိုးတက်စေရန် အကြံပြုချက်များ ရှိပါက ပြောပေးပါ။

Questionnaire for Patient Safety Culture in Yangon Children Hospital

Patient Safety is the prevention of errors and adverse effects to patients associated with health care.

No Harm: A failure has taken place, but this did not have any impact on the patient.

Part-A Background Information

1. Age __________ years
2. Gender Male

Female

3. How long have you worked in this hospital?

    ________________________ (months/years completed)

4. How many hours per week do you work in the current ward/department?

    ________________________ (hours)

5. How long have you worked in your current profession?

    ________________________ (months/years completed)

6. What is your current profession?

    ____

7. What is your primary work area or unit in this hospital?

    ____

8. In your staff position, do you typically have direct interaction or contact with patients?

    Yes

    No

Part-B Patient Safety Culture Dimensions and Items

1	Teamwork Within Units	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
(1)	People support one another in this unit.					
(2)	When a lot of work needs to be done quickly, we work together as a team to get the work done.					
(3)	In this unit, people treat each other with respect.					
(4)	When one area in this unit gets really busy, others help out.					
2	**Supervisor/Manager Expectations & Actions Promoting Patient Safety**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.					
(2)	My supervisor/manager seriously considers staff suggestions for improving patient safety.					
(3)	Whenever pressure builds up, my supervisor/manager wants					

	us to work faster, even if it means taking shortcuts.					
(4)	My supervisor/manager overlooks patient safety problems that happen over and over.					

3	**Organizational Learning-Continuous Improvement**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	We are actively doing things to improve patient safety.					
(2)	Mistakes have led to positive changes.					
(3)	After we make changes to improve patient safety, we evaluate their effectiveness.					
4	**Management Support for Patient Safety**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	Hospital management provides a work climate that promotes patient safety.					
(2)	The actions of hospital manage-ment show that patient safety is a top priority.					
(3)	Hospital management seems interested in patient safety only after an adverse event happens.					
5	**Overall Perceptions of Patient Safety**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	Patient safety is never sacrificed to get more work done.					
(2)	Our procedures and systems are good at preventing errors from happening.					
(3)	It is just by chance that more serious mistakes don't happen around here.					
(4)	We have patient safety problems in this unit.					

6	**Feedback & Communication About Error**	**Always**	**Most of the time**	**sometime**	**Rarely**	**Never**
(1)	We are given feedback about changes put into place based on event reports.					
(2)	We inform about errors that happen in this unit.					
(3)	In this unit, we discuss ways to prevent errors from happening again.					
7	**Communication Openness**	**Always**	**Most of the time**	**sometime**	**Rarely**	**Never**
(1)	Staff will freely speak up if they see something that may negatively affect patient care.					
(2)	Staff feel free to question the decisions or actions of those with more authority.					
(3)	Staff are afraid to ask questions when something does not seem right.					
8	**Frequency of events Reported**	**Always**	**Most of the time**	**sometime**	**Rarely**	**Never**
(1)	When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?					
(2)	When a mistake is made, but has no potential to harm the patient, how often is this reported?					
(3)	When a mistake is made that could harm the patient, but does not, how often is this reported?					

9	**Teamwork Across Units**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	There is good cooperation among hospital units that need to work together.					
(2)	Hospital units work well together to provide the best care for patients.					
(3)	Hospital units do not coordinate well with each other.					
(4)	It is often unpleasant to work with staff from other hospital units.					
10	**Staffing**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	We have enough staff to handle the workload.					
(2)	Staff in this unit work longer hours than is best for patient care.					
(3)	We use more agency/ temporary staff than is best for patient care.					
(4)	We work in "Crisis mode" trying to do too much, too quickly.					
11	**Handoffs & Transitions**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	Things "is fall between the cracks" when transferring patients from one unit to another.					
(2)	Important patient care information is often lost during shift changes.					
(3)	Problems often occur in the exchange of information across hospital units.					
(4)	Shift changes are problematic for patients in this hospital.					
12	**Non-punitive Response to Errors**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**

(1)	Staff feel like their mistakes are held against them.					
(2)	When an event is reported, it feels like the person is being written up, not the problem.					
(3)	Staff worry that mistakes they make are kept in their personnel file.					
13	**Patient safety grade**	**Failing**	**Poor**	**Accept-able**	**Very good**	**Excell-ent**
	Please give your work area/unit in this hospital on overall grade on patient safety.					
14	**Number of event reported**	**No event**	**1-2 event**	**3-5 event**	**6-10 event**	**11-20 event**
	In the past 12 months, how many event reports have you filled out and submitted?					

Interview guidelines for In-depth interview

Age (completed age in year) -

Sex -

Designation -

Education -

Government service -

Service in current hospital -

1) For promoting Patient Safety Culture, what tasks are being done in your hospital?
2) If you have experience concerned with Patient Safety Culture, please describe.
3) During implementation of Patient Safety Culture, which challenges do the hospital face?

   Please mention strength & weakness in implementation of Patient Safety Culture.
4) To improve Patient Safety Culture, if you have any suggestion or opinion?

ANNEX (4) SCORING SYSTEM

1	**Teamwork Within Units**	**Strongly**	**Agree**	**Neither**	**Disagree**	**Strongly**

		Agree				Disagree
(1)	People support one another in this unit.	1	2	3	4	5
(2)	When a lot of work needs to be done quickly, we work together as a team to get the work done.	1	2	3	4	5
(3)	In this unit, people treat each other with respect.	1	2	3	4	5
(4)	When one area in this unit gets really busy, others help out.	1	2	3	4	5
2	**Supervisor/Manager Expectations & Actions Promoting Patient Safety**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.	1	2	3	4	5
(2)	My supervisor/manager seriously considers staff suggestions for improving patient safety.	1	2	3	4	5
(3)	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.	5	4	3	2	1
(4)	My supervisor/manager overlooks patient safety problems that happen over and over.	5	4	3	2	1

3	**Organizational Learning-Continuous Improvement**					
(1)	We are actively doing things to improve patient safety.	1	2	3	4	5
(2)	Mistakes have led to positive changes.	1	2	3	4	5
(3)	After we make changes to improve patient safety, we evaluate their effectiveness.	1	2	3	4	5
4	**Management Support for Patient Safety**					
(1)	Hospital management provides a work climate that promotes patient safety.	1	2	3	4	5
(2)	The actions of hospital management show that patient safety is a top priority.	1	2	3	4	5
(3)	Hospital management seems interested in patient safety only after an adverse event happens.	5	4	3	2	1
5	**Overall Perceptions of Patient Safety**					
(1)	Patient safety is never sacrificed to get more work done.	1	2	3	4	5
(2)	Our procedures and systems are good at preventing errors from happening.	1	2	3	4	5
(3)	It is just by chance that more serious mistakes don't happen around here.	5	4	3	2	1
(4)	We have patient safety problems in this unit.	5	4	3	2	1
6	**Feedback & Communication About Error**	**Always**	**Most of the time**	**Some-time**	**Rarely**	**Never**
(1)	We are given feedback about changes put into place based on event reports.	1	2	3	4	5
(2)	We inform about errors that happen in this unit.	1	2	3	4	5
(3)	In this unit, we discuss ways to prevent errors from happening again	1	2	3	4	5

7	**Communication Openness**	**Always**	**Most of the time**	**Some-time**	**Rarely**	**Never**
(1)	Staff will freely speak up if they see something that may negatively affect patient care.	1	2	3	4	5
(2)	Staff feel free to question the decisions or actions of those with more authority.	1	2	3	4	5
(3)	Staff are afraid to ask questions when something does not seem right.	5	4	3	2	1
8	**Frequency of events Reported**	**Always**	**Most of the time**	**Some-time**	**Rarely**	**Never**
(1)	When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	1	2	3	4	5
(2)	When a mistake is made, but has no potential to harm the patient, how often is this reported?	1	2	3	4	5
(3)	When a mistake is made that could harm the patient, but does not, how often is this reported?	1	2	3	4	5
9	**Teamwork Across Units**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	There is good cooperation among hospital units that need to work together.	1	2	3	4	5
(2)	Hospital units work well together to provide the best care for patients.	1	2	3	4	5
(3)	Hospital units do not coordinate well with each other.	5	4	3	2	1
(4)	It is often unpleasant to work with staff from other hospital units.	5	4	3	2	1
10	**Staffing**	**Strongly Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	We have enough staff to handle the workload.	1	2	3	4	5
(2)	Staff in this unit work longer hours than is best for patient care.	5	4	3	2	1
(3)	We use more agency/ temporary	5	4	3	2	1

	staff than is best for patient care.					
(4)	We work in “Crisis mode” trying to do too much, too quickly.	5	4	3	2	1

11	**Handoffs & Transitions**	**Strongl y Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	Things "is fall between the cracks" when transferring patients from one unit to another.	5	4	3	2	1
(2)	Important patient care information is often lost during shift changes.	5	4	3	2	1
(3)	Problems often occur in the exchange of information across hospital units.	5	4	3	2	1
(4)	Shift changes are problematic for patients in this hospital.	5	4	3	2	1
12	**Non-punitive Response to Errors**	**Strongl y Agree**	**Agree**	**Neither**	**Disagree**	**Strongly Disagree**
(1)	Staff feel like their mistakes are held against them.	5	4	3	2	1
(2)	When an event is reported, it feels like the person is being written up, not the problem.	5	4	3	2	1
(3)	Staff worry that mistakes they make are kept in their personnel file.	5	4	3	2	1
13	**Patient safety grade**	**Failing**	**Poor**	**Accept-able**	**Very good**	**Excellen t**
	Please give your work area/unit in this hospital on overall grade on patient safety.					
14	**Number of event reported**	**No event**	**1-2 event**	**3-5 event**	**6-10 event**	**11-20 event**
	In the past 12 months, how many event reports have you filled out and submitted?					

ANNEX (5) Gantt Chart

Month	August				September				October				November				December			
Week	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Protocol preparation																				
Protocol defend																				
Pilot study – Preparation for data collection																				
Data collection																				
Data entry and analysis																				
Preparation for Grand Presentation																				
Thesis preparation																				
Submission of Thesis (Draft)																				
Thesis defend																				
Correction and Submission of thesis																				

ANNEX (6) Results of Patient Safety Culture

Sr No	Patient Safety Culture	Positive answer		Negative answer	
		N	%	N	%
(1)	Teamwork within units				
1	People support one another in this unit.	103	(100.0)	0	(0.0)
2	When a lot of work needs to be done quickly, we work together as a team to get the work done.	103	(100.0)	0	(0.0)
3	In this unit, people treat each other with respect.	101	(98.1)	2	(1.9)
4	When one area in this unit gets really busy, others help out.	64	(62.1)	39	(37.9)
(2)	Supervisor/Manager Expectations & Actions Promoting Patient Safety				
1	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.	65	(63.1)	38	(36.9)
2	My supervisor/manager seriously considers staff suggestions for improving patient safety.	84	(81.6)	19	(18.4)
3	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.	60	(58.3)	43	(41.7)
4	My supervisor/manager overlooks patient safety problems that happen over and over.	76	(73.8)	27	(26.2)
(3)	Organizational Learning-Continuous Improvement				
1	We are actively doing things to improve patient safety.	100	(100.0)	0	(0.0)
2	Mistakes have led to positive changes.	97	(94.2)	6	(5.8)
3	After we make changes to improve patient safety, we evaluate their effectiveness.	90	(87.4)	13	(12.6)
(4)	Management Support for Patient Safety				
1	Hospital management provides a work climate that promotes patient safety.	71	(68.9)	32	(31.1)

Sr No	Patient Safety Culture	Positive answer		Negative answer	
		N	%	N	%
2	The actions of hospital management show that patient safety is a top priority.	77	(74.8)	26	(25.2)
3	Hospital management seems interested in patient safety only after an adverse event happens.	49	(47.6)	54	(52.4)
(5)	Overall Perceptions of Patient Safety				
1	Patient safety is never sacrificed to get more work done.	79	(76.7)	24	(23.3)
2	Our procedures and systems are good at preventing errors from happening.	85	(82.5)	18	(17.6)
3	It is just by chance that more serious mistakes don't happen around here.	85	(82.5)	18	(17.6)
4	We have patient safety problems in this unit.	67	(65.0)	36	(35.0)
(6)	Feedback & Communication About Error				
1	We are given feedback about changes put into place based on event reports.	70	(68.0)	33	(32.0)
2	We inform about errors that happen in this unit.	96	(93.2)	7	(6.8)
3	In this unit, we discuss ways to prevent errors from happening again	87	(84.5)	16	(15.5)
(7)	Communication Openness				
1	Staff will freely speak up if they see something that may negatively affect patient care.	99	(96.1)	4	(3.9)
2	Staff feel free to question the decisions or actions of those with more authority.	88	(85.4)	15	(14.6)
3	Staff are afraid to ask questions when something does not seem right.	52	(50.5)	51	(49.5)
(8)	Frequency of events Reported				
1	When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	82	(79.6)	21	(20.4)

Sr No	Patient Safety Culture	Positive answer		Negative answer	
		N	%	N	%
2	When a mistake is made, but has no potential to harm the patient, how often is this reported?	48	(46.6)	55	(53.4)
3	When a mistake is made that could harm the patient, but does not, how often is this reported?	94	(91.3)	9	(8.7)
(9)	Teamwork Across Units				
1	There is good cooperation among hospital units that need to work together.	98	(95.1)	5	(4.9)
2	Hospital units work well together to provide the best care for patients.	93	(90.3)	10	(9.7)
3	Hospital units do not coordinate well with each other.	81	(78.6)	22	(21.4)
4	It is often unpleasant to work with staff from other hospital units.	45	(43.7)	58	(56.3)
(10)	Staffing				
1	We have enough staff to handle the workload.	24	(23.3)	79	(76.7)
2	Staff in this unit work longer hours than is best for patient care.	72	(69.9)	31	(30.1)
3	We use more agency/ temporary staff than is best for patient care.	60	(58.3)	43	(41.7)
4	We work in “Crisis mode” trying to do too much, too quickly.	6	(5.8)	97	(94.2)
(11)	Handoffs & Transitions				
1	Things “is fall between the cracks” when transferring patients from one unit to another.	46	(44.7)	57	(55.3)
2	Important patient care information is often lost during shift changes.	83	(80.6)	20	(19.4)
3	Problems often occur in the exchange of information across hospital units.	84	(81.6)	19	(18.4)

Sr No	Patient Safety Culture	Positive answer		Negative answer	
		N	%	N	%
4	Shift changes are problematic for patients in this hospital.	79	(76.7)	24	(23.3)
(12)	Non-punitive Response to Errors				
1	Staff feel like their mistakes are held against them.	49	(47.6)	54	(52.4)
2	When an event is reported, it feels like the person is being written up, not the problem.	81	(78.6)	22	(21.4)
3	Staff worry that mistakes they make are kept in their personnel file.	31	(30.1)	72	(69.9)

ANNEX (7) Curriculum Vitae

Name	Dr Thanda
Gender	Female
Date of birth	15.4.1977
Race	Bamar
Religion	Buddhist
Permanent address	No (61), Forest Road, Ahlone Township, Yangon
Phone number	095196884
Email address	thanda.td77@gmail.com
Academic qualification	Dip.Med.Sc (Hospital Administration), (2014), University of Public Health, Yangon M.B.,B.S (2003), University of Medicine (2), Yangon
Employment history	Assistant Director, Yangon Eye Hospital (1.10.2015 to date) Assistant Medical Superintendent, Yangon Eye Hospital (19.8.2014-1.10.2015) Assistant Surgeon, Botataung Township Public Health Department (5.8.2009-18.8.2014) Assistant Surgeon, Phyapon District Hospital (27.10.2006-31.7.2009) Assistant Surgeon, Central Women Hospital, Yangon
Publication	-