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Perspectives of Healthcare Providers Towards Quality and Patient Safety in Healthcare: Systemic Review of Literature

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Abstract

Aim: Quality and patient safety ensure safe, high-quality treatment and staff well-being. This systematic study examines healthcare providers' quality and safety views. Aim of the study was to look for the perspectives that affect the quality and safety.

Methods: Search and selection followed the Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). This was a systematic review of articles in databases such as PubMed and Google Scholar without regard to language or publication date. The study analyzes five healthcare practitioner perspectives: Teamwork, medication errors, time management, workload and conditions, and patient safety culture.

Results: The findings showed that teamwork can simplify goal achievement and that working together makes health providers happier. The findings further showed that time management, patient care, and job unpredictability due to interruptions, unplanned changes in patient-care management, emotional and physical tiredness, and unpredictable schedules or work duties may be out of one's control and may hinder work planning. Teaching providers problem-solving and critical thinking is a major time management factor.

Conclusion: Problem-solving training helps providers manage time. Medication errors endanger patients. Distractions, incorrect doses, and illegible writing cause pharmaceutical errors. To address these issues, doctors must take multiple pharmaceutical error prevention courses. Quality, patient safety, and care require these perspectives.

Recommendations: Policymakers, healthcare administrators, and clinicians must prioritize patient safety for patient safety culture. Health care providers must match the hidden curriculum to the explicit curriculum because it has a big impact on workers. This will foster safety and quality care. Workload greatly affects job quality and patient safety. Increased workloads per person lower work quality, which may harm patients. They need more providers and a lower patient-to-provider ratio to improve patient safety. Healthcare workers struggle with time and job quality.

Keywords: *Quality and patient safety, perspectives, medications errors*

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1.0 INTRODUCTION

Patient safety (PS) is defined as the elimination of any possible damage that might be caused to patients as a consequence of errors that occur during the administration of medical treatment (World Health Organization (WHO), 2011). Within the scope of this term is the elimination of any or all potential dangers that are involved with receiving medical care. Patients who expose themselves to potentially hazardous medical procedures run the risk of suffering injuries as a consequence of the procedure. In the most extreme cases, such patients may even succumb from the operation or be rendered permanently unable to function normally. The rise in occurrences of these catastrophes has led to a heightened awareness of the necessity of cultivating a patient safety culture (Azyabi et al., 2021). Because of this understanding, the medical community has embraced the needs of patients like the quality of work, the treatments the patient get, and access to healthcare. Within the framework of the healthcare administration system, patient safety is quickly becoming an increasingly vital component of long-term strategic planning (Azyabi et al., 2021). There has been a decline in both the quality of care and general level of patient safety as a direct result of the advancements that have been achieved in medical technology over the course of the last several decades (Farokhzadian et al., 2018). Concerns and challenges pertaining to healthcare systems have been significantly more noticeable as a result of a rise in the number of clinical risks and safety mistakes (Farokhzadian et al., 2018).

It is difficult to provide accurate estimates of the scope of the problem. However, it is anticipated that clinical risk and safety mishaps will cause the deaths to millions of people and the incapacitating impairments of millions in the coming years. It is anticipated that one patient out of every ten receiving potentially dangerous treatment at hospitals situated in wealthy nations may get an injury while obtaining treatment at one of these facilities (Farokhzadian et al., 2018). In addition, the chance of getting hurt is much higher in countries that are still in the process of developing as opposed to those that have already reached a state of prosperity (Farokhzadian et al, 2018). For instance, the risk of contracting an illness caused by medical treatment is twenty times higher in some less developed countries in compared to wealthier nations (Farokhzadian et al, 2018). On the other hand, if suitable safety procedures and practices are created and implemented, the vast majority of injuries and deaths that are caused by safety-related concerns are entirely avoidable. This includes both on-the-job injuries and fatalities (WHO, 2019).

As a result of increased risks, there is a growing amount of pressure placed on healthcare organizations to build effective safety cultures so that they can meet the challenges that they face and make improvements in both quality and safety. This is because effective safety cultures allow healthcare organizations to meet their challenges and make improvements in both quality and safety. Healthcare organizations that have strong safety cultures are better able to address the difficulties they are now facing and achieve gains in both quality and safety. The attitude that the culture takes toward the safety of patients is one of the characteristics of the company's culture that is investigated. Specifically, the level of commitment that a health organization has toward patient safety management is determined by values, beliefs, attitudes, perceptions, norms, procedures, competences, and patterns of behavior that are held by individuals and groups (Croll et al, 2012).

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1.1 Objectives of the Study

The aim of this research was to assess the healthcare providers' perspectives on quality and patient safety in healthcare.

The specific objectives were:

1. Describing and synthesizing the problem of patient safety attitudes held by the next generation of healthcare workers (health professional students, newly graduated health professionals, newly registered health professionals, and resident trainees).

2. Evaluating potential differences in next generation of healthcare workers based on the number of years of education received, areas of specialization, and gender.

1.2 Research Question

1. What are the healthcare providers perspectives on quality and patient safety in healthcare?
2. Are there differences among healthcare providers' perspectives on quality and patient safety in healthcare based on their personal and professional characteristics?

1.3 Significance and Contribution

When it comes to rendering high-quality medical treatment, one of the most essential factors that must be taken into consideration is the protection of the patients. This is one of the main reasons why cultivating a culture of greater safety in healthcare facilities is essential to continuously improving care, and it is becoming increasingly common knowledge that this is one of the main reasons. There is a link between a robust safety culture and more successful results in healthcare settings, most notably hospitals. The research will be helpful to the management of the healthcare institutions and policymakers. It will assist them in understanding the effect of their healthcare providers perspectives and coming up with relevant strategies to boost the performance of the providers. The results will be an essential management method for boosting quality management and patient safety in the healthcare sector, since this would increase the performance of healthcare professionals and that of the organization.

2.0 LITERATURE REVIEW

It is now universally acknowledged that productive teamwork is an indispensable resource for the development of health care delivery systems that are both more efficient and more focused on the needs of individual patients (Babiker et al., 2014). To begin, a number of studies have shown that the hazards associated with communication and coordination are prevalent in nature. Observational studies in surgical services indicate that approximately thirty percent of team interactions include a communication failure of some type. Additionally, patients receiving care from providers who have poor teamwork are almost five times more likely to experience complications or death (odds ratio = 4.82, 95% confidence interval [CI]). According to the findings of a significant research conducted in Australia, errors in communication are twice as likely to be the cause of avoidable patient fatalities as errors in technical competence (Rosen et al., 2018). Researchers have found that there are positive associations between the quality of teamwork in inpatient facilities and patients' self-reported satisfaction with their care, with patients receiving care from teams that perform better having higher levels of self-reported satisfaction with their

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treatment. Although the level of importance placed on patient satisfaction has not changed over time, this factor has lately been linked to hospitals' ability to collect payment (Lyu et al., 2013). Patients who get treatment from teams that have better levels of role clarity, mutual trust, and quality information sharing often report lower levels of postoperative pain, higher levels of postoperative functionality, and shorter durations of stay.

Patient safety is a major issue that has to be addressed in the health care worldwide. In many medical institutions, the avoidance to patients and the maintenance of patient safety are translated into a robust culture of patient safety and high-caliber care that is focused on the patient (Alswat et al., 2017). According to Nadarajan et al. (2020) the average positive response rate (APRR) for the Attitudes Toward Patient Safety Questionnaire (APSQ) was greatest for the Team Functioning area (94.6%), and lowest for the Disclosure Responsibility category (68.5%). In six of the nine areas, Malaysian medical students have a positive attitude toward patient safety that exceeds the acceptable threshold of 75%. Overall, students' opinions about disclosure responsibility, professional incompetence, and safety curriculum are worse, with APRR levels of 68.5%, 70%, and 71.1%, respectively. Almaramhy et al. (2011) found that 52.7% of participants self-rated their patient safety knowledge as excellent, compared to 27.3% for particular knowledge concerns. Patient safety was valued by 60.7%. The majority (76.0 to 80.7%) supported peers who made unintended mistakes and did not condemn them. About 44.7 percent of responders agreed that healthcare providers should avoid errors, while 47.3% said they should disclose errors. ILS participants recognized patient safety concerns including problem solving ($P< 0.01$ OR: 3.0) and error control ($P< 0.001$ OR: 2.4) better than their peers. Medical mistake reporting improves patient safety and health care quality. According to Tegegn et al. (2017), more over half (56.6%) of our students agreed or strongly agreed that pharmacists should disclose medical mistakes to patients and their families if they cause damage. If they observed a mistake, most pupils would report it. Similar to this, 73.9% of Dow Medical College medical students said they would report a medical mistake. However, 37.3 percent of students in the present poll said they would keep it to themselves if the inaccuracy didn't hurt. A lack of understanding of "near miss" occurrences and their possible influence on service improvement may explain the large proportion of students who did not recognize the need to correct a "no harm" mistake.

Time management and quality of work is an ongoing struggle that healthcare workers face both in their personal lives and in their working lives. The specific professional obligation of duty to the patient poses difficulties often for those who work in the healthcare industry. Time management in addition to the unpredictability of one's work as a result of interruptions, unanticipated shifts in patient-care management, emotional and physical fatigue, and erratic schedules or work responsibilities, may not be entirely under one's control or subject to modification (Gordon et al, 2014). According to Farokhzadian et al. (2020), the intervention group received significantly higher overall mean scores on nursing care quality as well as its psychosocial and communication components after receiving training in time management skills. This was in comparison to the group that received no such training. Training programs may assist participants acquire new information and abilities, as well as enhance their professional learning and performance on the job. According to Chanie et al. (2020), there was a low percentage of workers that used time management techniques.

The concept of workload is essential to the analysis of performance and quality in healthcare systems. One of the most significant psychological elements that might inspire workers is job

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satisfaction, which has a positive emotional role and is considered to be one of the most essential aspects associated to employees. Employees' feelings about their employment are a major factor in determining their levels of job satisfaction (Rostami et al., 2021). According to Leiter and Maslach' et al. (2003), job control was shown to be a significant factor in employee burnout as well as the amount of work they had to do. Workers are granted the ability to make choices about their work when there is sufficient job control. Midwives and registered nurses have influence over their work environments to a nearly same degree. Reducing the amount of labor required in workers would result in increased levels of job satisfaction, as well as a greater sense of ownership over the responsibilities they were given. The difference in the amount of mental strain that is experienced by nurses and midwives may be ascribed to the working environment with nurses handling a greater volume of patients than midwives (Rostami et al., 2021). A rise in mental burden was associated with a decrease in job satisfaction. The ability to have some level of influence over one's work environment is one factor that should be considered while trying to enhance the working conditions of healthcare professionals and boost levels of job satisfaction. It is vital to build organizational management practices that permit job control (Rostami et al., 2021).

Pharmaceutical mistakes may occur at any stage of the drug management process, including prescribing, transcribing, dispensing, administering, and monitoring (Makary et al., 2016). According to Rodziewicz et al. (2022), distraction is one of the primary factors that contribute to drug mistakes. This factor has been linked to almost 75% of all pharmaceutical mistakes. In addition to their other responsibilities in a hospital, physicians are frequently asked to write drug orders and prescriptions. These responsibilities include examining patients, ordering laboratory and imaging studies, speaking to consultants, rounding on their patients, speaking to patient family members, and conversing with insurance carriers before ordering studies. Even the most careful and skilled of doctors is not immune. In spite of the fact that many medical professionals refuse to admit that these distractions are a problem, research has shown that they are often to blame for pharmaceutical mistakes.

According to Leahy et al. (2018), incorrect dose involves over-dose, under-dose, or additional dosage. An error in dosage occurs when a medication dose that is inappropriate or otherwise different than what was ordered is administered. Errors of omission occur when a scheduled dose of medication is not administered, and an incorrect route of administration occurs when a drug is administered in the wrong manner. Erroneous routes are the most common cause of errors, and the most common cause of incorrect routes is tubing that is adaptable to different connections or lines of access. Because doctors are typically pressed for time, they routinely scrawl down instructions that are illegible, which frequently leads to serious errors in prescription administration. Taking shortcuts while filing medicine orders is a certain way to get yourself involved in a legal dispute. It is fairly uncommon for the practitioner or the pharmacist to be unable to read the order, in which case they will make their best educated guess. If the patient needs the medication immediately, there is an increased likelihood that they may have adverse effects. The majority of hospitals have guidelines that practitioners and pharmacists are required to follow to eliminate such mistakes. For example, if the medication order is unreadable, the physician must be contacted and requested to redo the order so that it is legible (Cohen et al, 2017).

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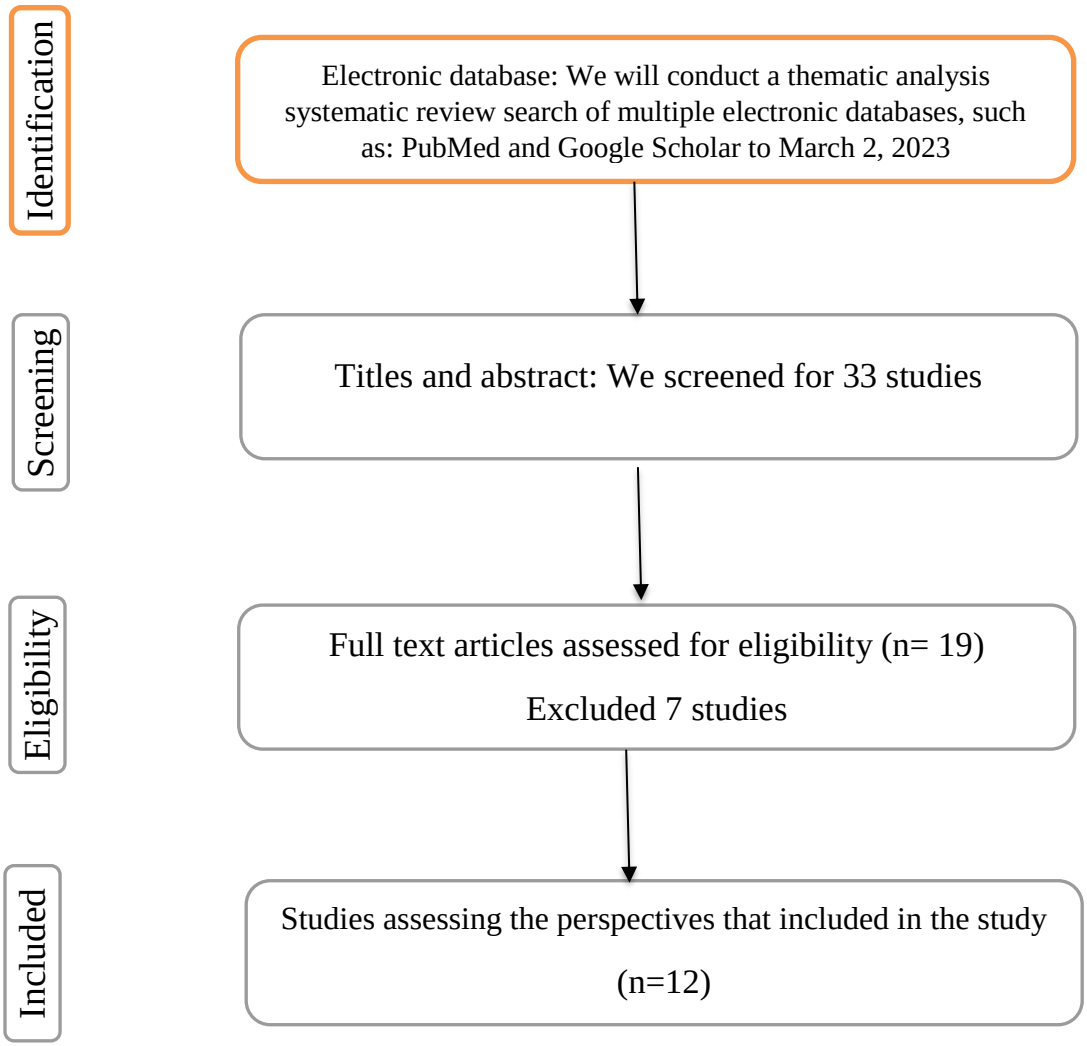
3.0 METHODOLOGY

The search and selection procedure were carried out in accordance with the recommendations included within the Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). The researchers employed a systematic review search of multiple electronic databases, such as PubMed and Google Scholar without regard to language or publication date. The keywords search strategy was used with key words being patient safety and quality, patient safety and quality attitude, quality and safety climate, patient safety competence, patient safety culture, patient safety and quality values, patient safety and quality behavior.

3.1 Inclusion, Exclusion, Data analysis

The inclusion of the study all healthcare providers working in hospital, all perspectives of patient safety and quality. Exclusion criteria involved hospital employees who were not working as healthcare provider. After extracting the data from the previous studies regarding patient safety and quality from the perspective of the healthcare provider. The data will be distributed among the perspectives of the healthcare providers in pt. safety and quality from the previous researches.



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4.0 RESULTS

This study found that the perspectives of the health providers may have an effect on the job they do as well as the attitudes they have. For example, Gordon et al. (2014) indicated that healthcare employees struggle with time management and job quality in their personal and professional lives. Healthcare workers struggle with their patient responsibility. Time management is difficult due to interruptions, unplanned adjustments in patient-care management, emotional and physical weariness, and unpredictable schedules or job duties. Many times, corporate time management technologies don't fulfill patient time management needs. Elaraby et al. (2018) suggest that enhancing the next generation of healthcare workers' attitudes toward quality and patient safety, as well as their skills, knowledge, and safety behaviors, may help create safer healthcare settings. Attitudes determine quality, patient safety, and work atmosphere. Makary et al. (2016) state that pharmaceutical errors may occur when prescribing, transcribing, dispensing, administering, and monitoring. Medication errors are a global killer with WHO estimating that medication errors cost $42 billion each year, this is 0.7% of worldwide healthcare spending. Eldeeb et al. (2016) states that patient safety remains a worldwide healthcare issue. Medical practitioners must decrease patient unintended injuries and enhance patient-centered care to ensure patient safety. Table 1 show how these perspectives has been affected mostly.

Table 1: Summary of the perspectives

Perspectives	Criteria
Teamwork among providers	Effective communication
	job satisfaction
	work climate
Patient safety culture	Team management
	Clear instructions
Quality and time management	Unanticipated shifts in patient-care management, emotional and physical fatigue
	Erratic schedules or work responsibilities
Loads of work among providers and the conditions of work	Heavy workload
	Working hours
	Poor culture
	Mental workload
Medications errors	Distraction
	Illegal writing
	Incorrect dosing

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4.1 Discussion

This study found that there are many perspectives on healthcare providers towards quality and patient safety in healthcare This study focused on five components as follows: Teamwork among providers, patient safety culture, quality and time management, loads of work conditions of work, medication errors, and teamwork among providers.

First, teamwork among health care providers. This study looked into different and multiple studies that this perspective affects the behavior of the provider. According to Rosen et al. (2018), patients receiving care from providers with poor teamwork are nearly five times more likely to experience complications or death. Additionally, communication errors are twice as likely to be the cause of avoidable patient fatalities as technical competence errors. Rosen et al. (2018) discovered a relationship between clinical patient outcomes and collaboration in healthcare settings. Patients who get care from teams with greater levels of role clarity, mutual trust, and quality information exchange often report lower levels of postoperative pain, higher levels of postoperative functioning, and shorter lengths of stay. According to Lyu et al. (2013), there exist positive associations between the quality of teamwork in inpatient facilities and patients' self-reported satisfaction with their care, with patients receiving care from better-performing teams reporting higher levels of self-reported satisfaction with their treatment. Although the value of patient satisfaction has remained constant throughout time, it has recently been connected to hospitals' capacity to collect payment.

The second is the patient safety culture. In this viewpoint, the researchers investigated various researches that show how this perspective influences the provider's conduct. According to Nadarajan et al. (2020), they assessed Malaysian medical students' attitudes toward patient safety. The average positive response rate (APRR) for the Attitudes Toward Patient Safety Questionnaire (APSQ) was highest (94.6%) for team functioning and lowest (68.5%) for disclosure responsibility. Malaysian medical students show a good attitude toward patient safety that surpasses the acceptable level of 75% in six of the nine domains. Reporting medical errors enhances patient safety and health-care quality. According to Tegegn et al. (2017), more than half of the students who participated in the research agreed that pharmacists should reveal medical errors to patients and their families if they cause harm. Most students would report a mistake if they saw one. According to Almaramhy et al. (2011), 52.7% of participants assessed their patient safety knowledge as outstanding, compared to 27.3% for specific knowledge issues while 60.7% of respondents valued patient safety.

The third perspective analyzed was the time management. In this viewpoint, the study analyzed several studies that demonstrate how this perspective changes the provider's behavior. Poor time management strategies have been connected to a variety of various causes, according to Chanie et al, (2020). The most important factors that influence employees' time management practices are personal factors (punctuality, time wasters), administrative and organizational time management obstacles (organizational policy, lack of incentives, performance appraisal), and employees' performance in an organization. According to Farokhzadian et al. (2020), after obtaining time management skills training, the intervention group earned substantially better overall mean ratings on nursing care quality as well as its psychological and communicative components. For that reason, time management is one of the important perspectives.

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The fourth perspective was workload condition. Within the context of this perspective, the researchers conducted analysis of numerous research that indicate how this perspective alters the behavior of the health care providers. According to Leiter and Maslach' (2003), job control was demonstrated to be a key influence in employee burnout as well as the quantity of work they had to perform. According to Rostami et al. (2021), increasing the quantity of labor that is not needed of employees will lead to a rise in the levels of job satisfaction experienced. Also, an increase in mental strain was connected to drop in work satisfaction. Therefore, management strategies should be used to lessen the stress caused by the amount of work that has to be done and to increase the level of task control in order to increase job satisfaction among healthcare workers.

The last perspective was medication errors. In this perspective the researchers examined diverse research that show how this perspective influences the conduct of the provider. Distraction is one of the key variables that lead to medication blunders (Rodziewicz et al., 2022). Almost 75% of all pharmacological errors have been connected to this component. Physicians are regularly required to make medicine orders and prescriptions in addition to their other obligations in a hospital. Despite the fact that many medical practitioners fail to acknowledge the existence of these distractions, research has proven that they are often to fault for pharmacological errors. Incorrect dose (Leahy et al., 2018) includes overdose, underdose, and an extra dosage. A dosage mistake happens when a pharmaceutical dose that is incorrect or otherwise differs from what was prescribed is delivered.

Errors of omission occur when a medication's prescribed dosage is not provided, and inappropriate route of administration happens when a medicine is supplied incorrectly. According to Cohen et al. (2017), unreadable writing has been a concern for both nurses and pharmacists. Due to time constraints, physicians sometimes write down unreadable instructions which frequently leads to major mistakes in prescription administration. Taking shortcuts while making medical orders is a sure way to get oneself in legal trouble. The most effective way to improve quality and patient safety is to create a multifaceted education and preventive approach. The importance of healthcare practitioners working as a team and communicating, as well as encouraging patients to be better aware about their prescriptions, should be emphasized. Medication dispensing mistakes may be decreased with a safety culture.

Because of the connection that exists between the five perspectives and quality and patient safety, it is essential to foster an environment in education and clinical practice that is conducive to high patient safety and quality standards. It's possible that the perspectives are quite widespread throughout all areas of the health care industry, and they're also linked to poorer levels of quality and patient safety. On the other hand, ensuring high quality treatment and the safety of patients may have a beneficial effect on the perspectives of those who work in the healthcare industry. This relationship between the five perspectives and quality and patient safety highlights how insufficient attention to safety culture may trigger a vicious cycle. For example, poor quality and patient safety may lead to problems for the patient, which may in turn lead to decreased quality and patient safety.

4.2 Conclusion

This study examined five healthcare practitioner-impacting perspectives namely teamwork, medication errors, time management, workload and conditions, and patient safety culture. These perspectives showed how their role affected healthcare practitioners. Teamwork can help a team

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accomplish a goal and make it easier. Since the hidden curriculum has a big impact on health care workers, companies that provide health services must make sure it matches the explicit curriculum. This will establish a strong safety culture and promote high-quality care. Workload was one of the most important factors affecting work quality and patient safety. Higher workloads per person lower work quality, which could harm patients. To improve patient safety and care, they need to hire more providers and lower the patient-to-provider ratio.

Healthcare workers battle time management and job quality in their personal and professional lives. Due to their patient-centered duty, healthcare professionals face daily challenges. Time management, patient care, and the unpredictability of one's work due to interruptions, unanticipated shifts in patient-care management, emotional and physical fatigue, and erratic schedules or work responsibilities may not be under one's control. These factors may hinder work planning. One of the biggest factors affecting time management is teaching providers how to solve problems and improve their critical thinking. Teaching healthcare providers problem-solving skills can fix time management issues. Medication errors affect patient safety and care. Examine the causes of medication errors, such as distractions, wrong doses, and illegible writing. Healthcare providers should attend several lectures on pharmaceutical errors and how to fix these issues.

Patient safety culture is affected by team management and clear instructions. Workload and the environment condition are affected by working hours, poor culture, time management, emotional and physical fatigue, erratic schedules or work responsibilities. Medication errors are brought by distraction, poor handwriting, and incorrect dosing.

4.3 Recommendations

Policymakers, healthcare management, and doctors must prioritize patient safety processes for patient safety culture. This will establish a strong safety culture and promote high-quality care. Workload was one of the most important factors affecting work quality and patient safety. Higher workloads per person lower work quality, which could harm patients. To improve patient safety and care, they need to hire more providers and lower the patient-to-provider ratio. Healthcare workers battle time management and job quality in their personal and professional lives. The study recommends that healthcare providers should attend lectures on pharmaceutical errors and how to prevent them to fix these issues. These perspectives are needed to build quality, patient safety, and high-quality care.

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