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# Patient safety culture in home care: experiences of home-care nurses

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**Patient safety culture in home care: experiences of home-care nurses**

*Aim* To explore home-care nurses' experiences of patient safety in their delivery of home care to older clients.
*Background* High-risk organisations, such as the airline industry and the petroleum industry, have long been preoccupied with safety. Only recently has this also become a central theme in health care.
*Method* Four focus group interviews with 20 nurses who work in home care. A qualitative thematic analysis was performed.
*Results* One main theme was identified: struggling with responsibility in different situations. It comprises five subthemes: poor work morale and work ethic; documentation; lack of functional leadership; competence; and lack of updated routines and guidelines.
*Conclusions* Patient safety culture is compromised by a lack of leadership, lack of responsibility among leadership, lack of routines, failure to update procedures, and a lack of knowledge and education among health-care workers.
*Implications for nursing management* Nurse managers need to be made more aware of the dilemmas faced by nurses, how they struggle with their responsibilities, how they experience powerlessness in certain situations, and the lack of support they receive in decision-making.

*Keywords*: elderly, focus groups, home care, patient safety culture, qualitative study

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## Introduction

Concern over patient safety is a recent phenomenon in health care (Stevenson *et al.* 2008, Wagner *et al.* 2009, Deilkås 2010, Wakefield *et al.* 2010), in spite of the fact that safety has long been a preoccupation for high-risk organisations, such as the airline industry and the petroleum industry (IOM 2000). The World Health Organisation (WHO) recently put patient safety on its agenda and released a report on how the culture of patient safety affects health organisations (WHO 2008). Although patient safety culture has become a central theme in health care (Stevenson *et al.* 2008, Wagner *et al.* 2009, Deilkås 2010, Wakefield *et al.* 2010), there is still no common definition. However, one of the most common definitions of culture is that given by Cooper (2003) as 'the way we do things in an organisation'. A good safety culture emphasises how tasks are followed through, organisational learning, teamwork, open communication,


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feedback and non-punitive responses to errors (Cooper 2003, Castle & Sonon 2006). Deilkås (2010) emphasises that a good safety culture is very important in maintaining patient safety. Patient safety involves the anticipation and prevention of injuries or unfortunate events arising from health-care processes (Vincent 2006). Obstacles to patient safety within the health-care system and factors that can compromise patient safety include particular situations, teams, personnel, tasks or the organisation itself (Reason 1997, Vincent *et al.* 1998, Cooper 2003, Ödegård 2006, Lang *et al.* 2008). In nursing, patient safety also encompasses those nursing care functions for which the profession has sole responsibility (Berland *et al.* 2008).

Research concerning patient safety has so far concentrated on the area of acute inpatient departments (Castle & Sonon 2006, Lang *et al.* 2008, Masotti *et al.* 2010) and only limited data exist concerning the quality of the safety culture in primary care (Wagner *et al.* 2009). Although patient safety is important for health-care institutions (Chappy 2006, Berland *et al.* 2008, Rush *et al.* 2008), recent studies have shown that older patients in both hospitals and primary care constitute a high-risk group for adverse events (Madigan & Tullai-McGuinness 2004, Ödegård & Andersson 2006, Masotti *et al.* 2010). However, the failure to emphasise patient safety among those caring for older patients may be attributed to shortcomings in coordination, communication, collaboration, assessments, monitoring, administration or education (Castle & Sonon 2006, Scott-Cawiezell *et al.* 2006, Masotti *et al.* 2010). A recent review of home care noted a prevalence of unfortunate adverse events ranging from 4 to 15% (Masotti *et al.* 2010). It also reported that unfortunate events could compromise patient safety in home care because they clearly exist and adversely influence patient care, patient outcomes, family or support care and resource use (Masotti & McColl 2005). Masotti *et al.* (2010) identified various categories of unfortunate events in home care such as adverse drug events, line-related events, such as catheter-related blood stream infection, catheter site infections and line/catheter occlusion, technology-related events, infections and urinary catheter infections, wounds and falls. A more recent quantitative study has shown that the causes of unfortunate events in health care often lie predominantly within the organisation. Leadership, personnel competence, routines and personnel factors can also play a role (Ödegård & Andersson 2006). In addition, a recent qualitative study reported that factors in the work-place, such as leadership, governance, employee fatigue and team communication, might influence patient safety in home care (Lang *et al.* 2008).

Previous studies have addressed patient safety culture in hospitals or in primary care, but only a few have examined the safety of older patients in home care (Ödegård 2006, Madigan 2007, Lang *et al.* 2008, Stevenson *et al.* 2008). In Norway, home care is regulated by law and is organised differently from nursing in hospitals or in nursing homes. Furthermore, home care is organised according to geographical boundaries and it forms an integral part of the health-care service within communities. The responsibilities of home-care nurses include the continuation of medical treatment, teaching and guidance, administrative duties, coordination of patient health care, and the observation of a patient's situation to evaluate their ongoing care requirements (Fermann & Næss 2008).

Because older patients often have more symptoms and behavioural problems and a higher level of functional impairments, they are at a higher risk of adverse events (Madigan 2007). A recent WHO (2008) report emphasises that further research is required to examine patient safety in home care.

### Aim

The aim of this study was to explore home-care nurses' experiences of patient safety in their delivery of home care to elderly patients.

## Methods

An exploratory qualitative research design (Polit & Beck 2006) was used to explore nurses' experiences of patient safety in home care. Focus group interviews were used as an appropriate method for evaluating attitudes, knowledge and experiences in the health-care field (Barbour & Kitzinger 1997). The focus group is a qualitative method by which complex themes can be discussed and analysed with more than one person. Focus group interviews were also chosen because they allow the researcher to explore the interactional processes that takes place among group members (Kitzinger 1994), and they can be used to observe the collaborative process of meaning construction (Kitzinger 1994).

### Participants

Four focus groups were assembled consisting of 20 nurses from the home-care sector in Norway.

Twenty-four nurses were invited to participate in the study and four declined. Two communities were chosen to participate and the nurses came from various fields within the home-care sector. The selection criteria were: (1) the groups could be composed of female or male licensed nurses working within home-care services; (2) the participants did not hold a nursing management position, to guarantee that they all had direct contact with patients. Those who fulfilled the criteria to participate in the study received verbal and written information about the study from the nursing leadership. Those who wished to participate returned a written consent form for participation. Appointments for the interviews and additional information concerning the study were provided to participants during their telephone conversations with the first author.

All participants were female, in the age range 23–56 years. The mean age was 31 years. The nurses' work experience within home care was 1–12 years, with a mean of 6 years' experience. Two of the participants were specialized in elderly care and another was specialized in oncological nursing.

## Data collection

The interviews lasted for 1.5–2 hours, and were conducted by the first author, who acted as a moderator. The responsibility of the first author was to moderate the discussion, posing introductory and open-ended questions. The first author also kept the discussions fluent and ensured that the discussions between the participants were relevant to the theme provided. The last author offered suggestions, observations, helped with notations and ensured that the recording equipment was operating properly. A topic guide and open-ended questions were used to keep the discussions flowing and to ensure that the informants adhered to the intended theme. The theme for the group discussion was 'patient safety culture in home care'. The moderator encouraged the participants to speak of their experiences concerning patient safety in home care. An example of the questions asked was 'Can you describe your experiences regarding safety culture, and how this compromises patient safety?' To obtain a complete description, participants were asked to elaborate on their statements using questions such as 'Can you describe that in more detail?' and 'Can you give an example?' The interviews were recorded on tape and listened to several times before they were transcribed verbatim by the first author.

## Thematic analysis

According to Polit and Beck (2008), a thematic analysis essentially involves the identification of patterns and regularities, as well as inconsistencies. The first step involved analysing the text from all four focus groups to identify expressions of patient safety culture in home care. The intention was to understand the meaning of the whole text of the focus groups. The text revealed that participants struggled with responsibility in certain situations. The authors therefore agreed to interpret the entire text as conveying one main theme at a higher level of abstraction: 'struggling with responsibility'. The text was then analysed to identify the themes and subthemes that could be sorted into tabular form. According to DeSantis and Ugarriza (2000), a theme is an abstract entity that brings meaning and identity to a current experience and its various manifestations. Hence, a theme captures and unifies the nature or basis of an experience into a meaningful whole. In this process, the researchers validated the text by discussing how it could be understood and interpreted (Table 1). The interpretation of the themes and subthemes was important in reaching a consensus about the meaning of the text, because it allowed us to sort out and label the underlying meanings embedded in the quotations (Granheim & Lundman 2004, Polit & Beck 2006).

## Trustworthiness

Awareness of the need to establish the trustworthiness of the qualitative research process is based on Lincoln and Guba (1985). In our study, the credibility of the research was confirmed through the process of ongoing discussion of the findings and analysis by the authors until they reached a consensus. Moreover, on completion of the focus groups, participants were given a summary of the subjects that emerged, and were invited to confirm these and to add further information. All authors read the transcripts independently,

**Table 1**
Overview of the main theme and subthemes

| *Main theme* | *Struggling with responsibility in different situations* |
|---|---|
| Subthemes | Poor work morale and work ethic<br>Documentation<br>Lack of functional leadership<br>Competence<br>Lack of updated routines and guidelines |

and discussed their content repeatedly, thus ensuring confirmability.

## Findings

One main theme was identified from the analysis: struggling with responsibility in different situations. It comprised five subthemes: poor work morale and work ethic; documentation; lack of functional leadership; competence; and lack of updated routines and guidelines.

### Struggling with responsibility in different situations

In the interviews, the nurses expressed concerns over their responsibility for patient safety. This responsibility was experienced as a burden placed upon them in the form of different demands. They found that transferring this responsibility to the home-care leaders was a way of protecting themselves and removing their feelings of powerlessness. Their concerns were concentrated on the lack of safety in many situations throughout their working day, in terms of poor work morale and work ethic, documentation, lack of functional leadership, competence, and a lack of updated routines and guidelines.

*Poor work morale and work ethic*

In the group discussions, the nurses described a work morale and work ethic that was not always optimal. They also pointed out that the level of interest in patient safety varied among nurses:

> 'You have groups that are not at all concerned with patient safety, only with their pay cheque, but others who are very concerned and interested in patient safety. And then you have some who just want to get away and accept this lack of interest in their jobs and the work-place.'
>
> (FG3, P5)

*Documentation*

The nurses pointed out that because they worked in shifts, the transfer of documentation between colleagues during hand-over was haphazard. This was an economic saving but compromised patient safety. The following statement exemplifies this:

> 'You receive word that you can read the report when you have already visited two patients, so it is not uncommon that nurses sit down at 9:30 to read a report that should have been read at 7:15. It just doesn't get done. But we save money, shift work is economical. This compromises patient safety. Reports are not read ahead of time and this also affects the quality of patient care'.
>
> (FG1, P2)

The nurses also reported that some of their colleagues did not want to take responsibility for this documentation because they were not familiar with the currently used electronic documentation system 'Gerica', and were not interested in learning how to use it. Consequently, information was relayed to others by chance, if at all. The nurses also questioned their individual responsibilities, as illustrated by the following comments:

> 'The fact is that many different personnel work these shifts and oral information is not good enough if there is no documentation; this can easily lead to problems'.
>
> (FG2, P2)

> 'It can be a while before the next person receives the correct information. This could definitely use improvement'.
>
> (FG2, P4)

*Lack of functional leadership*

The nurses were concerned that unskilled personnel performed the nurses' duties and they attributed this to a lack of leadership and economic concerns. They were concerned that uneducated personnel visited patients alone. The nurses were of the opinion that there was a lack of definition in who could perform nursing duties, as illustrated by the following statement:

> 'The assistants and assistant nurses are given a mini course and then they can be put on all types of shifts. This has to do with leadership and the pressure to save money and does not take into account patient safety. There are no clear guidelines as to who can perform nurses' duties'.
>
> (FG2, P6)

*Competence*

The nurses discussed the different aspects of competence related to patient safety. This discussion primarily concerned uneducated personnel performing duties that required formal nursing education. Despite their lack of education, these personnel

performed nurses' duties when there was a shortage of nurses:

> 'It is difficult to find personnel in the summer months; there are few educated nurses looking for a summer job. We end up with 16–17-year-olds driving around on a moped. How responsible is this, you ask'.
>
> (FG3, P1)

It was clear that the lack of education among the assistants and the employment of temporary personnel in areas outside their area of competence were concerns for the nurses in terms of patient safety. They pointed out that this lack of education was crucial and these personnel could not maintain hygiene standards, undertake the appropriate documentation, or perform the relevant duties. Several of the informants made statements such as the following:

> 'As I see it, it is often that education is lacking in the new personnel, both with hygiene and documentation; most of them fall into this category. It is much too sloppy'.
>
> (FG4, P4)

In these interviews, the nurses stated that patient safety was compromised by the shortage of nurses. This was especially noted during the weekends, when the nurse covering a second nurse's shift had his/her own patients in addition to the patients of the other nurse, with whose backgrounds and families they were unfamiliar. The nurses stated that it was often only by good luck that things went well at all. The following statement exemplifies this:

> 'It seems like in home care they want action, action, action, and things go according to minimal standards. Usually things go well. I don't know. There is a "never mind" attitude from the leaders. Is this OK? One day things will go wrong; there is too much luck involved'.
>
> (FG1, P2)

*Lack of updated routines and guidelines*

The nurses reported that they worked with no routines or guidelines, or with incorrect or outdated ones. They lacked written guidelines, which was a problem for the new personnel and in stressful situations, where practical procedures had to be performed quickly. Several of the nurses expressed this as follows:

> 'There are routines, but they are not updated, and this lack of updating is a problem'.
>
> (FG1, P5)

> 'I think about routines and guidelines, but I need my leader to agree with me… I miss that we do not have more collaboration. I have tried to say something but I don't feel it is a priority'.
>
> (FG1, P2)

In contrast, some of the informants said that in their work-places, there was an increasing awareness of the need for new routines. As an example, those responsible for the nursing profession were cited as working quickly to establish new routines:

> 'Some of those responsible for the nursing profession have stated that there is something to be said for taking action right away. We will do it this way now and put these new routines into action, this is now clear…'.
>
> (FG3, P3)

## Discussion

The aim of this study was to explore home-care nurses' experiences of patient safety in their delivery of home care to elderly patients. The findings have identified one main theme, struggling with responsibility in different situations, comprising five subthemes: poor work morale and work ethic; documentation; lack of functional leadership; competence; and lack of updated routines and guidelines.

The informants revealed a struggle with their own, their co-workers' and their leaders' responsibilities. According to Kim (2000), moral responsibility is a phenomenon that can be identified in nursing practice, and includes the cognitive, behavioural, social and ethical aspects of clinical practice. According to patient safety guidelines, nurses have sole responsibility (Berland *et al.* 2008). The meaning of responsibility in nursing practice has not received much attention in the empirical literature, even though nurses face several ethical challenges in their daily practice (cf. Lindh *et al.* 2007). Feelings of uncertainty, pain and loneliness were cited by Sørlie (2001). The nurses seemed to be particularly burdened in the home-care sector, especially when they felt they could not handle a situation. They seemed to fall short of their ideal of being a good nurse. According to Higuchi Smith *et al.* (2002), a significant change is needed in nursing practice to address the increased responsibility of nurses to deal with complex clinical situations with limited support. Thus, ethical and responsible decision-making appears to be one of the most difficult aspects of

practice for home-care nurses. However, to be able to change oneself, one must create a compromise that might lead to future behaviours. According to Lindh *et al.* (2007), one way to solve this problem morally in nursing practice is to develop a relational way of responding to the needs of others that is not restricted to correct actions, but is relational and responsive practice that uses knowledge and collective action (Hartrick Doane 2002).

Concerns over poor morale and ethics in the work situation appeared to increase the nurses' concerns about patient safety. In nursing, reflection is a recognized method of arriving at best practice. According to Jasper (2003), a practitioner using reflection can think through alternative possibilities and determine the consequences for all involved. A study of moral responsibility in nursing practice proposes that reflection is important for the development of an inner compass, and that this can serve as a guideline in the training of nurses (Lindh *et al.* 2007).

This study describes the lack of a framework for oral discussions, which was attributed to economic considerations. This can lead to a patient receiving less than optimal care. To successfully change this situation, a conscious effort among politicians is required, as is an improvement in their vision of patient safety when economic frameworks are decided. This study also reveals a lack of necessary documentation, which would contribute to good and safe nursing practice. Norwegian legislation (The Health Personnel Act of 2 July 1999) states that health-care workers are obliged to document their working practices in the medical records of the patient. Refusal to use an electronic documentation system was reported in a previous study also (Moen & Obstfelder 2006). Other studies have found that documentation was accorded less status and priority than patient care, and was regarded as excessively time-consuming (Payne *et al.* 2000, McGarry 2008). Nurse managers must meet the challenge of communicating to their co-workers the importance of their obligations for oral discussion and documentation in patient health and care during hand-overs and throughout the working day.

Our informants confirmed wide variations in the competence of co-workers that could compromise patient safety, for which they held their leaders and economic management responsible. The work-force situation regarding personnel and competence is important if nurses are to provide ethical and responsible health care. According to Olsvold (2003), the question of worth within health care is coupled to ethics and there is a strong tendency to assign moral responsibility to the individual, a state that does not relate to the economic frameworks for professional work. Ethics should be coupled to the framework conditions, and to social, political and institutional relationships (Olsvold 2003).

Loyalty to the system and its frameworks can be very strict in nursing, and consequently, nurses often overlook irresponsible practices and do not report them to their leaders. This is not consistent with Norway's Patients' Rights Act of 2 July 1999. Under this law, nurses are obliged to report and/or warn authorities when patients are at risk of receiving irresponsible or questionable treatment. Loyalty to the organisation should not hinder this.

The findings of this study reveal that nurses must tolerate routines that are not updated and guidelines that lead to problems when they have to tackle unforeseen situations that can decrease patient safety practises. Norwegian legislation (The Health Personnel Act of 2 July 1999) obliges nurse managers to provide safety guidelines and procedures to ensure the safety of all patients (Moen *et al.* 2002). Earlier research into patient safety has found that in the consideration of patient safety, there has been a shift from the individual to the system level (Ödegård 2006, Lang *et al.* 2008). Hjort (2007) also maintains that leaders are responsible for the patient safety culture that is established and practised in their departments.

## Conclusion

Patient safety culture in the home-care sector is compromised by a lack of leadership, failure to update routines and procedures, and a lack of knowledge and education among health-care workers. Nurse management and leadership need to become more aware of the dilemmas that home-care nurses experience because of these shortcomings.

## Implications for nursing management

There is room for improvement in several aspects of nursing management to protect patient safety and promote best practice in this area. An important implication of our study is that clear steps should be taken to establish meetings of nurses to address these issues. The main topics of these meetings should include the dilemmas experienced by nurses as they struggle with responsibility. Nurses need support to reduce their feelings of powerlessness. One way to handle this challenge is to support nurses in decision-making; such support could become the responsibility

of leadership and nursing management. Giving support to nurses in decision-making is important for several reasons: to reduce nurses' experience of excessive responsibility; to clarify who is in charge; and to express interest in all the situations that can threaten the safety of patients. Most importantly, nursing management needs to listen more to nurses and the challenges they experience in making decisions about patient safety.

## Conflict of interest

The authors report no conflict of interest. The authors alone are responsible for the content and writing of this paper.

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## Ethical approval

Permission for data collection and registration was granted by the Norwegian Social Science Data Services (No. 21 931). Participants provided consent to participate in the project. All participants were informed by the authors' confidentiality agreements, the assurance of participant anonymity, and how the data would be presented. It was emphasised that participation was optional and that participants were free to withdraw from the study without explanation. No data were collected that could be used to identify the participants.

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